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Vallerie Hancock

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Walden University
2019

Abstract

Clinicians' Attitudes Toward Sex Offender Treatment

by

Vallerie Hancock

MC, University of Phoenix, 1999

BA, University of Arizona, 1996

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

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Abstract

Clinician attitudes toward a client have a significant influence on outcomes for that client's treatment. Exploring the attitudes of clinicians toward sex offenders can provide additional insights into methods to improve treatments for this population. The purpose of this qualitative grounded theory study was to examine the attitudes of clinical professionals who work with sex offenders to identify the specific ways that these attitudes influenced professional behaviors and client interactions. Grounded theory was used to move beyond a general description of the issue to formulate a theory regarding clinician work with sex offenders and its implications. The sample comprised 10 clinical professionals who worked with sex offenders in community mental health agencies. Open coding and axial coding were used to generate themes from in-depth semistructured interviews to collect data from clinicians who treated sex offenders. Findings indicated that the professionals were mostly concerned for the behavior of sex offenders, were willing to work with them despite feelings of anger and disgust and were curious about the possibility of treatment. Participants treated sex offenders like any other clients but emphasized the importance of safety during treatment. Participants balanced their obligations to the profession and the client with negative images and views of sex offenders. These professionals struggled when providing treatment to sex offenders but described strategies for coping or overcoming negative feelings, emotions, and biases. Clinicians can use these findings to deliver better planned care to this population, resulting in better therapeutic outcomes for sex offenders.

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Dedication

This dissertation is dedicated to the inmates at Arizona State Prison Complex-Aspen SPU.

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Chapter 1: Introduction to the Study

Social attitudes toward sex offenders have indicated significant stereotypes and biases permeate how society has viewed these perpetrators. Miller (2010) noted that as far back as 1911, leaders of various states included language in their laws proclaiming that sex offenders were nothing more than "defective delinquents" and/or "criminal psychopaths" (p. 2096). Although these labels were reinforced in the context of a criminal justice system that promoted offender rehabilitation over punishment, Miller argued that, by the 1970s, rehabilitation rarely worked to meet the needs of this group. Therefore, attitudes of the criminal justice system and society once again shifted, with negative labels remaining with a general belief that most sex offenders could not be rehabilitated (Miller, 2010).

Miller's (2010) observations were, to some extent, reinforced by Thornton (2013) who noted that current treatments for sex offenders were still evolving. Thornton (2013) argued that the methods of the modern era of treatment, which began in the early 1990s, were "somewhat effective" (p. 62) and appeared to represent a departure from older treatment methods, which were deemed ineffective. However, Thornton (2013) noted that individuals labeled as sex offenders often faced challenges in acquiring any type of treatment. In addition to challenges associated with the effectiveness of treatment, issues derived from the abilities and willingness of clinicians to work with this population (Thornton, 2013). Due to these current gaps in treatment options for sex offenders, it is not surprising to find that this group faces ongoing challenges for rehabilitation and reintegration into the community (Thornton, 2013).

Despite significant barriers existing for the treatment of sex offenders, evidence has shown that treatment of this group can be effective for rehabilitating and reducing recidivism rates (Sanghara & Wilson, 2006). Although there is a lack of empirical research showing ways to address the needs of sex offenders, case study and anecdotal evidence indicates treatment can be useful for improving outcomes for this population (Charles, 2010). Nonetheless, literature on the topic of sex offenders remains limited by focusing on policy efforts to address community needs related to safety and protection against crimes committed by this group (Kernsmith, Craun, & Foster, 2009).

The topic under investigation in this study was clinician attitudes toward the treatment of sex offenders. The research was warranted due to the nature of the therapeutic relationship and its implications for client health and outcomes. Sex offenders represent a socially despised group that might not fully benefit from therapy because of the negative attitudes of clinicians. Understanding and working to improve these attitudes might have important implications for rehabilitating sex offenders and improving outcomes for both the offender and society. With these issues in mind, the current chapter provides a foundation for the work and includes the following sections: Background of the Problem; Research Questions; Purpose of the Study; Theoretical Framework; Operational Definitions; Assumptions, Limitations, Scope, and Delimitations; Significance of the Study; and Summary.

Background of the Problem

The challenges that exist in providing treatment for sex offenders are often exacerbated because many clinicians report difficulty treating these clients. D'Orazio

(2013) noted that mental health professionals who work with sex offenders often reported the work as emotionally draining. D'Orazio noted that one of the critical components of clinical work was the ability to empathize with clients to address their needs. In the case of sex offenders, D'Orazio (2013) contended that empathy could "be a genuine job hazard that contributes to dissatisfaction, burn-out, vicarious traumatization and impaired work performance" (p. 7). Although appropriate care for the helping professional was often needed to mitigate these outcomes, D'Orazio (2013) asserted that this support might not be available, thereby influencing the ability of the helping professional to contribute to the sex offender's healing.

The professional may face negative attitudes, stereotypes, and biases when treating sex offenders. As noted at the outset of this investigation, negative images and labels for sex offenders have been codified in criminal statutes for this population (Miller, 2010). Those working in clinical care must overcome these negative attitudes and stereotypes, but this process can be difficult. Clinician attitudes toward sex offenders are often shaped by public opinion and further ingrained by a lack of effective and proven approaches to treatment (Kleban & Jeglic, 2012). Moreover, research has shown that treatment is more effective than punishment, but there is a general lack of social and political support for engaging in treatment over punishment (Kleban & Jeglic, 2012).

Studies regarding clinician attitudes toward sex offenders are also complicated by the lack of research regarding the topic and its systemic implications for clinicians, clients, and therapeutic processes. Punitive social attitudes toward sex offenders have created a situation where efforts to punish offenders have taken precedence over

rehabilitation (Olver & Barlow, 2010). Scarce resources for the treatment of all offenders has further stopped efforts to expand the scope and breadth of research regarding what works to provide effective therapeutic support for sex offenders (Olver & Barlow, 2010). Although evidence has shown that treatment can be effective for reducing the recidivism rates of sex offenders, there is a dearth of empirical research showing the role and importance of clinician attitudes in developing effective treatments and outcomes for these clients (Olver & Barlow, 2010).

Understanding the role and influence of clinician attitudes is further hampered by research that has focused on designations of *positive* and *negative* as the sole foundation for assessing attitudes (Church, Sun, & Li, 2011). Although these classifications were initially developed in the context of examining public attitudes toward sex offenders, they were also used when evaluating the attitudes of clinicians. Although positive and negative designations provide some indication of the general direction of the clinician's emotions, research regarding the treatment of sex offenders has shown that clinicians' views are complex and shaped by a wide range of factors (Church et al., 2011). Thus, current efforts to classify clinician attitudes continue to prove ineffective for understanding the scope and breadth of the perceptions of this group.

Statement of the Problem

Synthesis of this information has shown that mental health professionals treating sex offenders often exist in an environment that creates a number of challenges for effective intervention. Given all these issues, clinicians face difficulty providing treatment for this population (D'Orazio, 2013). Clinician attitudes toward sex offenders

can be shaped by a wide range of variables despite the presence of larger social justice frameworks within the profession to encourage and direct treatment. The problem is made more complex because clinicians' attitudes toward clients will affect outcomes. Scholars examining this issue have noted that negative attitudes on the part of helping professionals working with sex offenders can result in poorer therapeutic outcomes (Yates, 2013).

Despite evidence showing that clinicians' negative attitudes have been implicated in the development of poorer outcomes for sex offenders, the situation remains complex. Scholars examining clinician approaches to the treatment of sex offenders have argued that although empathy, altruism, and support can be critical factors contributing to the success of treatment, these issues can create a situation where the clinician experiences considerable emotional distress (Ward & Durrant, 2013). This situation is a paradox for clinicians working with this population. Despite the clinician needing to have positive and proactive attitudes for the client to achieve therapeutic outcomes, the outcomes for the clinician can be detrimental, overall. Thus, a true challenge for the treatment of sex offenders arises. Counselors, therapists, and all licensed mental health professionals are responsible for addressing clients' needs to develop positive changes and improvements, but they are not immune to the social context that has developed negative views of the sex offender population. For clinicians to rise above ingrained social attitudes toward sex offenders may be difficult, but they must establish a therapeutic relationship with the offender to obtain the best possible therapeutic outcomes.

Research Questions

To better understand the scope and influence of clinician attitudes toward the treatment of sex offenders, the following research questions were asked:

RQ1: What are the attitudes and beliefs of clinical professionals (therapists, counselors, and licensed mental health workers) toward sex offenders?

RQ2: How do clinical professionals view the treatment of sex offenders?

RQ3: What frameworks do clinical professionals use to balance their obligations to the profession and the client with negative images and views of sex offenders?

RQ4: What internal struggles do clinical professionals face when providing treatment to sex offenders?

RQ5: How do clinical professionals overcome negative feelings, emotions, and biases toward sex offenders to deliver effective treatment?

Purpose of the Study

The purpose of this study was to examine the attitudes of clinical professionals who work with sex offenders to identify the specific ways these attitudes influenced professional behavior and client interaction. The literature regarding the influence of providing treatment to sex offenders has shown that this process is challenging for helping professionals (D'Orazio, 2013). Researchers have investigated negative outcomes for the helping professional that include burnout, emotional exhaustion, and traumatization (Dean & Barnett, 2011). However, current research has not shown how professionals' attitudes impact clinical work and how these attitudes are addressed to

deliver care commensurate with the demands and obligations of the mental health profession.

Current literature is lacking regarding the complexity of clinician attitudes toward sex offenders. The research on this topic has indicated that the attitude of the clinician is shaped by many factors, of which public opinion is only one consideration. Clinician attitudes are shaped not only by the environment in which intervention is provided but also by characteristics of the offender, supports for delivering care, and abilities to manage the reality of vicarious traumatization and burnout. The broad scope of variables shaping clinician attitudes toward sex offenders requires more than a classification of attitudes as positive or negative. By providing a more in-depth analysis of clinician attitudes, I have identified additional insights into these attitudes, the ways they have been addressed, and their influence on the treatment of sex offenders.

Theoretical Framework

The theoretical framework for this research was also the research design: grounded theory. Creswell (2012) provided a general overview of grounded theory, noting that this approach to research attempts to move beyond a review of common experiences for individuals (phenomenology) by generating a theory that could be used to integrate and synthesize the information, creating a deeper understanding of the issue under investigation. Creswell (2012) asserted, “A key idea is that this theory development does not come ‘off the shelf,’ but rather is generated or ‘grounded’ in the data from participants who have experienced the process” (p. 83). Based on using this theoretical framework, the focus of the research was to provide an integration of common themes

found in the data to generate a theory regarding the attitudes of clinical professionals toward sex offenders and the ways these attitudes have been addressed in practice to balance the needs of the offender, the profession, and the professional.

Operational Definitions

Attitude: "A person's evaluation of an objective of thought" (Pratkanis, Breckler, & Greenwald, 2014, p. 72).

Clinical professional: Any individual educated and licensed to provide psychological services to those in need; examples include licensed counselors, licensed social workers, and master's and doctoral level psychologists with certification (Eklund & Tenenbaum, 2014).

Sex offender: Any individual "who either has admitted to, or been convicted of, a sex crime or has encountered legal difficulties such as allegations, arrests, convictions, and/or customer because of sexual habits other than prostitution" (Coleman & Miner, 2013, p. 107).

Assumptions, Limitations, Scope, and Delimitations

The assumptions of this research were grounded in the belief that most clinical professionals would have some negative bias toward sex offenders and their treatments. Sex offenders have been largely reviled in society, and these cultural images and stereotypes should have some implications for shaping professionals' attitudes toward this clinical population, despite larger frameworks of social justice and equality inherent in the helping professions. I also assumed that these negative attitudes would have implications for behaviors that could be articulated and observed by the professionals.

The limitations, scope, and delimitations of the study were all integrally linked. The study was limited by the number of participants who could be enrolled due to time constraints. I examined the attitudes of clinical professionals working with sex offenders. I used interviews to collect data, which limited the number of participants enrolled in the study, thereby shaping the scope and boundaries of the research. These issues had implications for the generalizability of the findings. However, because there was a paucity of research exploring this facet of treatment for sex offenders, I provided important insights into the phenomenon to facilitate additional investigations of the topic. The research was limited in scope by the experiences of the clinical professionals interviewed.

Significance of Study

The significance of this study was in the ability to understand better how attitudes of counselors could influence professionals and the therapeutic process. Researchers have shown that counselor attitudes have influenced outcomes for clients (Streets, 2011). If the counselor has a negative view of the client, this view can impede the ability of the professional to connect with the client. This issue leads to systemic challenges in the counseling relationship, ranging from client nonadherence to treatment recommendations or the decision of the client to stop attending counseling sessions (Streets, 2011). Thus, if the therapist cannot connect with the client, significant disruptions in treatment may occur. Given the basic challenges in the treatment of sex offenders, improving therapeutic relationships is critical to facilitate better outcomes for this population. Thus, by confronting the attitudes of professionals in providing treatment for this group, future

researchers and clinicians may better understand the challenges that exist and what steps can be taken to mitigate these challenges.

Summary

The treatment of sex offenders represents a significant undertaking for clinical professionals. Although the outcomes for clinicians who engage in the treatment of sex offenders has been well reviewed in the literature, the attitudes of this group and the steps taken to address these attitudes in clinical practice have not been well researched. By exploring the attitudes of clinicians toward the treatment of sex offenders, I acquired a deeper insight into how these issues influence professional behaviors while identifying the steps taken by professionals to mitigate the difficulties associated with providing treatment for this group. By focusing on these issues, it may be possible to begin the task of advancing and improving intervention to meet the needs of this treatment population.

Although this chapter provides a foundational understanding of the topic and its significance, one must consider the existing literature on the topic. Based on what has been noted regarding the scope and context of the problem, I provide a theoretical foundation for what is known regarding the issues involved with treating sex offenders. Chapter 2 comprehensively reviews the issues and what is currently known, creating a foundation linking the issues to support the need for the current research.

Chapter 2: Literature Review

Introduction

A cursory overview of the literature regarding the treatment of sex offenders has shown a number of avenues of research. Specifically, the literature has indicated the challenges that exist regarding providing effective treatment for offenders, the specific needs of this group that warrant treatment over punishment, and the outcomes for clinicians providing therapeutic support for this population. Although this literature provides an important foundation for developing this review, the role of clinician attitudes on outcomes for the clinician are also important to consider. Research on this topic has indicated that although empirical investigations into the influence of clinician attitudes on outcomes for sex offender treatment are limited, there is extensive insight into how professional attitudes and biases can negatively influence therapeutic outcomes for vulnerable populations. Thus, an exploration of this literature is included to link these outcomes with sex offender treatment.

Research Strategies

To conduct this literature review, I searched electronic databases in EBSCOhost, ProQuest, and Google Scholar. Databases used for this investigation included Academic Search Complete, Business Source Complete, CINAHL Plus with Full Text, Communication & Mass Media Complete, E-Journals, Health Source: Nursing/Academic Edition, LGBT Life with Full Text, MasterFILE Premier, MEDLINE with Full Text, Military and Government Collection, Political Science Complete, Professional Development Collection, PsycARTICLES, PsycBOOKS, SocINDEX with Full Text,

SPORTDiscus with Full Text, TOPICsearch, and Education Source. I set limiters on the searches conducted as follows: full-text articles published in scholarly peer-reviewed journals in the last 15 years (1999 to 2014).

Search terms varied based on the specific topic identified for research. The initial search consisted of the terms *sex offender* and *treatment*. This general search provided insight into the topics selected for this literature review. Following the literature searches on sex offender treatment, I conducted another general search for *clinician* and *attitudes*. To refine the results of this search, I added the term *bias*. For all searches, I completed a review of the first 100 abstracts of full-text articles. If I deemed the abstract relevant, then I moved the full-text article to a folder for later review. I reviewed full-text articles for relevance and incorporated these into the literature review if germane to the focus of the study.

Literature Review

Public Attitudes Toward Sex Offenders

Although the central focus of this investigation was to understand better the attitudes of clinicians toward sex offenders, these attitudes are socially constructed as negative attitudes toward this group, thereby influencing how clinicians view this group. P. Rogers, Hirst, and Davies (2011) noted that various factors could contribute to negative attitudes toward sex offenders, including stereotypes, gender roles, media portrayals of sex offenders, and myths that perpetuate the social beliefs that all sex offenders are the same and cannot be rehabilitated. The public views sex offenders as "a homogenous group all of whom pose an equal and indefinite risk to society" (P. Rogers et

al., 2011, p. 512). According to P. Rogers et al. (2011), all these issues serve as the basis for evoking emotions such as repulsion and hostility toward sex offenders, which consistently give rise to the development of negative public attitudes.

The true implications of negative public attitudes toward sex offenders is fully illuminated in views on punishment and rehabilitation of this group. As reported by P. Rogers et al. (2011), public attitudes toward the punishment and rehabilitation of sex offenders are often harsher and more restrictive as people are "more skeptical of treatment and tend, instead, to advocate (longer) custodial sentences" (p. 512). These attitudes persist despite the results of various studies and meta-analyses showing that recidivism among sex offender populations can be significantly reduced with treatment (P. Rogers et al., 2011). P. Rogers et al. (2011) argued that these public attitudes influenced the perceptions and attitudes of clinicians, as even experienced professionals continued to debate the merits of sex offender treatment, despite data quantitatively indicating the efficacy of intervention.

Other scholars have explored the issue of negative public attitudes toward sex offenders. For instance, Olver and Barlow (2010) argued that sex offenders remained a particularly reviled group in society, often evoking emotions such as "disgust, fear, and more outrage," and terms such as "monster," "predator," or "psychopath" (p. 832) were often applied by laypeople when describing sex offenders. These terms not only reinforce negative images and stereotypes of sex offenders but also serve as a foundation for eliminating understanding of the offender and the complexity of the issues leading to sex crimes (Olver & Barlow, 2010). The result is the perpetuation of negative opinions and

attitudes toward sex offenders, with the public favoring harsher sentences and providing less support and less funding for treatment and rehabilitation (Olver & Barlow, 2010).

Day et al. (2014) further reviewed the scope and challenges involved in addressing the needs of sex offenders in practice, noting, “It is now well-established that public attitudes toward sex offenders are consistently negative, often fueled by distorted portrayals in the media which stereotype all sex offenders as predatory pedophiles” (p. 6). Day et al. (2014) contended that this negative image of sex offenders was not always a part of popular culture. During the 1960s, sex offenders were viewed as having some type of health impairment warranting medical treatment (Day et al., 2014). By the 1980s, media reports about sex offenders began to fuel what Day et al. referred to as a *moral panic*, creating an environment where punitive measures were needed for those who engaged in this type of activity. Day et al. argued that current negative public opinions of sex offenders have created an environment where most citizens have little sympathy for this group and are unwilling to provide the supports needed to ensure sex offenders are rehabilitated and reintegrated into communities.

Harper and Hogue (2015) quantified the influence of this situation using the community attitudes toward sex offenders scale to measure the attitudes and beliefs of 400 British citizens. The results indicated that risk perception, stereotype endorsement, and sentencing and management were prominent measures for explicating the public’s response to sex offenders (Harper & Hogue, 2015). Stereotype endorsement and risk perception involved personal beliefs of the basic understanding of sex offenders, whereas sentencing and management reflected public attitudes toward the need to punitively

address the crimes committed by this group (Harper & Hogue, 2015). Overall higher stereotype endorsements and risk perceptions prompted beliefs that sex offenders should be punitively treated for their crimes (Harper & Hogue, 2015).

The situation created in this context is quite serious. D. L. Rogers and Ferguson (2011) illustrated this point by examining trends in punitive attitudes toward crime and sex crimes. D. L. Rogers and Ferguson (2011) argued that although punitive public attitudes toward crime have increased over the last three decades, sex crimes have continued to represent a “special case” and that sex offenders were “deserving of punishment not allocated to other classes of offenders” (p. 397). Regardless of statistical data and efforts to educate the public about sex offenders, D. L. Rogers and Ferguson (2011) argued that the public continues to believe this group has the highest rates of recidivism and the highest rates of mental illness. When combined, these attitudes have, to some extent, led to what D. L. Rogers and Ferguson referred to as *homo sacer*. This Roman concept implied a space outside of the law where an offender “can be treated in ways that would otherwise be illegal” (D. L. Rogers & Ferguson, 2011, p. 397). Sex offenders were viewed so negatively and punitively by the public that many people believed it would be acceptable to punish this group beyond the extent of existing law.

At the heart of public attitudes toward sex offenders appears to be fear. Kernsmith, Craun, and Foster (2009) noted the role and importance of sex offender registries in protecting the public from sex offenders. The passage of legislation, such as Megan’s Law, has served as a foundation to ensure community members are aware of sex offenders living among them (Kernsmith et al., 2009). When surveyed about these

registries, the public has expressed a 95% approval rate, with most believing these registries keep communities and children protected from sexual predators (Kernsmith et al., 2009). However, Kernsmith et al. (2009) reported that there was no empirical evidence indicating that registries reduced recidivism or prevented sex crimes from occurring. Public attitudes toward sex offenders had not only prompted harsh legislation for sex offender registration but also resulted in the implementation of ineffective policies. According to Kernsmith et al., the ability to quell fear has been the primary reason for maintaining sex offender registries.

Similarly, Levenson, Brannon, Fortney, and Baker (2007) examined the issue of public fear and sex offenders, stating the topic of sex offenders has often evoked considerable public anxiety and fear over safety from individuals committing these crimes. According to Levenson et al., the first legislation enacted to protect communities from sex offenders was implemented in 1994: the Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act. Since this time, there has been no empirical research establishing the efficacy of this type of legislation "in preventing sexual violence or decreasing sex offense recidivism" (Levenson et al., 2007, p. 138). Based on this assessment, Levenson et al. (2007) made a similar conclusion to that noted by Kernsmith et al. (2009): Public attitudes toward sex offenders are driven by fear. Thus, efforts to protect against sex offenders represent this fear rather than a consideration of what empirically works to reduce recidivism and protect the community.

Evaluating public attitudes toward sex offenders should include a consideration of the implications of these attitudes in sex offenders being able to receive treatment and to

reenter the community following incarceration and rehabilitation. Negative and punitive public attitudes toward sex offenders continue to serve as the foundation for limiting this group's ability to acquire and access treatment (Olver & Barlow, 2010). Once sex offenders are released, the challenges for successful rehabilitation are hindered by a wide range of issues comprehensively and holistically impacting them. Willis, Malinen, and Johnston (2013) highlighted these obstacles when making the following observations:

> Landlords are unlikely to rent houses to released sex offenders and those fortunate enough to find housing often run the risk of being driven out of town through community-organized pickets, vigils, and evictions …. It is well established that employment instability, lack of prosocial support and poor prison release plans are associated with increased risk of sexual recidivism. (p. 230)

Willis et al. (2013) asserted that all of these outcomes were typically based on "emotionally fueled public responses" (p. 230) to the release of sex offenders from prison. In many instances, these responses were unwarranted (Willis et al., 2013).

Viki, Fullerton, Raggett, Tait, and Wiltshire (2012) furthered efforts to understand public attitudes toward sex offenders, contending that the public tends to dehumanize those people involved in these crimes. Although the specific context of dehumanization was not widely examined in the current literature, Viki et al. argued that a broad review of information regarding sex offenders in the scholarly literature indicated key elements of dehumanization commonly used in describing people who have committed these crimes. Viki et al. noted the presence of animalistic dehumanization where sex offenders were described as being devoid of human attributes, such as moral sensibility.

Mechanistic dehumanization was also integrated into discussions of sex offenders, who were portrayed as lacking basic components of human nature, such as interpersonal warmth or cognitive openness. These basic foundations for describing sex offenders have contributed to public beliefs and attitudes, creating the perception that sex offenders represent markedly different criminal behaviors antithetical to effective social development.

Willis et al. (2013) further reviewed public attitudes toward sex offenders and surveyed 401 community members to assess the cognitive, affective, and behavioral dimensions. The results were compared with respondents' age, sex, education, occupational status, parental status, and familiarity with victims of sex crimes (Willis et al., 2013). The results of the investigation indicated that women demonstrated more negative attitudes toward sex offenders compared with men. Additionally, individuals with less education were likely to have a more negative view of sex offenders. Public attitudes toward sex offenders might inhibit this group from successfully reintegrating into society following rehabilitation (Willis et al., 2013).

Burchfield and Mingus (2014) demonstrated how public attitudes toward sex offenders influence the reintegration of offenders back into society through survey data from 333 in-treatment sex offenders to understand stress and potential risk factors for recidivism. They found that when the neighborhood context was positive, with less prejudice and negative attitudes, sex offenders were less likely to experience stress and develop risk factors for recidivism. Because of these results, Burchfield and Mingus argued that neighborhood context might significantly contribute to outcomes for sex

offenders in terms of effective rehabilitation and reintegration. Thus, these issues have notable implications for understanding how public attitudes toward sex offenders influence long-term outcomes following punishment.

Clinician Attitudes Toward Sex Offenders

The role of public attitudes toward sex offenders has implications for how clinicians respond to this group. As noted by P. Rogers et al. (2011), public attitudes may shape clinician attitudes toward offender treatment and rehabilitation despite statistics indicating that treatment can be effective for this group. Clinician attitudes toward sex offenders have extensive implications for shaping their rehabilitative outcomes; therefore, researchers should examine how clinician attitudes toward sex offenders compare to those of the general public, ways that these attitudes have influenced outcomes for sex offenders, and what, if any, steps can be taken to facilitate positive and therapeutic attitudes toward this group.

Comparison with public attitudes. The literature regarding clinician attitudes toward sex offenders and how these attitudes compare with those of the public has shown mixed results. Jung, Jamieson, Buro, and DeCesare (2012) considered these issues by providing a comprehensive assessment of differences between laypeople's and professionals' attitudes toward sex offenders. They found that laypeople and professionals held similar levels of negative attitudes toward sex offenders who had committed crimes against children; laypeople's and clinicians' attitudes toward sex offenders were shaped by interactions with the population; more contact with sex offenders led to less negativity toward them; and negative attitudes toward sex offenders

by both laypeople and clinicians were associated with perceptions of higher levels of mental illness. These data indicated some similarities existed between attitudes of clinicians and the public regarding sex offenders. These similarities persist despite clinicians typically having access to information and data that have shown a more accurate clinical profile of sex offenders. For instance, Jung et al. argued that the public believed that recidivism rates for sex offenders were three times higher than reported in the empirical literature.

Other scholars comparing public and professional attitudes toward sex offenders have noted similar results. Church, Sun, and Li (2011) reported that although clinicians who worked closely with sex offenders often had a more positive view of this group, the attitudes of mental health professionals toward sex offenders was similar to those held by the public. Church et al. (2011) reported that a synthesis of the current literature on attitudes toward sex offenders indicated "sex offenders are viewed negatively by specific professions (e.g., mental health professionals and researchers) and the public" (p. 84). Church et al. (2011) argued the relationship among the attitudes of mental health professionals toward sex offenders and integration of clinical understanding of the population was often complex. The situation was well-illustrated by challenges faced when efforts were made to expand community rehabilitation programs for sex offenders; clinicians have found themselves advocating for rehabilitation against negative public attitudes that seek to prevent the location of treatment facilities in neighborhoods.

Based on these outcomes, Church et al. (2011) contended that simplistic comparisons of clinician and public attitudes toward sex offenders did not provide the

foundation needed for understanding the subtle nature of clinician attitudes toward sex offenders. Although evidence indicated some professionals in the mental health community held negative attitudes toward sex offenders, Church et al. asserted that at the present time, there were only two classifications for comparison: positive and negative. These two methods for classifying attitudes did not shown enough information to acquire a true understanding of how mental health professionals truly view this group. Church et al. noted some professionals might have negative views toward the crimes committed by sex offenders but might believe in the process of rehabilitation, thereby seeking to advocate for this group as a foundation for building core values of counseling or social work practice (e.g., social justice). Based on this assessment, efforts to examine clinician attitudes toward sex offenders must be expanded to include more than just positive or negative designations when comparing and analyzing how professionals feel about this group.

Gakhal and Brown (2011) highlighted efforts to understand the subtleties and differences that exist when comparing public and clinician attitudes toward sex offenders. These authors noted language used by the public when referring to sex offenders, such as “predator,” “monster,” or “pervert” (p. 106). These terms were similar to those noted by Olver and Barlow (2010). Gakhal and Brown (2011) asserted that the public commonly used these terms when describing sex offenders; however, these authors argued that even when clinicians held negative views of sex offenders, these terms were often not employed. Given this outcome, the scope of negative attitudes toward sex offenders held by clinicians might not be as deep-seeded, absolute, or uncompromising as those held by

the public. When reviewing the literature regarding clinician attitudes toward sex offenders, the dehumanization employed by the public appears absent in clinician views toward this group (Viki et al., 2012). This assessment leads to the conclusion that there are varying degrees of attitudes toward sex offenders that transcend classifications of negative or positive.

Clinician attitudes in general. Although comparative research regarding clinician attitudes toward sex offenders provides some important insight into how attitudes compare, differ, and align with those of the public, research regarding this topic has focused on efforts to understand clinician attitudes toward sex offenders in the context of the professional boundaries of helping professions (e.g., social workers, counselors, mental health practitioners, etc.). A review of this literature has shown the challenges that clinicians face in delivering service to this group as public perceptions as well as a lack of support often play a significant role in shaping the abilities of professionals to meet the needs of this group effectively (Olver & Barlow, 2010).

Closer examination of the literature regarding clinician attitudes toward sex offenders does indicate that the research on this topic does demonstrate a wide scope of inquiry. For example, Nelson, Herlihy, and Oescher (2002) conducted a direct survey of attitudes of counselors toward sex offenders seeking to understand how counselor experience, training, and personal characteristics influenced outcomes. Nelson et al. included 437 professionals who voluntarily agreed to participate in the study. The results indicated that the general attitude of counselors toward sex offenders was neutral to positive, with most counselors expressing a desire to help those who had been accused of

sex crimes (Nelson et al., 2002). Even though these general trends were reported in survey results, Nelson et al. (2002) reported that there were specific variables that did influence counselor attitudes toward sex offenders. These authors reported that past experiences with sex offenders, training to work with the population, and past history of the offenders (i.e., the presence of abuse) all influenced the attitudes of clinicians when working with sex offenders.

Although Nelson et al. (2002) considered a wide range of variables influencing clinician attitudes toward sex offenders, other empirical studies examining the topic have considered one specific issue and its implications for shaping clinician attitudes. For instance, Carone and LaFleur (2000) examined the past histories of sex offenders and their implications shaping clinician attitudes toward treating sex offenders. As noted by these authors, clinicians were more likely to hold positive views of sex offenders if the client had a past history of childhood abuse or trauma. Carone and LaFleur argued that these attitudes were integrally linked to the ability of the clinician to associate the current behavior of the client to past experiences over which the client would have had no control. In these situations, there is an origin for the development of behavior that may impart a positive view of both the offender and the ability of the clinician to rehabilitate the offender (Carone & LaFleur, 2000).

Nelson (2007) further considered the specific issue of clinician attitudes toward juvenile sex offenders. Juvenile sex offenders represent a unique group because of their potential to be rehabilitated due to their ages (Nelson, 2007). Even though juvenile sex offenders may provide an opportunity for rehabilitation, Nelson (2007) argued that

specific factors predicted how clinical professionals would respond to this group. Nelson argued that professionals with experiences with sex offenders and those who received training to work with this specific group were more likely to have positive tendencies toward sex offenders. Thus, training and experience were noted as critical issues that might influence outcomes for ways that helping professionals would approach clinical work with clients accused of sex offenses.

Scholars have examined the role and influence of clinician experience on attitudes toward sex offenders. Sanghara and Wilson (2006) used a sample of 60 clinical professionals involved in the direct work with sex offenders and 71 schoolteachers to determine if clinicians with experiences held fewer stereotypes toward sex offenders. The results indicated that experienced professionals endorsed fewer negative stereotypes of sex offenders, had more positive views toward this group, and had an extensive understanding of the pathology of child abuse (Sanghara & Wilson, 2006). Further, Sanghara and Wilson (2006) reported that knowledge of child abuse and its development played a significant role in shaping how sex offenders were viewed in both groups. Educators with more experience with child abuse had a more favorable view of sex offenders compared to educators whom did not (Sanghara & Wilson, 2006). Experience with this group to understand better child abuse serves an important role in shaping ways that professionals view sex offenders.

Researchers have also examined training and its implications for the development of clinician attitudes toward sex offenders in the literature. Craig (2005) used a pre/posttest design to evaluate clinician attitudes toward sex offenders before and after an

intensive training program on the topic. Craig reported that the training program lasted 2 days and focused on the treatment of sex offenders in the context of residential settings. The results indicated that before the training, clinicians expressed more favorable attitudes toward criminal clients whom had not committed sexual offenses compared with those whom had committed these types of crimes (Craig, 2005). Following the training, there was little changes in clinician attitudes toward sex offenders (Craig, 2005). However, Craig (2005) reported that 86% of clinicians involved in the training did express higher levels of competence in working with sex offenders. Craig contended that this finding had implications for shaping positive attitudes of clinicians toward the rehabilitation of sex offenders, potentially leading to changes in attitudes in the future.

Scholars examining clinician attitudes toward sex offenders have argued that the views of those providing treatment is often influenced by the response of the perpetrator. Freeman, Palk, and Davey (2010) contended that among sex offenders, a large group often denied their involvement in these crimes, thereby creating a paradox for treatment. These denials often persisted, even after an offender was convicted of a sex crime (Freeman et al., 2010). For clinicians working with this group, challenges arise regarding how to provide effective treatment and rehabilitation support for an offender whom does not recognize that a crime has been committed (Freeman et al., 2010). Freeman et al. (2010) argued that this situation could result in considerable frustration for the clinician, influencing attitudes toward the offender and the ability of the clinician to provide effective treatment and support. This insight indicated that a wide range of factors unique to the treatment environment would influence the clinician's attitude toward the sex

offender. Thus, although larger public attitudes shape outcomes in this domain, direct work and treatment of sex offenders engenders certain realities that also shape clinician views individuals in this population.

Even though the literature provided some insights into clinician attitudes toward sex offenders, Duggan and Dennis (2014) argued that there was a lack of data regarding treatment of this population. Research has indicated that sex offenders comprise a relatively small percentage of the total population; according to Duggan and Dennis, of those who did offend, only about 1% were prosecuted and subjected to treatment. Thus, treatment for sex offenders is often challenging, as there is a dearth of practical or evidence-based literature upon which to build practice. Duggan and Dennis argued that this issue could create challenges for shaping the attitudes of clinicians, as public views on this group might influence clinical views, even if public views were inaccurate.

Hubbard (2015) detailed additional challenges involved in providing therapeutic support for sex offenders. Working from a personal perspective on the topic, Hubbard argued that clinical professionals faced the reality of not only meeting the needs of sex offenders in practice but also professionals challenged to balance negative public opinions and attitudes toward this group. Hubbard noted the public scorn and vitriol that could result from providing service to sex offenders. In many instances, the public did not support treatment of this group and expressed aggression and anger toward those who provide care for this group (Hubbard, 2015). Hubbard (2015) posited these issues complicated the ability of the professional to provide service to sex offenders. Managing

public opinions toward this group does appear to shape how professionals view this work and may influence bias and discrimination toward sex offenders in clinical practices.

The Effect of Clinician Attitudes

The scope and context of clinician attitudes toward sex offenders represents a complex reality. Although the topic may not appear to have extensive implications for the outcomes experienced by offenders, the ways in which offenders are treated in practice will have extensive implications for the ability of the offender to complete treatment, avoid recidivism, reintegrate into the community, and experience rehabilitation through the development of a therapeutic relationship. Willis, Levenson, and Ward (2010) reviewed negative attitudes toward sex offenders by helping professionals and indicated, "Professionals holding negative attitudes toward sex offenders risk adopting a punitive, confrontational style in their interactions with them" (p. 546). This finding threatened to compromise the therapeutic relationship with the client, which was viewed as the nexus of change (Willis et al., 2010). Even though these realities were well noted on a theoretical level, research examining the negative attitudes of clinicians toward sex offenders and the outcomes that result was scant. However, a broader examination of the literature examining negative clinician attitudes and implications for client outcomes did indicate that the attitudes of the clinical professional could have significant implications.

Researchers have addressed negative attitudes among helping professionals and the implications for practice with specific populations, including the poor (Landmane & Renge, 2010); lesbian, gay, bisexual, and transgender (LGBT) clients (Chonody, Woodford, Brennan, Newman, & Wang, 2014); and older adults (Tice, Hall, & Miller,

2010). Synthesis of this research indicated that when negative attitudes were present, bias could result, thereby influencing the behavior of the professional and shaping outcomes, including the ability of the professional to connect with the client and build a therapeutic relationship. Over time, these issues can lead to treatment failure, further exacerbating the problems experienced by the client. Based on this assessment, negative attitudes toward a specific client or client population will have implications for the outcomes that result for the client. Given this reality, along with the current negative social stereotypes of sex offenders, the attitudes of the professional may have implications for therapeutic outcomes.

Research regarding how bias effects the development of the therapeutic relationship provides insight into how clinician attitudes toward sex offenders may influence outcomes for these clients; however, research examining this issue and sex offenders does facilitate a deeper understanding into the scope of the issue. For instance, Jones, Pelissier, and Klein-Saffran (2006) argued that negative attitudes of clinicians could prevent those in need of treatment from voluntarily seeking support. These authors argued that individuals in need of treatment might be unwilling to seek treatment, resulting in committing sex crimes or recidivism (Jones et al., 2006). Jones et al. (2006) stated these outcomes had substantial implications for sex offenders, victims, clinicians, and society creating a foundation for better understanding. This better understanding may change the attitudes of professionals, such that these outcomes do not result, and those in need of care can access it in a timely manner.

Eastman (2005) also facilitated a deeper understanding of how clinician attitudes toward sex offenders could influence outcomes for offenders. Eastman asserted that a wide range of factors in the therapeutic relationship could influence treatment success (or failure) for the client. For instance, Eastman noted the issue of amenability to treatment. If sex offenders were not amenable to treatment, they would be less likely to engage and acquire therapeutic benefit from clinical work. Although amenability to treatment could be difficult to change, Eastman contended this issue could be shaped by the clinician's attitude toward the client. If the clinician demonstrated a true and genuine interest in the client, the amenability of the client could be altered or improved (Eastman, 2005). However, if the clinician expressed a negative attitude toward the client, changing amenability and engagement might be impossible (Eastman, 2005).

Although amenability is the principle variable reviewed by Eastman (2005) when examining treatment failure or success for sex offenders, this author goes on to note the clinician attitudes will have a systemic impact on the therapeutic process, shaping the degree to which the client chooses to participate in therapy. According to Eastman, clinician attitudes have been shown to influence the willingness of the client to accept responsibility for his or her action, to identify detrimental or deviant patterns of behavior, and to enhance self-concept to change and improve behavior. Although these outcomes can be achieved, these cannot be achieved without the support of the clinician and a positive attitude toward change and rehabilitation of the sex offender.

Ward, Mann, and Gannon (2007) noted the role of the therapeutic relationship in the development of improved outcomes for sex offenders. These authors contended that

when a sex offender entered treatment, the development of the therapeutic relationship was consistently highlighted as a critical factor for success in engaging the client in treatment. Although Ward et al. reviewed the role and importance of the therapeutic relationship in building a foundation for addressing the needs of the client, these authors asserted that little attention was given to the role of clinician attitudes in shaping the therapeutic relationship. Ward et al. asserted that this omission from the literature was disconcerting, as clinician attitude was demonstrated to have implications for establishing relationships with clients from diverse backgrounds.

The insight provided by Ward et al. (2007) not only highlights the need to better understand clinician attitudes toward sex offenders but also the insight demonstrates the importance of providing a formidable empirical foundation for understanding clinician attitudes specifically in the context of sex offender treatment. As Ward et al. demonstrated there was a theoretical foundation for arguing that clinician attitudes would have direct implications for the development of therapeutic relationships with sex offenders, leading to a reduction in recidivism. However, there was a paucity of empirical evidence that supported this link in practice. Thus, there was an impetus to fill this gap in the literature and provide a definitive foundation upon which to improve, enhance, and address clinician attitudes as integral components of treatment for sex offenders.

Charles (2010) studied the role of clinician attitudes in the development of treatment and outcomes for sex offenders and detailed a relationship approach to the treatment of young male sex offenders. As reported by this author, sex offender treatment employs a prescriptive, manualized process that creates significant distance between the

clinician and the client. Charles assessed the current methods used to deliver treatment to sex offenders, noting the formal procedures used serve as the basis for alienating the client in treatment, negating positive and supportive attitudes of the clinician. When this aspect occurs, the client does not experience the human interactions and relationships needed to connect with the therapist and acquire insight into his or her actions (Charles, 2010). Therefore, Charles (2010) advocated for the use of interaction-based therapeutic interventions to place the clinician in direct contact with the sex offender to build relationships and positive attitudes. Charles stated this process could change the ways that both clinicians and offenders have viewed the therapeutic process.

Charles (2010) advocated for the development and evolution of positive clinician attitudes toward sex offenders as integral components of the therapeutic process. Due to this transformation, the clinician and client benefit as both experience a positive relationship based on a mutual understanding of individuals, rather than of stereotypes (Charles, 2010). Although Charles (2010) did not provide large-scale, longitudinal data regarding the influence of this approach on outcomes for offenders and clinicians, the author included anecdotal case study data from a program using this approach in a small residential sex offender treatment program. Charles's results indicated the approach could be successful for addressing key issues related to stereotypes, which could influence the ability of the clinician to build a therapeutic relationship effectively with the client. Therefore, evidence indicated this approach could be helpful for building positive attitudes of clinicians, while supporting the needs of the client.

The research regarding the influence of clinician attitudes toward sex offenders is scant. Despite a dearth of information on this topic, one may acquire a theoretical understanding of the implications of clinician attitudes toward this group. If clinicians do not exhibit a belief in their clients for change and rehabilitation, it will more than likely have significant ramifications for the ability of the offender to complete treatment, avoid recidivism, and reintegrate into the community. Given the issues at stake, the importance of understanding clinician attitudes toward sex offenders became more urgent, thereby supporting the need for this research and continued efforts to augment and improve interventions for this clinical population.

Issues in the Treatment of Sex Offenders

The literature regarding the effective treatment of sex offenders has shown that notable challenges have occurred in this field. Efforts to reform treatment programs for sex offenders have been stymied by a lack of research and support for rehabilitation programs in this population (Kleban & Jeglic, 2012; Miller, 2010). Treatment for the sex offender is complicated by the ethical issues and implications of providing this type of intervention. Prescott and Levenson (2010) noted that even with advancements made in treatment, many viewed current options for intervention as forms of punishment. Treatment was often coercive and might inflict harm on the offender. To illustrate this point, Prescott and Levenson (2010) made the following observations: “Current treatment models force the offender to undertake the therapy chosen by the clinician, demand that confidentiality be broken, and compromise the client’s autonomy” (p. 276).

Similarly, Jung and Nunes (2012) considered current treatment approaches for sex offenders, noting the specific issue of treatment motivation. These authors reported most sex offenders entered treatment due to the condition of their punishment by the court. Jung and Nunes noted that when this occurred, many offenders were not motivated to change and were unwilling to admit they engaged in any wrong doings. Because awareness and acceptance of behavior remained needed to motivate change in any therapeutic setting, Jung and Nunes argued that motivating the offender to engage in treatment was often a complex and difficult task; it becomes more complex in the context of treatment approaches that might be ineffective for meeting the needs of the patient.

These barriers to treatment create an issue for clinicians working with this population. Sellen, Gobbett, and Campbell (2013) argued that research regarding the use of cognitive behavioral-based interventions indicated these approaches could be more effective for reducing recidivism for sex offenders compared with incarceration for the offender. Even though these interventions have shown considerable promise, if the offender is not motivated to engage in treatment, intervention will not yield any salient outcomes: "An offender cannot, however, benefit from a treatment program unless she or he is prepared to engage constructively with its requirements" (Sellen et al., 2013, p. 204).

Even when the offender agreed to participate in treatment, Olver and Wong (2009) contended that problems continued to persist. Olver and Wong (2009) argued the small body of literature regarding outcomes for the treatment of sex offenders consistently indicated that offenders "frequently respond poorly to treatment, display

poor motivation, show little improvement, and have high rates of attrition" (p. 329). Olver and Wong (2009) noted that many personality traits of sex offenders created treatment-interfering behaviors difficult to overcome in practice. Because the field of treatment for sex offenders was limited, these issues continued to influence the abilities of clinicians to make significant progress when treating this group (Olver & Wong, 2009). Thus, even when options for treatment were provided, considerable obstacles occurred for meeting the needs of offenders to improve long-term outcomes for this group.

Further contributing to the challenges that exist in the treatment of sex offenders is the reality that to successfully complete treatment, sex offenders must be willing to take responsibility for their actions. According to Strecker (2011), professionals working with sex offenders have agreed that "participants must take responsibility for their actions to render rehabilitation meaningful" (p. 1560). Strecker (2011) asserted that taking responsibility was also essential for cognitively accepting punitive measurements taken to address the crimes of the offender and for facilitating the treatment process. The challenges of this paradigm for treatment could create a number of obstacles for clinicians in addressing the needs of this population. Strecker maintained that even when offenders willingly participated in treatment, accepting responsibility for sex crimes could be a difficult process that could require extensive support impossible in prison or outpatient settings.

Treatment delivery for sex offenders is negatively influenced by a lack of standardization regarding what works for comprehensively addressing the needs of this

group. Moon and Shivy (2008) contended that over the course of the last two decades, several meta-analyses indicated that treatment for sex offenders could be effective for preventing recidivism. Although this research supported the use of treatment as a foundation for the rehabilitation of sex offenders, Moon and Shivy contended that this research was missing a review of the specific techniques that worked best to facilitate treatment success. Moon and Shivy argued that there was a dearth of data indicating what strategies should be used for clinician training, client monitoring, and client interaction. Without these critical data, clinicians faced notable challenges when providing treatment to sex offenders. Moon and Shivy contended that this situation was one of notable concern in a results-focused environment often constrained by cost issues.

Effective treatment delivery for sex offenders is also influenced by the development of effective assessment protocols to determine what will work regarding the treatment of the offender. Collie, Ward, and Vess (2008) noted that over the course of the last 20 years, progress was made in unraveling the theoretical foundations needed for understanding sex offenders and the crimes that they committed. This research facilitated the ability of clinicians to apply specific supports and interventions that could be useful for targeting and addressing the specific needs of the offender. Even though there have been important advancements in these areas, Collie et al. (2008) argued, “Applying knowledge of the causes of sexual offending and what works to reduce offending … hinges on practitioners’ ability to appropriately assess individuals who commit sexual offenses” (p. 65). Collie et al. (2008) noted that effective, comprehensive, and accurate

assessment of sex offenders remained an overlooked area of research that continued to hinder the abilities of clinicians to provide needed therapeutic support for the offender.

Research regarding what works for addressing the needs of sex offenders has also been hampered by the high rate of attrition that occurs in sex offender treatment programs. Beyko and Wong (2005) noted that statistics indicated that between 30% and 50$ of sex offenders left treatment before its completion. Beyko and Wong asserted that this situation had notable implications for sex offenders and the community. Beyko and Wong (2005) argued, "Sex offenders who drop out from treatment obviously cannot benefit from treatment. As well, dropouts tend to have higher recidivism rates than those who complete treatment" (p. 376). Even though attrition was noted as a significant issue of concern for the treatment of sex offenders, Beyko and Wong (2005) maintained that efforts to address the issue were meager. If efforts are not made to determine what factors contribute to attrition or facilitate retention, treatment programs will continue to be hindered by these ongoing problems related to basic components needed for treatment success.

Synthesis of this research has shown a wide range of challenges and issues related to the development of effective treatment for sex offenders. Although the research has indicated that treatment challenges stem from a lack of research and standardization in various aspects of clinical work, evidence has indicated treatment issues are also influenced by clinician attitudes to some extent. For example, Ward and Durrant (2013) considered the role of empathy and altruism in developing sex offender treatment. According to these authors, current treatment methods often produce a disconnection

between the client and clinician resulting in the inability of the offender to connect with treatment and to avoid recidivism. These issues were similar to what Charles (2010) noted regarding the treatment of young male sex offenders. As reported by Ward and Durrant (2013), the development of empathetic and altruistic relationships between clinicians and clients provides a basic platform for therapeutic exploration essential for understanding the issues facing the client. Therefore, if clinicians cannot connect in this manner, treatment will be ineffective for addressing the core needs of the offender.

A critical review of the literature regarding the treatment of sex offenders has shown a number of areas for change and improvement. In many respects, the current state of research regarding interventions to meet the needs of sex offenders is reflective of the challenges that offenders face in society. Because sex offenders continue as one of the most reviled groups, efforts to meet the needs of sex offenders have not been extensively reviewed, addressed, or prioritized. This process has resulted in significant gaps in the literature, which have implications for the abilities of clinicians to provide effective support for clients in this clinical population. The roles and implications of clinician attitudes toward sex offenders appears to have a significant influence on shaping interventions for this group. However, a lack of integrated and comprehensive information on the topic makes it difficult to create a complete picture of how clinician attitudes fit in the larger context of treatment and treatment effectiveness.

Clinical Needs of Sex Offenders

Treatment for sex offenders is further complicated by the clinical needs of this population. A review of the literature regarding sex offenders and their mental health and

psychosocial needs has indicated that this population faces a number of different challenges, which can make treatment more complex and difficult. For instance, Hulme and Middleton (2013) noted that sex offenders could have multiple psychiatric comorbidities including paraphilia, childhood sexual abuse, personality disorders, substance use disorders, and/or mood disorders. This sequela of mental health issues can complicate treatment, making it difficult for the clinical professional to effectively intervene. Craissati, Bierer, and South (2011) highlighted the challenges of providing treatment for sex offenders, arguing that developmental problems focused on experiences of childhood abuse and neglect influenced outcomes for sex offenders and were overlooked in the context of treatment.

Ricci and Clayton (2008) demonstrated the scope and influence of this situation, arguing that although the developmental trajectories of sex offenders were well delineated in theory, there was a significant gap between theory and practice when providing therapeutic intervention to meet the needs of this population. According to Ricci and Clayton, the etiological issues involved in sex offender treatment are often overlooked to focus on targeted, time-specific interventions that address the immediate behavior of the individual. However, the underlying causes of sex offender behavior are often rooted in etiological issues, making the absence of these issues in treatment a significant concern for improving treatment outcomes (Ricci & Clayton, 2008).

The clinical needs of sex offenders are also influenced by many developing posttraumatic stress disorder (PTSD) symptomology due to their offense related treatment in the criminal justice system (Crisford, Dare, & Evangeli, 2008). Crisford et

al. (2008) maintained that when sex offenders faced the reality of their actions, they experienced considerable guilt, which could lead to the development of additional health issues, including PTSD. Although this situation is one that may elicit little empathy from the public or from treatment providers, this outcome can significantly shape the mental health trajectory of the sex offender, thereby influencing intervention (Crisford et al., 2008). The psychological ramifications of crimes committed on the sex offender is overlooked when providing intervention for this population. These issues will have some implications for the outcomes that result for the sex offender.

Treatment Influence on Clinicians

Researchers have widely explored the influence of providing sex offender treatment on clinicians in the literature, as conceptualized in the context of burnout and vicarious traumatization. Kadambi and Truscott (2003) considered the influence of vicarious traumatization for clinical professionals working with sex offenders. Kadambi and Truscott (2003) reported work with sex offenders resulted in the therapist's exposure to "human cruelty" as well as "participating in traumatic re-enactments" (pp. 216-217), thereby producing an experience for the therapist unlike that encountered in work with any other client population. Kadambi and Truscott (2003) argued that these experiences could result in changes to the therapist's worldview, identity, and cognitive schema. Over time, this change could influence the therapist's approach to practice as well as personal attributes, including the ability to express empathy (Kadambi & Truscott, 2003).

Other scholars examining clinician outcomes that result from working with sex offenders have reported significant challenges for the professional. For instance, Sandhu,

Rose, Rostill-Brookes, and Thrift (2012) reported that clinical professionals working with sex offenders consistently reported "a range of negative effects, including negative emotional reactions, burnout, and vicarious traumatization" (p. 309). Clarke (2011) noted that most staff members working with sex offenders reported significant changes in their worldviews due to repeated contact with sex offenders. These changes have systemic implications that can make it more difficult for clinicians to engage in the treatment of this group (Clarke, 2011). There is a paucity of empirical literature that considers changes in the professional that may lead to further challenges with treatment. Overall, there is widespread support for the assertion that clinical professionals working with sex offenders will face significant challenges in protecting their emotional and mental well-being.

The issues facing clinicians when providing therapeutic support for sex offenders are important to consider because of the implications that these issues have on outcomes for both the clinician and the client. Lee et al. (2010) addressed how clinical work with sex offenders could comprehensively influence the clinician and therapeutic outcomes. Lee et al. (2010) asserted that therapists working with sex offenders were "significantly influenced by their work in ways that product multiple emotional and physical ailments manifesting cognitively or in the workplace, in addition to jeopardizing both the therapist's well-being and treatment efficacy" (p. 16). Although these issues could arise in any therapeutic setting, Lee et al. (2010) argued these issues have been more widely noted for clinicians providing therapy for sex offenders.

Adding to the complexity of the issues facing clinicians in providing treatment for sex offenders is that there is scant research regarding what techniques work to ameliorate this type of distress. Lee et al. (2010) contended that although the work of clinicians in providing support for sex offenders was desperately needed, a paucity of empirical research provided comprehensive insight into what would work for addressing the needs of clinicians involved in this work. Lee et al. argued that although efforts to alleviate burnout could be helpful, the experiences of clinicians working with sex offenders was often so intense that additional supports might be needed to address the emotional, physical, and cognitive needs of this group. Therefore, the lack of research regarding treatment for sex offenders and its implications for addressing the needs of both clinicians and clients becomes evident.

Lee et al. (2010) demonstrated that clinician work with sex offenders could result in changes that influence therapeutic efficacy. Other scholars have explored this issue; for example, Kraus (2005) noted the dilemma facing clinicians who worked with sex offenders. According to this author, positive clinician attitudes toward sex offenders will facilitate the development of a therapeutic relationship, enabling the clinician to connect with the client but exposing the clinician to a wide range of emotional, cognitive and psychological trauma: “Clinicians who treat sex offenders listen to memories of horrific experiences, some with graphic details, of the offender’s own history of abuse and the abuse afflicted on others” (Kraus, 2005, p. 81). Empathetic engagement of the clinician in this environment can create a situation where therapy is facilitated, but the emotional influence on the clinician is severe (Kraus, 2005).

Kraus (2005) described a situation that could create a significant problem for the clinician. Although there is strong theoretical support for the development of positive attitudes of clinicians toward sex offenders, this positive attitude can create a foundation for empathy and trauma that can be difficult for the clinician to manage. When coupled with the reality that few supports are in place to help clinicians cope with this type of traumatization (Lee et al., 2010), the environment for providing treatment for sex offenders becomes quite challenging and tenuous. When developing clinician attitudes toward sex offenders, the clinician may expose himself or herself to extensive vicarious trauma and victimization, thereby leading to psychological distress and burnout. Based on this assessment, evidence indicated a balance must be achieved when building clinician attitudes toward sex offenders.

Summary

The literature indicated that clinician attitudes toward sex offenders was a significant issue of concern for both augmenting treatment and creating a foundation upon which to build practice in the treatment of this population. Research regarding public attitudes toward sex offenders indicated these issues did have implications for shaping the attitudes of clinicians toward this population. However, general classifications of negative and positive currently employed to designate how specific groups perceive sex offenders do not appear adequate for explicating the complex reality that encompasses how clinicians view and respond to sex offenders receiving care. Simplistic assessments of clinician attitudes may not be effective for acquiring a comprehensive understanding of this issue.

Research regarding the treatment of sex offenders, the needs of sex offenders, and the influence of treatment on clinicians further demonstrated current gaps in the literature regarding the scope and ramifications of clinician attitudes. Although there was ample theoretical support for the role that clinician attitudes played in developing the therapeutic relationship and outcomes for the client, there was a dearth of empirical literature on this subject. Further, evidence indicated that a true dichotomy could arise for the clinician who would engage empathetically and altruistically, as severe psychological distress and burnout could result. Based on these issues, the literature on clinician attitudes toward sex offenders seemed incomplete, thereby creating the need to explore these attitudes and to understand fully the implications for practice.

The literature indicated pertinent gaps existed in understanding the attitudes of clinical professionals toward the treatment of sex offenders. The current gap in the literature required an encompassing methodology to ensure the topic was explored in a practical, real-world context. A qualitative methodology was needed to include all potential variables involved in developing clinician attitudes and outcomes for the offender. By employing this methodology, I acquired needed insight to fill these current gaps in the literature. Chapter 3 includes an explanation of the methodology used, as well as data collection and analyses techniques.

Chapter 3: Methodology

Introduction

The treatment of sex offenders poses a number of unique challenges for clinical professionals. Larger social and cultural views on sex offenders shape professional attitudes for this group. Additionally, research has indicated that clinicians' attitudes toward sex offenders are shaped by the attributes of the offender, training of the clinician, and experience with sex offenders in treatment. The literature has shown clinician attitudes can have a significant theoretical influence on treatment outcomes, but empathetic and altruistic attitudes can negatively influence the psychological, emotional, cognitive, and physical well-being of the clinician. Clinician attitudes toward sex offenders represent a complex issue that must be addressed beyond simplistic classifications of positive or negative.

To acquire a theoretical understanding of how clinician attitudes have developed and their influence on sex offender treatment, there was a dearth of empirical research exploring this phenomenon. Understanding clinician attitudes toward sex offenders requires a foundation for comprehensive and systemic review of the topic to facilitate greater insight and to apply information in a practical manner to positively influence the development of clinical practice. This chapter outlines a qualitative method for exploring clinician attitudes toward the treatment of sex offenders.

Research Methodology

For this investigation, I selected a qualitative approach to inquiry. The qualitative approach lets the researcher employ an inductive approach "to develop understanding and

theory where none currently exists" (Given, 2008, p. 430). At the time of this study, the influence of clinician attitudes on the treatment of sex offenders had not been explored through the experiences of clinical professionals. Although the outcomes of providing this treatment have been extensively reviewed in the literature, current gaps indicate a lack of insight into the ways that attitudes shape the behaviors of clinicians when working with offenders. Given the lack of insights and methodological structures for investigating this topic, a qualitative framework appeared a rational choice.

A qualitative methodology for the current investigation was selected based on the current gaps in the literature indicating that researchers focused on surveys to classify clinician attitudes as positive or negative. These general classifications do not provide effective insights into the complex issues involved in the development of clinician attitudes or the systemic implications of clinician attitudes for both the professional and client. There was a strong theoretical basis for linking positive clinician attitudes toward sex offenders to establish a therapeutic relationship that facilitated rehabilitation and reduced recidivism. Evidence also indicated that the scope of positive attitudes remains difficult to quantify with certain positive clinician attributes potentially contributing to the development of burnout and vicarious traumatization. Based on the complexity of this phenomenon, using qualitative research methodology was essential.

Scholars reviewing qualitative methodologies have argued that these approaches are useful when variables involved in an investigation are extensive and cannot be measured in the context of a specific measure (Lichtman, 2012). Quantitative researchers can use surveys, hypotheses, and specific measures to link variables together to provide a

succinct foundation for evaluating a research problem when the variables involved are clearly identifiable and measurable (Lichtman, 2012). Conversely, qualitative researchers explore multiple variables without placing limitations on the scope of variables that can be investigated (Lichtman, 2012). The literature regarding clinician attitudes toward sex offenders distinctly indicated that the phenomenon was too broad and complex to review using the succinct measures of a quantitative approach.

The use of a qualitative methodology for the research was supported in the context of the underlying approach, where data were collected, analyzed, and used to draw conclusions about the subject. In a qualitative investigation, a researcher collects a broad scope of data and employs an inductive approach to analyze and review those data (Lichtman, 2012). The researcher reviews large amounts of data to find common themes and formulate a hypothesis about the phenomenon based on analysis of the data (Lichtman, 2012). This process differs from a quantitative approach where a deductive approach is used and a hypothesis formulated first, and then accepted or rejected based on data collected (Lichtman, 2012). The literature regarding clinician attitudes toward sex offenders indicated that the topic was notably complex, thereby making the formation of a hypothesis impossible. Only by collecting a broad range of data, identifying common themes, and using those data to form hypotheses is it possible to acquire a complete understanding of the topic.

The application of a qualitative approach to the topic under investigation was viewed as essential due to the fundamental nature of qualitative inquiry. Lichtman (2012) argued, “The main purpose of qualitative research is to provide an in-depth description

and understanding of the human experience. It is about humans" (p. 17). Qualitative researchers seek to ask, describe, and understand human phenomena, interaction, and discourse (Lichtman, 2012). Without the ability to understand the lived experiences of humans, researchers cannot gain insight into the everyday actions and interactions that shape the scope of human existence (Lichtman, 2012). This assessment of qualitative research indicated that human phenomena, such as the development of attitudes, can only be measured through a qualitative approach, which ensures comprehensive understanding of the complexity involved.

Research Design

The theoretical framework I selected for the research design was bias. Boysen (2010) provided a review of bias in the context of professional counseling practices, stating that bias includes prejudice, discrimination, and stereotypes that can influence clinical practices. Although many helping professionals might be directly aware of certain biases regarding particular clinical populations, bias toward client groups could manifest in "subtle and unintentional ways," and many types of bias are unintentional, implicit, "hard to control, not always consciously accessible, and measured indirectly" (Boysen, 2010, p. 210). Even though bias can significantly impact the way a professional interacts with a client, bias is often overlooked as a significant factor of concern when providing client care (Boysen, 2010).

Clinicians' attitudes toward various groups can be influenced by the presence of bias. Ramirez, Ekselius, and Ramklint (2013) considered the influence of clinician bias on outcomes for the client, framing the issue in the context of Axis IV diagnosis under

Diagnostic and Statistical Manual of Mental Disorders' classification. According to these authors, formal diagnoses of clients in clinical practices involved evaluating Axis IV issues, including the presence of psychosocial and environmental problems. Although these issues commonly involve variables specific to a client's circumstances, Ramirez et al. asserted that psychosocial stress might result from bias, including negative attitudes of the clinician toward the client. This finding indicates that bias could influence the therapeutic relationship, thereby affecting the ability of the client to connect with the therapist and make progress to overcome other issues of concern (Ramirez et al., 2013).

Based on this assessment, bias was selected as the theoretical framework because it includes the attitudes of the clinician, which might be implicit or explicit. Bias has implications that can facilitate or hinder the therapeutic relationship. For clients accused of sex crimes, helping professionals' biases might significantly and negatively influence the ability of the client to engage in therapy. Although bias represents a significant issue of concern, Boysen (2010) argued that efforts could be made to overcome this problem through self-awareness and engagement in reflective practice. Therefore, clinicians could use the findings from this study to develop greater awareness of bias and its implications.

Measures

The principal foundation for data collection in this investigation was the use of in-depth interviews with clinical professionals with past experiences working with sex offenders. To collect these data, a guiding interview form was employed. The form is provided in the Appendix and includes the questions used to elicit responses from the interviewee. All the questions posed were open-ended and structured to facilitate

discussion with the interviewee. The measure was validated through expert review and pilot testing with a group of clinicians who did not have any experiences working with sex offender populations.

Data collection techniques for grounded theory investigations usually include the use of in-depth interviews. In-depth interviews are used in grounded theory studies to collect sensitive and personal information (Lichtman, 2012). The researcher uses these data collection tools to explore complex subjects while enabling participants to provide a wide range of information on the topic (Lichtman, 2012). This data collection tool provided the needed supports for acquiring the needed information for the current investigation. This data collection process ensured clinicians could discuss a sensitive subject in a confidential manner to explore various facets of their practices and provide insights into how their attitudes developed and the variables that shaped outcomes for clinician attitudes in practice.

Research Questions

RQ1: What are the attitudes and beliefs of clinical professionals (therapists, counselors, and licensed mental health workers) toward sex offenders?

RQ2: How do clinical professionals view the treatment of sex offenders?

RQ3: What frameworks do clinical professionals use to balance their obligations to the profession and the client with negative images and views of sex offenders?

RQ4: What internal struggles do clinical professionals face when it comes to providing treatment to sex offenders?

RQ5: How do clinical professionals overcome negative feelings, emotions, and biases toward sex offenders to deliver effective treatment?

Ethical Protections

All clinical professionals agreeing to participate in the research were asked to sign a consent form and were instructed that they could leave the study at any time. Information collected from the interviewees was labeled only with the participant's initials to ensure confidentiality. Data collected during the research were secured either in a locked filing cabinet to which only I had access or through a password-secured laptop only accessible to me. Therefore, I ensured all information collected from this investigation would remain confidential.

During the interview process, I asked the clinicians to refrain from using the names or identifying information of clients. I used pseudonyms at all times to ensure clinicians did not engage in ethical breaches of confidentiality regarding their clients. All of these issues for the ethical protection of clinicians and their clients were discussed before the initiation of the interviews. A written review of the information was provided to the clinicians before the interview begins. I asked clinicians to sign a copy of the agreement indicating that they were aware of the procedures in place to maintain confidentiality and privacy as part of the research process.

Role of the Researcher

The role of the researcher in the current investigation was one of neutrality. Although the researcher would bring certain biases to the inquiry and interpretation of the data, researchers should strive to remain neutral to provide a succinct understanding of

the participants' views (see King & Horrocks, 2010). Exploring bias before undertaking the research could be useful for identifying issues of concern in data collection an analysis (King & Horrocks, 2010). Further, efforts to have the data verified (member checks) and evaluated by independent coders enhanced neutrality in my role. I tried to ensure I acted solely as a data collector to preserve neutrality.

Procedures/Data Collection

The instrument developed for the research was validated through expert review and pilot testing with a group of clinicians whom did not have any experience working with sex offender populations. This process not only provided a foundation for ensuring that the interview schedule was validated but also served as the basis for developing the interview skills needed for the research. To prepare, practice interviews with six clinicians were performed with feedback provided to augment interviewing skills and capabilities.

Pilot Study

Recruitment for the pilot study included using a convenience sample of mental health practitioners currently working in the community. This sample included clinicians not engaged in direct work with sex offenders. The pilot study was used to practice interviewing skills and to acquire feedback regarding the interview schedule. Because the clinicians used for the pilot study did not have experience working with sex offenders, this group should have provided constructive feedback regarding the interview questions. Comparison of responses from clinicians involved in the pilot study should have been similar, indicating that the instrument was capable of eliciting similar responses. Equal

numbers of clinicians from each profession were used to compare results (e.g., three social workers, three mental health practitioners, and three psychologists).

Research Study

Recruitment from the research study involved convenience sampling from community mental health agencies. Additionally, snowball sampling was used to identify additional clinicians involved or currently involved in the treatment of sex offenders. I asked clinicians from the pilot study to make referrals. In addition, I asked clinicians working with sex offenders to make referrals for additional participants in the study. Equal numbers of professionals from each area of specialization were used (i.e., three social workers, three mental health practitioners, and three psychologists). However, because of the area of specialization—work with sex offenders—it might not be feasible to acquire a uniform sample for the investigation.

I contacted clinicians directly through professional relationships with community mental health services. I asked professionals agreeing to participate to recommend additional helping professionals to reach a sample size goal of 10 to 15 candidates. Once all participants provided informed consents, I conducted in-depth, one-on-one interviews. Data collected through the interviews were analyzed and compared to identify common themes used as the basis for building a theory related to the topic (grounded theory).

I scheduled and conducted the in-depth interviews at a time and place convenient for the clinician. I anticipated that the interviews would take between 60 and 90 minutes to complete. All interviews were audio recorded for later transcription. I transcribed all the interviews within 48 hours of completion. During these interviews, I remained

responsible for facilitating a conversation with the clinician. I used the interview form (see Appendix). I remained responsible for collecting field notes during the interview to highlight specific issues of concern expressed by the clinician through body language or facial expressions. Field notes were included with the interview transcripts to provide the coder with a comprehensive understanding of the interview environment.

Data Analysis

Data analysis for this investigation began with member checking of the information provided during the interview. Interview transcripts were sent to the participant to verify that the information was correct. I addressed any issues noted by the participants at this time to ensure the transcripts were complete. Additionally, analysis of the transcripts was provided to all participants to ensure the analysis represented their views on the topic under investigation. Participants could verify if the themes identified reflected their opinions and responses regarding the topic.

Data analysis for this investigation followed the grounded theory approach through open and axial coding. I analyzed interview transcripts to identify major categories of information (open coding), followed by axial coding to identify issues integrally linked with the open codes (see Creswell, 2012). Coding was undertaken by three graduate students with codes identified by three of three or two of three coders included in the final review of each transcript. This process was completed for each of the interviews with comparisons of the codes to identify similarities. Similar codes noted most interviews (75%) were included as part of the final analysis to identify a theory that related those concepts.

Open and axial coding are critical elements of grounded theory research. Babbie (2012) defined open coding as requiring the researcher to essentially open the text to "expose the thoughts, ideas, and meaning contained therein" (p. 397). The process of open coding, according to Babbie, facilitates the ability of the researcher to break down the text into discrete parts to provide closer examination. During this process, similarities and differences in texts were identified; therefore, I created a conceptual understanding of the topic under investigation (see Babbie, 2012). Open coding represented the starting point for the coding process in grounded theory and required a deconstruction of the text to provide the foundation for reassembling ideas and creating meanings from the information collected (see Babbie, 2012). I used multiple coders to establish these codes and ensure accuracy in data analysis.

Axial coding, the second step in analyzing the data, requires the identification of core concepts that are integral to the study (Babbie, 2012). Open codes identified through the first round of coding are used as the basis for regrouping the data and identifying connections between core issues essential to meaning in the information provided by participants (Babbie, 2012). Axial codes not only reflect the direct language used by the participant but also underlying issues of importance to the participant that must be interpreted by the researcher (Babbie, 2012). Once this second round of coding was completed for each of the interviews, I compared the results for each of the questions to formulate a broader understanding of the topic through clinician responses to build the foundation for grounded theory.

I used results from the pilot testing to study the themes elicited from participants. I used this information to determine if the questions were worded appropriately to provide similar responses. Results from the research were used to formulate a foundation for understanding clinician attitudes toward sex offenders. Results from clinicians treating sex offenders were studied to identify similarities and differences in responses.

Verification of Findings

I verified the findings using member checks, external audits, and clarifying researcher bias (see Creswell, 2012). I used member checks after completing the transcripts to have participants review their responses and ensure accuracy. External audits included using additional coders to verify open and axial codes for the transcripts. Coders included three graduate students who completed qualitative data analysis in the past to ensure they had the training to analyze qualitative research effectively. I avoided bias through coding the transcripts to study results with coders and identify potential areas for bias in the research.

Summary

I used a qualitative methodology to facilitate an in-depth exploration of the topic and build further insights and understandings of the attitudes of clinical professionals toward the treatment of sex offenders. Measures, including pilot-testing of the interview instrument, using member checking, and performing external audits by coders, ensured the reliability and validity of the study. The application of the qualitative grounded theory study led to the collection of data for review.

In the following chapter, an overview of the results from the investigation is provided. Chapter 4 includes the demographics of the population and the themes identified for use. Chapter 4 presents the results from the interviews with participants.

Chapter 4: Results

Introduction

Mental health professionals who treat sex offenders experience highly charged environments that can create a number of challenges for effective intervention and can lead to difficulty providing treatment for this population (D'Orazio, 2013). The purpose of this study was to examine the attitudes of clinical professionals who work with sex offenders to identify the specific ways that these attitudes influence professional behaviors and client interactions. The aim of the study was to provide an in-depth analysis of clinician attitudes to determine what attitudes are present, how they are addressed, and what impact they have on the treatment of sex offenders. To address the purpose of this study, answers to the following research questions were sought:

RQ1: What are the attitudes and beliefs of clinical professionals (therapists, counselors, and licensed mental health workers) toward sex offenders?

RQ2: How do clinical professionals view the treatment of sex offenders?

RQ3: What frameworks do clinical professionals use to balance their obligations to the profession and the client with negative images and views of sex offenders?

RQ4: What internal struggles do clinical professionals face when providing treatment to sex offenders?

RQ5: How do clinical professionals overcome negative feelings, emotions, and biases toward sex offenders to deliver effective treatment?

This chapter contains a description of the setting of the study, followed by the demographics. The sample of the study consisted of 10 clinical professionals who worked

with sex offenders. The data collection method using in-depth interviews, data analysis procedure using open and axial coding, and the evidence of trustworthiness are summarized in this chapter. Then, the results are presented in the form of themes from data analysis. The themes are analyzed for relationships to formulate the theory for this grounded theory study. The chapter is concluded with a summary.

Setting

The setting of the study was community mental health agencies. The agencies consisted of clinical health professionals from medical, mental, and social backgrounds. I focused on three groups of clinicians: social workers, mental health practitioners, and psychologists.

Demographics

The sample of the study consisted of 10 clinical professionals who worked with sex offenders. I selected 10 participants through convenience sampling and snowball sampling. Social workers, mental health practitioners, and psychologists in community mental health agencies involved or currently involved in the treatment of sex offenders were the participants of the study.

Data Collection

The data for this grounded theory study were collected through semistructured interviews. Participants were selected using a convenience sampling technique, in which I used my professional relationships with community mental health agencies to invite potential participants. Additionally, I used the snowball sampling technique to recruit more participants. The sample consisted of 10 clinical professionals who had worked or

were working with sex offenders. The sample size of 10 was determined when data saturation was achieved. I was in contact with the participants prior to the interviews to build rapport and explain the nature and purpose of the study. I asked the participants about when they would have time for the interviews.

All 10 participants were asked to sign an informed consent prior to the interview. I used the informed consent form to protect the participants' rights and provide the scope and limits of participation. The participants were made aware that the interviews were audio recorded for data collection and analysis purposes. Once a participant signed the informed consent form and agreed to the recording, I began the interview. The interviews were semistructured in nature. All the questions in the interview protocol were open-ended to allow discussion with the participant to collect in-depth information. All the interviews were one-on-one and lasted about 60 minutes. Each recording was transcribed within 48 hours after the interview.

Data Analysis

The data analysis procedures involved open coding and axial coding to generate themes. The themes were used to develop a theory about the specific ways that clinicians' attitudes influence professional behaviors and interactions with sex offender clients. The data analysis procedures for this study are described in this section.

Data analysis commenced with member checking of the data collected from the interviews. I sent the transcript of each interview through e-mail to the corresponding participant to verify accuracy of the transcript. After verification by the participants, I began open coding.

Open coding started with reading and rereading the first transcript line by line. In rereading the transcript, I coded chunks of texts related to the research questions. The codes were compared and contrasted, and similar codes were grouped in a category. The categories that emerged from the analysis of the first transcript were used to guide the analysis for the succeeding transcripts. I developed as many categories or open codes as possible until no new information surfaced from the data.

I examined the relationships between the categories or the open codes through axial coding. I determined the relationships through identifying causal relations, the context in which the phenomenon occurred, intervening factors, and consequences of the relationships. Similar open codes were clustered to form a theme.

The themes were compared with each other to identify relationships. The relationship of the themes was used to formulate the theory and answer the research questions. The interpretations of the data were then sent to the participants through e-mail for member checking. The participants verified that the themes and the theory reflected their perceptions and experiences as clinicians who had worked or were working with sex offenders and addressed the purpose of the study.

Evidence of Trustworthiness

The evidence of trustworthiness involved verification of findings through member checks, data saturation, and reflexivity. Member checks involved allowing the participants to review and verify the accuracy of the transcripts and interpretations (see Creswell, 2012). I e-mailed the transcripts and interpretations to each participant for verification. Data saturation refers to the exhaustion of data until no new information

emerges from the analysis (Creswell, 2012). I used the codes and themes developed from the first participant to guide the analysis of the data collected from succeeding participants to compare the findings. Reflexivity involved self-inquiry to minimize bias. I repeatedly questioned whether the data and interpretation were aligned with the purpose of the study and the research questions.

Results

This section contains the presentation of the results, which are in the form of themes derived from data analysis. Descriptions of the themes and excerpts from the data are provided. The section concludes with the proposed theory developed through identifying the relationships among the themes.

Theme 1: Concerned for Behavior of Sex Offenders

The participants received the profiles of their clients prior to their meetings; therefore, the participants were aware they would be working with sex offenders. After meeting the sex offenders, most participants mentioned that they focused their attitudes and beliefs toward sex offenders on the concern for the behaviors exhibited by them. The participants were specific about hearing the clients' stories. Participant 10 stated the following:

> You have to remember that we deal with these people just about day-in and day-out. My emotions are coming dull at the beginning because I like to hear their story. Everyone has a story, and every sex offender is different, so my emotions are kind of level at the beginning.

As a clinician, Participant 08 mentioned that they made attempts to reduce or eradicate bias or *preconception* to move forward with the treatment of sex offenders. The participant's belief was to understand how and why the sex offender behaved in certain ways. Participant 08 shared the following:

> When I work with clients, I always think what was the catalyst for them to do what they did? And that's what always was [on] my mind, what triggered them or what was the thing that caused them to do this sadistic [behavior].

Participant 08 mentioned sadistic behavior and stated that certain offenses made staying neutral difficult:

> But, you know, like I said, there's different sides of the story. I think a lot, I would have to say, it depends on the crime and if it's something that [inaudible 00:00:45] put motion until actually see what the crime is. I think sadistic pedophilia is difficult. It would just bring up feelings … Like probably anger, sadness.

Participant 04 believed that long-term experience was needed to control an emotional response toward sex offenders. Participant 04 stated that "over time," she developed a concern for clients' behaviors without an emotional response:

> But as time went on, and I just got to know my clients more, my perspectives changed. Now if I walk into a room with a client who was a sex offender, I don't really have an emotional response beyond, "What are his goals, and what can I do to help them achieve them?" I don't really have that strong of an emotional response anymore. I don't know if it's desensitization.

Conversely, Participants 01 and 05 developed sympathy and empathy toward the sex offenders, as the participants became more concerned for their behaviors rather than their offenses. Participant 05 stated, “Sometimes I can feel compassion for the guy themselves when I listen to their background, and how they got to where they are.” Participant 01 reported,

> I think there’s understanding that develops. There may be a little sympathy. But I think there’s understanding of how they got there. That makes it a little bit easier. I always said that I don’t mind working with perpetrators because I would rather them get some help and recognize what their issues are instead of them not getting any help and being out there.

Participant 07 was the only participant who mentioned that he was often unaware of the offenses committed by his clients. Therefore, his concern for clients’ behaviors developed in the clinic. Participant 07 shared the following:

> I try not to, a lot of times, read the reports until after I’ve met with them, so that I’m not going into it biased and already thinking about that. A lot of my guys that are coming from state corrections, I don’t even get any of that information, so I just have their side of the story.

Theme 2: Curious About Whether Treatment Was Possible

Most participants perceived that clinicians focused their attitudes and beliefs toward sex offenders on the treatment. The participants shared that they wanted to help the clients. Participant 02 noted the following:

> And, you know, I suppose curiosity would spill into [it]. Would I be able to be of any help and will they be someone that I can eventually feel like I'm doing something positive with? Are they even going to be open to being in treatment?

Some participants felt frustrated when clients were in denial of their offenses, which made treatment more difficult. Participant 05 shared that she tried to do her best to work with every client, but if she determined treatment was impossible, she would pass the client on for recommendation:

> Well, I think the negative feeling usually is a result of their resistance. Their denial. Because I don't really have negative judgments against them. It's more about how they decide to do the treatment. When I do have somebody that's really resistant and really just fighting tooth and nail, I will try a lot of motivational interviewing techniques and try to find what is gonna motivate this person. Then, if I can't, I will recommend a transfer to another therapist or an entirely other provider altogether.

Participant 03 perceived that clients who were sex offenders believed that counseling was a form of "punishment," as they were caught committing an offense, and they were unwillingly subjected to counseling. The participant shared that some sex offenders tried to be manipulative in counseling and might sabotage their own treatments. Therefore, Participant 03 believed that working with sex offenders entailed a curiosity for whether treatment was possible:

> Well if they're sabotaging their self or doing things that are outside of common sense, most people would call them "stupid" things. That can be frustrating. I

> might even point that out to them and have them realize that it's incredibly frustrating to counsel when this is the kinda check-in that you're giving me at the beginning of the session. Because you have a list of things you're expected to do and all you have to do is follow them.

Participant 07 had similar experiences and claimed that when clients responded well to treatment, he felt "excitement," but when clients struggled, he felt frustrated. Participant 07 mentioned the following:

> When you see them struggling and not caring there's a lot of frustration that just like with your own kids, "Oh, God, why can't you just get this?" But when you see that light, like I said, go on, and you see them toward the end of their treatment and they're being kind of the group leader themselves.

Theme 3: Willing to Work With Sex Offenders Despite Anger and Disgust

Some participants shared that they felt negative emotions, such as anger and disgust, after learning that their clients were sex offenders. However, the participants' attitudes and beliefs involved willingness to work with sex offenders despite these negative emotions. Participant 01 shared the following:

> I was going to say, yeah, I feel a little angry because I'm like, "How could you do that?" But I'm willing to work with them. Sometimes even in what they did you might have a little … I might feel a little disgust, because sometimes the crimes are just horrendous.

Participant 06 was aware of the feelings associated with working with sex offenders; however, the participant shared that she felt "excited" for the challenge of treating sex offenders. Participant 06 shared the following:

> I've always wanted to work in the area of sexual addiction treatment. When I found this job online, I was just like "Wow, I've always wanted to work with sexual addictions, but I never really pictured myself working with sex offenders." I didn't really know much about the sex offender population. I guess at first, I was feeling excited about it, just to learn more about their background and what led them to become sex offenders, I guess.

As a mother, Participant 06 felt angry about the offenses committed by such clients. Nonetheless, the participant shared that she was "okay" with the work. Participant 06 added the following:

> It's kind of hard to balance that, you know thinking if someone ever did this to my child, I would want to really hurt them, but then having to completely ignore those feelings during therapy is hard. I feel like I'm doing okay at it.

Theme 4: Treat Like Any Other Client

During the treatment of sex offenders, most participants stated that the treatment was like that of any other client. Participant 09 shared that the treatment for all her clients began with rapport building. Participant 09 stated, "Really I don't [do anything differently]. I think the main thing is building that rapport, connecting with my client, hearing their story." Most participants believed that treatment of all clients differed from case-to-case, as with the treatment of sex offenders. Therefore, some participants

believed that treatment needed to be tailored to the clients' needs. Participant 02 shared, "Clients are, whether they're sex offenders or not are, am I going to be able to kind of get an idea of what might help them see things differently, behave differently."

Participant 10 mentioned, "Well, it just is case by case. 'No' is the answer. But it comes case by case, and it's not so much treating them as what I will do to help them." As with any other client, Participant 10 took moments to slow down during treatment to allow the client and herself to calm down. Participant 10 expressed the following:

> Well, there's a few things but as with most clients I have them take a deep breath, so they'll be able to slow down. Most of the time they're either slow, they're agitated, or they talk real fast. So, most of the time I have to tell them to take a deep breath, and that helps me as well.

Some participants believed that treating sex offenders as human beings who made mistakes made the treatment easier on the clinicians. Participant 03 reiterated, "But what I found in my actual experience with clients is everyone is actually a person. That even if they've done monstrous things, I don't actually see them as a monster." Participant 03 further explained the following:

> And counselors, they acknowledge client autonomy. They're non-maleficent. They're honest. They engage in communications with a quality of veracity, the ethical terminology. And so, I'm not there to judge. I'm there to be their counselor, and that gives me the window to just give my best shot using theories and interventions. They've already been judged. That's what judges do, they judge. They issue penalties and rulings. And that's already happened. So for me,

> I'm looking at them as a person who's dealing with those chains and how do they grow as a person to not hurt other people, see value in empathy, share empathy toward other people, and not look at people like they're just instruments for their own gratification, or their own scheme.

Participant 04 emphasized that treating sex offenders was similar to treating other clients because "the person is a person [who] made bad choices." Participant 04 explained the following:

> There are always exceptions. But in my experience, most of them had very traumatic childhoods, or something very traumatic in their early adulthood, that has led them to making these really bad choices, and learning really bad coping mechanisms. If you can learn to focus on the person as a whole, and that this is a product of bad choices. That is something we can help clients learn to change; then it makes it easier to work with this population.

Theme 5: Practice Safety During Treatment

The participants practiced safety when working with sex offenders. Female clinicians reiterated that they ensured they could access an exit if working with sex offenders. Some female participants expressed feeling fearful when working with sex offenders, especially rapists. Participant 04 mentioned the following:

> I mean, it's changed over time. So, when I first started treating, the first client had that was a sex offender, I did not know was a sex offender. He was in my office, and he was between me and my door. Yeah. I rearranged my office after that. But

> he told me that he had just gotten out of prison for 25 years, for aggravated rape. Yeah. That scared me a little bit, because I had no idea.

Participant 02 admitted that she might have bias when working with rapists: "I know that they hate women and I'm a woman." The participant believed that working with rapists required more safety practices that working with child molesters. Participant 02 stated the following:

> As far as a child molester, I don't particularly have ethical dilemmas working with them because I feel like they've … The crime's already been committed, somebody needs to work with them. It might as well be me. I think I'm pretty good at what I do. As far as the rapist, then there I have a lot less hope, a lot less inclination to even ... Like when I get the first bit of resistance from them, I'm probably not going to probe them too far to try to work with them. Because if I don't feel like they're willing to work with me, I'm not going to put myself at risk for being abused.

Participant 05 shared that the difference between treating male sex offenders and other clients was the additional safety measures for female clinicians. The participant mentioned that she immediately established a "power structure" when treating sex offenders. Participant 05 discussed the following:

> Yes, actually I do. Not everyone would admit this, okay. In addition to all of the other things like being respectful, treat them with positive regard, there are some things that I've found, especially as a female therapist, that I have to do different. I have to set up the power structure right away, and so I instruct them where to sit.

> I immediately take control of the interview so that they know that I'm the one that's directing it. I've found that doing that has helped with kind of setting the boundaries right from the start. Yeah.

Participant 06 believed that as a female clinician, she needed to treat male sex offenders differently than the way she treated other clients. Participant 06 explained the following:

> I guess I, I tend to be a little less cheery with them because I feel like sometimes, especially since I work with male sex offenders, I feel like sometimes if I'm really cheery and really overly friendly that they might misinterpret that, or you know, think that I am able to be easily manipulated or something like that. I try to tend to be a little bit more serious with them. More direct and to the point, at least during intake. Whereas with a general mental health client coming in for depression or something, I might just be more like making more eye contact and engaging them more and being, try to be a little more cheery [*sic*] and yeah.

However, some participants shared that they practiced safety with all clients. For instance, Participant 04 shared she ensured she could access the exit when clients with depression came in, as they might become violent:

> But I can put that aside and treat them the same way that I treat my clients. I think it's just important that they feel like, they're still a respected human being. That, I'm allowing them to keep that dignity. No, I really don't treat them any differently. The only difference I really see is, especially if it is a rapist, somebody who's been convicted of a rape offense, I just make sure that I have an

out … Of my office. [crosstalk 00:10:23]. But I do that really, with all of my clients. I want to have an out, no matter … because somebody might come in with depression and get very violent. You never know. I try to just make sure I have an out, in case something happens, and they're triggered. I've never had this come up as an issue though.

Theme 6: Treatment Based on Addiction Treatment

Two participants mentioned that the framework they followed in treating sex offenders was based on the addiction treatment model. However, both participants reiterated that they needed to remain careful not to treat sex offenders as addicts to avoid giving the offenders an "excuse" for their actions. Participant 06 mentioned the following:

> Since I'm a sexual addiction therapist, that's my specialty, I love going, my natural bias is to treat sex offenders from an addiction perspective. Like addiction treatment model. That is not really always allowed in this arena. Especially with probation officers and judges and prosecutors and things like that, they don't, at least from what I've heard, they don't like hearing the word addiction when it comes to sexual offense because they feel like that gives the offender an excuse for what they're doing.

Participant 04 posited that sex offenses were a form of addiction for the clients. Participant 04 reported the following:

> The first few that came through my office, were when I was doing addiction. They were mandated for their addiction issue, but I was treating everything: their

> depression, anxiety. The sex offenses come up, and they're usually a big part of the addiction for these particular clients.

Theme 7: Overcoming Moral Dilemmas

One of the internal struggles experienced by the participants involved overcoming moral dilemmas when treating sex offenders. Most participants differentiated moral dilemmas from ethical dilemmas. Participant 10 believed that giving sex offenders a fair chance at treatment was ethical. The participant claimed that she did not experience ethical dilemmas. However, when speaking of moral dilemmas, the participant claimed to have experienced moral dilemmas, such that the participant was treating a person she did not like. Participant 10 shared, "Well, there's always moral dilemmas. Ethical, no, because I think everyone deserves a chance. Although society might not think so." Participant 07 believed similarly and stated, "As far as personal ethical dilemmas, again, don't agree with the behavior, but that doesn't mean that they can't be a good person."

Participant 04 shared the difficulty of dealing with moral dilemmas when working with sex offenders:

> At first, it was pretty difficult. I was having some moral dilemmas, like, "How can I treat a person, who's treated another person like this?" At first, I felt like it was impacting me, in a way that I didn't feel like as being really effective in treatment. Because those thoughts just kept running through my head. As much as I wanted to help this person, I was having a really hard time putting it aside at first.

Nonetheless, the internal struggle of the participants regarding moral dilemma was eased by knowing their moral responsibilities. Some participants perceived that their

responsibilities as clinicians included treating the sex offenders so as not to cause harmful offenses in the community. Participant 06 shared, “If no one treats them they’re going, the chances of them re-offending are very high, so I kind of look at it as I’m helping the victim by helping the offender.” Similarly, Participant 08 stated, “Because if I can save a victim because I’m able to rehabilitate an offender then that is a positive, even if even it’s difficult to hear that what they did as a crime.” Participant 01 mentioned the following:

> No, because you’re always going to get clients that you may not agree with what they’ve done or morals. Your morals may be different, but that doesn’t mean you can’t treat them or work with them. It shouldn’t be any different with a sex offender. If you decide that you want to work with sex offenders, you should be aware of that.

Participant 09 emphasized keeping biases away from treatment. The participant shared that she understood some sex offenders experienced trauma during childhood, which might have caused them to behave in these ways. Participant 09 believed that treating sex offenders, despite disagreeing with their offensive behaviors, was a moral responsibility, which helped her overcome moral dilemma. Participant 09 reiterated the following:

> Internally. I think again, I just feel like I have a responsibility to do my part. Because if they’re coming to me for care because of a pattern of behavior, because someone has been victimized, then I think I have a responsibility to provide my professional service to that client. And so internally, that’s something

> that I deal with. It's the importance and the seriousness of me providing that care, to keep other victims safe. So, I'm really aware of that client's safety.

Theme 8: Speaking With Colleagues

To overcome negative feelings, emotions, and biases toward sex offenders to deliver effective treatment, most participants spoke with their colleagues. The participants did not hide emotions, especially negative ones, associated with treatment of sex offenders. Participant 01 mentioned the following:

> I usually try to set aside those emotions and then afterwards I'll go talk to a colleague about it. Like I said, working with sex offenders, you just have to be very aware of all your biases, very aware of emotions that can creep up, and just be very cognizant of that when you're working with them because you know it's going to happen. Then afterwards I just like to bounce things off my colleagues to make sure.

Participant 05 acknowledged that having a good support system among her colleagues was helpful in overcoming negative emotions. Participant 05 expressed the following:

> But when I do have something that hits me harder than normal, I talk to my colleagues. We have a really good support system here. Sometimes I might even call someone. I did have a situation a couple years ago, it was an evaluation I was doing on a guy, and his particular offense just it gave me a sick feeling to my stomach, and it shook me because it was heinous. I left here and made some phone calls to some colleagues and said, "I gotta talk to you. I need to tell you

> about this guy that came in today." It's really, really helpful to have people to talk to.

Participant 08 shared that after treating sex offenders, she would talk to her colleagues to overcome any negative emotions. Participant 08 claimed, "I think if it was something after a real disturbing interview, I definitely go in and process it with somebody because I know it affects me when I go home." Participant 08 added the following:

> I speak with my coworkers and my supervisors and ask them for advice. And I go back to my clinical. I go back to what I was taught in school. There are times it's just really hard and there's no question it was hard, but I rely on my coworkers and my clinical director to advise me.

Participant 08 believed that talking to a superior contributed to what the clinicians learned: "You think you've heard everything? You'll hear something you've never heard before." Participant 04 reiterated that talking to the supervisor did not only help control emotions but also practice ethical treatment:

> Initially, I would seek consultation with other therapists, or with my supervisor. Because these things happened, right when I started counseling. I'd just seek some consultation, talk with my coworkers, and process the emotions and the imagery. For me, I always just wanted to make sure I was still acting ethically. I tried to process through also, what I said to this person. To make sure that I was still, acting in the best interest of my client. Because I was afraid that maybe I wasn't, because of those strong emotion, and that strong reaction.

Theme 9: Being an Expert in the Field

For half of the participants, the years of experience related to the treatment of sex offenders contributed to overcoming negative emotions. Participant 09 claimed that treating sex offenders negatively affected her during the beginning of her career, but as she gained more expertise in the field, she learned to control her emotional responses. Participant 09 narrated the following:

> Yeah. That would've happened years ago. It's happened years ago, like I would get upset or I would take it home with me, and maybe be disappointed in what they did, or to totally disagree with what they did. But I think now, because I've been in the field over 20 years, I just don't feel that. It doesn't impact me anymore.

Participant 05 had similar experienced and claimed that she gained "detachment skills" when having emotional responses to clients. Participant 05 shared the following:

> It used to affect me a lot more when I first started, but you have to understand I've been doing this now for 25 plus years. I don't get as emotionally impacted as I used to before. Now, it feels more just like work. This is my job.

Participant 01 claimed that she gained the "awareness" to keep her emotions "in check" when treating sex offenders. Participant 01 claimed the following:

> I don't think it impacts my ability at all because I come in there knowing that I'm going to feel those emotions. I already know what they … I've already done this work before, so I know that if I work with another sex offender, I'm going to feel

> all those emotions. I have those in check. When I go in, I'm very aware so I'm not biased against my client.

Theme 10: Practicing Self-Care

The participants practiced self-care to overcome negative emotions associated with treating sex offenders. For some participants, physical activities helped them cope with negative emotions. Participant 08 shared the following:

> I think the healthiest output I have is going to the gym after work. I think that really, really helps. In fact, I can really tell the difference whether or not … I thing [*sic*] working out really makes a big difference.

Participants 02 and 04 mentioned regular exercise and a healthy lifestyle helped them cope with negative emotions. Apart from physical health, Participants 04 and 09 reiterated the contribution of good mental health. Participant 04 stated that "mindfulness skills" might help in dealing with negative emotions, while Participant 09 emphasized to seek professional help when the emotions became too much to handle. Participant 09 stated, "Make sure if you need counseling, if there's something that you need to identify that happened in your childhood, or maybe something that has occurred recently, make sure that you do the mental work for you." Participant 08 shared that having "worry beads" was helpful in staying calm:

> I actually have … They're like worry beads. It's like a fidget toy I have in my hands and worry beads. So, I fitted, so I have my little fidget hand thing. So, I'll just smile and I'm fidgeting with my little worry beads and I'll fidget and listen to the story. And I'm listening to them but I'm fidgeting, I'll fidget. And it's not

> something that they'll, you know … They're doing as well. Do something while listening to them but I'm definitely fidgeting. But I have my little worry beads. So that's something that's maybe like a calming or soothing or distracting [action].

Participants 02 and 03 perceived that knowing their limits as clinicians helped them overcome negative emotions. Participant 02 claimed that she would cut the session if the client became "antagonistic" and "assaultive." Participant 03 believed that taking breaks and managing the schedule of clients helped her maintain professionalism when treating clients:

> Well, I think it's important for me to not have eight consecutive sessions that are like this in a day. So, it's a little bit of calendar and schedule management, looking at the clients you have and what issues are gonna come up, and not every client in this category is actually exhausting and disappointing.

Some participants perceived that spiritual health helped them cope with negative emotions. Participant 06 mentioned, "My spirituality and religion is [*sic*] pretty big in my life and so I just pray to be able to see them in the way that I feel like God wants me to see them." Participant 04 claimed the following:

> Because I'm Christian, so I believe. I don't know if they do, and I don't tell them. But it helps me find peace, if I'm praying for my clients. Especially when I'm really struggling, with dealing with something that they're going through. Because, I know God's got it. That helps me a lot, is to pray for [my clients].

Some participants believed that being aware and prepared for the job helped them overcome negative emotions. Participant 06 noted the following:

> If it's during a session I try to, so I try to make a solid plan for sessions before the client comes in so if I tend to, if I find myself being triggered or any counter-transference or something I try to just focus on the plan and say "Okay, we're going to get this done, this done and this done in session today. So, let's just focus on that," so it they say something that triggers me or if they're purposefully trying to upset me then I try to just stay focused on the plan instead of engaging them. Especially the narcissistic ones, that's what they want.

Theme 11: Focusing on the Job

Most participants overcame negative emotions and biases when treating sex offenders through focusing on the job. Some participants believed that treatment of sex offenders allowed clinicians to make a difference in the community. The participants focused on their goals of making a difference. Participant 08 claimed the following:

> So, how I look at it is that I have the ability to work with sex offenders, a lot of people can't. And if there is that chance that they'd be rehabilitated, at least I have the ability to work with them and they can be rehabilitated where a lot of people will stay away and then won't get near it. So, I tried to look at it in the positive light, that maybe I can make that difference.

Participant 02 claimed that she treated working with sex offenders as a job, and her job as a clinician included making a difference for her clients. Participant 02 shared the following:

> I mean, morally and ethically, I am just not that person that gets crazy about ... To me it is a job. To me they're human beings and unless somebody, again, comes at me, I feel like I'm just here to see if I can make a difference.

Some participants focused on the job by remaining neutral and professional. Participant 07 mentioned, "I know I have to be professional and I know I have to get through it." Participant 09 claimed that remaining neutral helped:

> Yeah. For me, because I've worked with mostly all populations, my feelings kind of are the same. Like I said before, I just want to make sure that we're clear, that he understands me clearly, or if she understands me clearly. The feelings that I get is just I need to make sure that I'm doing all that I can to make sure that I provide support and attention to their needs, to client needs. And that I am listening really well, so I can get all the details. So, emotions, I would just say, are pretty standard, just as a professional. Very neutral.

To remain neutral and professional, some participants learned to separate their feelings from their jobs. Participant 02 stated, "Well, I would compartmentalize and get through a session." Participant 04 reported the following:

> Then I learned to compartmentalize it as well, and just put it in the filing cabinet and not let it impact me emotionally. Which is definitely a skill that has served me well, since the beginning of my counseling career. It took a little while, to learn not to take all that home with you. To [crosstalk 00:09:02] leave it.

Summary

This chapter contained the presentation of the results. The results addressed the purpose to examine the attitudes of clinical professionals who worked with sex offenders to identify the specific ways that these attitudes influenced professional behaviors and interactions with the client. I answered the following research questions:

RQ1: What are the attitudes and beliefs of clinical professionals (therapists, counselors, and licensed mental health workers) toward sex offenders?

RQ2: How do clinical professionals view the treatment of sex offenders?

RQ3: What frameworks do clinical professionals use to balance their obligations to the profession and the client with negative images and views of sex offenders?

RQ4: What internal struggles do clinical professionals face when providing treatment to sex offenders?

RQ5: How do clinical professionals overcome negative feelings, emotions, and biases toward sex offenders to deliver effective treatment?

The attitudes and beliefs of clinical professionals toward sex offenders involved them being concerned about the behaviors of the sex offenders, being willing to work with sex offenders despite anger and disgust, and being curious about whether treatment of sex offenders was possible. Although the participants felt anger and disgust toward the sex offenders, and certain offenses (e.g., pedophilia and rape) led to bias, the participants set aside their feelings and personal biases to understand how and why the sex offenders behaved in these ways.

The treatment of sex offenders did not differ from treatment of other clients, apart from added safety measures, particularly for female clinicians. The participants built rapport with their clients, saw their clients as people who made mistakes, and tailored the treatment to the sex offenders. Although some participants believed that added safety measures were needed when dealing with sex offenders, others believed that being safe, such as letting client know who was in-charge and having access to an exit, were practices applicable for all types of clients. Some participants believed that the treatment of sex offenders was similar to the treatment model used for addiction; however, the participants reiterated that sex offenders were not to be treated as addicts so as not to excuse their offensive behaviors.

The internal struggle that clinical professionals experienced when providing treatment to sex offenders was moral dilemma. Most participants emphasized that the offensive behavior of their clients was morally unacceptable. However, some participants believed that their jobs as clinicians entailed a moral obligation to prevent sex offenders from repeating such behaviors. Therefore, the participants could overcome the moral dilemma of treating sex offenders; moreover, some participants reiterated the differences between moral dilemma and ethical dilemma, whereas clinicians were ethically obliged to provide treatment to all clients. The participants did not experience ethical dilemma, as they focused on their jobs.

Focusing on their jobs was one of the ways that participants overcame negative feelings, emotions, and biases toward sex offenders to deliver effective treatment. The participants were motivated to make a difference when treating sex offenders. The

participants practiced remaining neutral and professional to focus on their jobs. The participants spoke with their colleagues to help them reflect and process their emotions, as well as to learn from their colleagues' and superiors' experiences. The participants emphasized the contribution of years of experience in the field to gain expertise in dealing with sex offenders. The results showed how attitudes of clinical professionals who worked with sex offenders influenced professional behaviors and interactions with the client. Figure 1 shows a visual representation of the proposed framework.

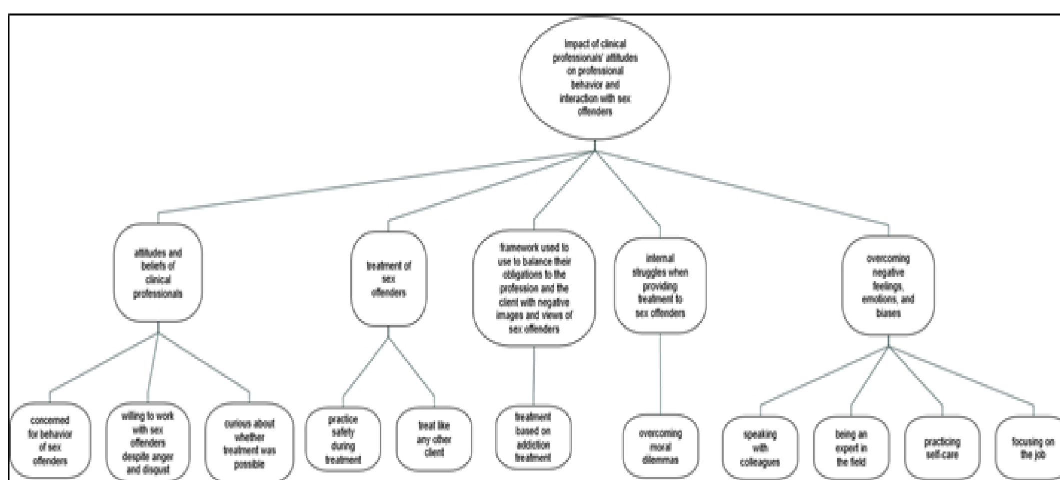

Figure 1. Proposed framework. The figure shows how attitudes of clinical professionals who work with sex offenders impact professional behavior and interaction with the client.

The themes and the framework presented in this chapter are discussed in the next chapter. The discussion relates the results of this study to existing literature and to the bias theoretical framework. The next chapter contains the recommendations, implications, and conclusions of this study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Attitudes and perspectives on sex offenders have varied among different groups from different times (Church et al., 2011). These attitudes and perspectives are affected by the fact that little is empirically known about sex offender treatment and recidivism (Duggan & Dennis, 2014). Rosselli and Jeglic (2017) volunteered evidence that sex offenders hold lower recidivism rates compared to other offender types, and yet, they remain one of the most abhorred groups in the public eye. While many hold purely negative views of sex offenders, clinicians and other professionals who work with them may display more complex views (Church et al., 2011). MacDonald, Clarbour, Whitton, and Rayner (2017) noted how previous studies on the influence of working with sex offenders have been inconclusive. As these professionals work extensively with sex offenders, they may have deeper insights regarding this group that influences their attitudes and perspectives on a less monochromic scale. In turn, these attitudes may adversely influence their work and treatment toward sex offenders.

The purpose of this study was to examine the attitudes of clinical professionals who worked with sex offenders to identify the specific ways these attitudes influenced professional behaviors and client interactions. The following research questions were formulated to achieve this purpose:

RQ1: What are the attitudes and beliefs of clinical professionals (therapists, counselors, and licensed mental health workers) toward sex offenders?

RQ2: How do clinical professionals view the treatment of sex offenders?

RQ3: What frameworks do clinical professionals use to balance their obligations to the profession and the client with negative images and views of sex offenders?

RQ4: What internal struggles do clinical professionals face when providing treatment to sex offenders?

RQ5: How do clinical professionals overcome negative feelings, emotions, and biases toward sex offenders to deliver effective treatment?

I conducted semistructured interviews with 10 clinical professionals who worked with sex offenders in community mental health agencies to answer the research questions. Using grounded theory as a lens, 11 themes emerged from the interviews, forming five categories. These themes and categories formed a complex framework that shows the influence of clinical professionals' attitudes on professional behaviors and interactions with sex offenders.

The first category in the framework showed the attitudes and beliefs of clinical professionals. Findings indicated that the professionals were mostly concerned for the sex offenders' behaviors; they were willing to work with them despite feelings of anger and disgust and were curious about the possibility of treatment. The second category showed clinical professionals' treatment of sex offenders, whom they said they treated like any other clients but emphasized the importance of safety during treatment. The third category displayed the framework that the professionals used to balance their obligations to the profession and the client with negative images and views of sex offenders, which comprised of treatment based on addiction treatment. The fourth category revealed the internal struggles that these professionals can have when providing treatment to sex

offenders and how they overcome these struggles or moral dilemmas. The fifth and last category described the specific skills and strategies that professionals have used in coping or overcoming the negative feelings, emotions, and biases they have encountered while working with sex offenders. These included speaking with their colleagues, being experts in the field, practicing self-care, and focusing on the job. These themes are discussed in detail and in line with existing literature in the following section, followed by a section on the limitations of the study, recommendations for future research, and the implications of the current study. The chapter concludes with a summary.

Interpretation of the Findings

This section includes the themes that formed the foundation of the framework derived from the findings. The findings are juxtaposed with previous findings from the literature to present a place in the current field of knowledge. The first three themes show the participants' attitudes and beliefs regarding their professions.

Theme 1: Concerned for Behavior of Sex Offenders

Initial public reactions to sex offenders mostly comprise a sense of moral panic and anxiety (Day et al., 2014), yet participants in this present study revealed steadier responses after knowing their clients' profile. They reported being more concerned for the behaviors exhibited by the clients, rather than their offenses. As one participant stated, "Every one [*sic*] sex offender is different." Sex offenders comprise a variety of people with different characteristics; as reported by Elias and Haj-Yahia (2016b), some could even pass off as their own friends.

The present study's participants said they have been able to treat each new sex offender client as a blank slate and not give in to negative emotions. Similarly, MacDonald et al.'s (2017) participants stated that the profiles of their clients as sex offenders did not influence their initial treatment of them. They stated that although the clients' offense lingered in their minds, they did not let these thoughts influence their treatment (MacDonald et al., 2017). These findings, along with the present study's findings, display a more neutral—rather than positive or negative—stance that professionals took when meeting sex offender clients.

As reported by this study's participants, the initial goal of the professional upon meeting the client was to understand their stories. Thornton (2013) found the role of understanding clients' pasts was mainly to identify risk factors and behavioral patterns that might help with treatment. The behaviors and even the strengths of the clients should be the focus in developing their treatments, as the professional formulates treatment plans around this information. In the present study, only one participant reported not reading the provided reports of their clients before meeting them to avoid bias. A veteran professional in Parsonson and Alquicira's (2019) study shared the same sentiments, stating that reading these reports might damage their frame of thought before actually meeting the client.

Although most participants in this present study, as well as in the aforementioned studies, displayed neutrality on their encounters with sex offenders, evidence from past studies has indicated more negative experiences. Some professionals reported having nightmares and mental images of the offense reported to them (Elias & Haj-Yahia,

2016a). A therapist from Elias and Haj-Yahia's (2016a) study relayed that he was so shocked by the report he had read, he actually wanted to refuse the client. Some sex offenders in Van den Berg, Beijersbergen, Nieuwbeerta, and Dirkzwager's (2017) study reported that they felt discriminated against by the correctional officers who worked with them compared to other offenders. These two studies revealed that, contrary to the present study's findings, the attitudes and beliefs of professionals who worked with sex offenders might still be negatively influenced by the clients' offenses. This finding also supported the idea of the present study's single participant who did not read reports prior to meeting clients to preserve the neutrality during their initial meeting with the client.

Theme 2: Curious About Whether Treatment Was Possible

As professionals met their clients and learned more about them and their behaviors, clinicians' attitudes and beliefs formed around the possibility of treatment. Participants in the present study expressed frustration over clients who were in denial or who seemed to be sabotaging their own treatments. Several previous researchers have found that offender denial may significantly hamper treatment progress (Freeman et al., 2010; Sturgess, Woodhams, & Tonkin, 2016; Thomas, Phillips, & Blaine, 2015; Thornton, 2013). Clinical professionals have to remain careful when dealing with this denial, as too much pushing may appear confrontational, which could discourage the client even further (Thornton, 2013; Watson, Daffern, & Thomas, 2016). Thornton (2013) emphasized the importance of encouraging the client to have just enough ownership over the offense so as to overcome denial while not placing too much blame on them.

In Freeman et al.'s (2010) investigation of denial, they found that it stemmed from clients' self-esteem or self-respect, antisocial attitudes, and fear of punishment or reprisal. Similarly, a participant from the present study suggested that sex offenders might view counseling as a form of punishment, which then negatively influences their cooperation. Fortunately, Thomas et al. (2015) found that time in treatment could eventually strip away this denial, as therapists patiently continue to work with sex offenders. Previous studies have shown that treatment is possible for sex offenders once they overcome this denial (Blagden, Winder, & Hames, 2016; Thomas et al., 2015).

Ward and Durant (2013) displayed contradictory results, finding that empathy intervention rarely worked for sex offenders. Nonetheless, the present study's findings display promising results, as professionals appear to care deeply about the treatment. One participant even equated the client to his own children, stating that it can be frustrating when they struggle. This type of caring attitude by the professionals allows them to put more effort into ensuring clients receive the best treatment possible.

Theme 3: Willing to Work With Sex Offenders Despite Anger and Disgust

As human beings with their own feelings and emotions, clinical professionals sometimes feel anger and disgust over their clients' offenses. The participants in this study admitted that it was difficult, at times, to ignore these feelings when they hear about the "horrendous" crimes of their clients. These feelings reflect the views held by the public, displaying disgust and not wanting to be anywhere near sex offenders (see Burchfield & Mingus, 2012). In Blagden et al.'s (2016) study, correctional officers found

it difficult to work and form bonds with sex offenders, more so than with other types of offenders, because of their feelings of disgust.

A positive side of this study's finding was that the participants could overcome their feelings of disgust and were willing to work with sex offenders. Other researchers supported this finding, revealing how professionals and even volunteers who worked with sex offenders often held more positive views of them than the public (Day et al., 2014; Kerr, Tully, & Völlm, 2017). A participant in Elias and Haj-Yahia's (2016b) study shared a sentiment with this study's participant in stating that they actually felt excited and fascinated about their job, despite the feelings of disgust. Caution must still be given, however, as feelings of disgust can influence not only professionals' attitudes and beliefs, but also their decisions regarding treatment (Allan, 2018). Professionals may be willing to work with sex offenders, but they must continuously keep these feelings in check during treatment. The next two themes discuss how professionals deal with these clients and the types of treatment they prescribe.

Theme 4: Treat Like Any Other Client

The present study's participants mostly did not differentiate their sex offender clients from any other clients. They emphasized how these sex offenders were human beings who made mistakes. As such, the participants prescribed treatment on a case-by-case basis, similar to how they treat other types of clients. Duggan and Dennis (2014) displayed how therapists might apply standardized treatment between patients to avoid therapeutic drift; therapists often chose to use evidence-based treatments with their

clients to ensure success, but the implementation of such treatment might still vary from case to case.

Treatment often began with rapport building with the client, as described by this study's participants. Other studies have shown support for this type of rapport building or "therapeutic alliance" between the client and the therapist (Sturgess et al., 2016; Watson, Thomas, & Daffern, 2015). Researchers have stated that a stronger alliance or rapport between a client and a therapist results in more successful treatments. Watson et al. (2015) emphasized the dynamism of therapy, stating that treatment success relied on the cooperation of both parties.

Participants in the present study also believe that sex offenders have often had traumatic experiences, especially during childhood, which may have contributed to their offensive behavior. This type of thinking allowed them to view sex offenders as "damaged" people instead of "monsters," as the offenses appeared to be bad coping mechanisms. Previous studies have also shown that sex offenders are often victims of childhood sexual abuse themselves (Gerhard-Burnham et al., 2016; Levenson, Willis, & Prescott, 2014; Thomas et al., 2015). Elias and Haj-Yahia (2016b) emphasized that these "damaged" people had suffered and developed these coping mechanisms that were not by choice. Levenson et al. (2014) revealed that 84% of sex offenders reported adverse life experiences, with 38% of them being childhood sexual abuse. With these statistics in mind, professionals who work with them may choose more positive, nonconfrontational techniques (Freeman et al., 2010; Yates, 2013). Yates (2013) further emphasized that,

just like other human beings, sex offenders can be goal-oriented, thereby prescribing goal oriented treatments that they might view as beneficial.

Theme 5: Practice Safety During Treatment

As professionals who worked with potentially dangerous clients, the present study's participants emphasized their own safety during clients' treatments. One participant revealed that safety measures were necessary in their occupations, even with clients other than sex offenders. She stated that she always ensured easy access to an exit in case a client started acting violently, regardless of the client. Kerr et al. (2017) found that volunteers who worked with sex offenders still found them dangerous, even though these volunteers were optimistic about their treatments. Some therapists have extended this fear outside of their work, to the extent that they have avoided walking alone at night and riding elevators alone (Elias & Haj-Yahia, 2016a).

In MacDonald et al.'s (2017) study, fear was also a prominent topic among professionals, but the fear mostly rested on false allegations made by clients. As seen in this present study's second theme, sex offenders might be uncooperative, even manipulative, in their treatment, and they might read any act by the professional as malpractice. A participant then shared how a balanced demeanor, not too friendly and not too confrontational, was necessary so as not to give the wrong idea to the client. Watson et al. (2016) echoed this finding, stating therapists should display collaborative and affiliative behaviors if no imminent risk of danger is presented by the client. They found that therapists who were too controlling were viewed negatively by offenders (Watson et al., 2016), which increased the risk of false allegations being made. These allegations,

although not physically dangerous, could pose serious threats to the professional (MacDonald et al., 2017). Probation officers who have worked with sex offenders likewise shared this fear, revealing how offenders' dangerous behaviors not only affect them physically, but may also cause them to react in ways that may be misconstrued as malpractice (Phillips, Westaby, & Fowler, 2016). In light of these types of dangers, participants in the present study also reported having to set up the power structure right away to set the tone of the therapeutic alliance. Elias and Haj-Yahia (2016b) supported this finding; their participants stated their jobs as sex offender therapists required a considerable amount of confidence and authority.

In the present study, female professionals were more emphatic on practicing safety during treatment. One participant suggested that sex offenders "hate women" and this affected her treatment of sex offenders, particularly rapists. She stated that once these clients showed the least bit of resistance, she would no longer probe them in fear of being abused. Cartwright, Mountain, Lindo, and Bore (2018) revealed that the additional factor of being pregnant incited even more fear from the professionals, to the point that they would make efforts to hide their pregnancy from their clients. On the other hand, several past studies displayed contradictory results showing how male professionals actually viewed sex offenders more negatively than female professionals (Baum & Moyal, 2018; Church et al., 2011; Day et al., 2014). Baum and Moyal (2018) purported that the risk of emotional danger from sex offenders were higher for male therapists than female therapists. They stated that male therapists might experience higher levels of vicarious traumatization, as they unconsciously identified with the offender (Baum & Moyal,

2018). Whether male or female, professionals must practice safety in different ways, not only physically or logistically but also in terms of setting authority within treatment, to decrease the risk of any type of danger to them.

Theme 6: Treatment Based on Addiction Treatment

The third category showed the framework used by professionals to balance their obligations to the profession and the client with negative images and views of sex offenders. Findings indicated that this framework was based on the addiction treatment model, as the sexual offenses were usually part of the offenders' addiction. This finding was shared by Thornton (2013) who stated that modern paradigm allowed clinical professionals to pattern treatments after related fields such as substance abuse treatment. Barroso, Pham, Greco, and Thibaut (2019) likewise stated that sex offenders may exhibit characteristics similar to mental disorders, including addiction, which would warrant similar types of treatment.

Persons with substance abuse disorders display lower self-monitoring and self-regulation, which are also shared by sex offenders (Stinson, McVay, & Becker, 2016). Stinson et al. (2016) then recommended a framework of safe offender strategies (SOS), which promoted offenders' self-monitoring and self-management skills. Caution must be given though, as some offenders may use the term "addiction" as an excuse for their actions, thereby avoiding responsibility for their actions (Evans, Ward, & Chan, 2019). This is echoed by a participant in the present study who stated that judges and prosecutors were often determined to repudiate it as an excuse rather than a real disorder.

Although addiction was the main focus of the framework presented by the participants, one participant shared other issues that she was also treating, such as depression and anxiety. Treatment frameworks for these types of disorders, especially ones that encouraged positive motivations and goal-setting, were also proven by previous studies to be effective on sex offenders (Sellen et al., 2013; Thomas et al., 2015; Yates, 2013). Specifically, the good lives model (GLM) has been an effective framework in resetting strategies for sex offenders in attaining their life goals (Thomas et al., 2015; Yates, 2013). Sexual offenses may be caused by bad coping strategies, or they may be caused by poor strategies to achieve life goals as well. The GLM allows clients to shift away from their maladaptive strategies and promote positive strategies instead (Thomas et al., 2015; Yates, 2013). Regarding frameworks, this present study's findings, as well as previous findings, indicated how certain frameworks from related disorders might be effective in treating sex offenders.

Theme 7: Overcoming Moral Dilemmas

The fourth category showed the internal struggles that clinical professionals underwent while treating sex offenders, which comprised mostly of overcoming moral dilemmas. Participants in the present study described moral dilemmas as treating someone whose actions they did not approve of morally. Idisis and Edoute (2017) revealed that therapists working with sex offenders attributed higher severity on these offenses than civilians, which they purported was due to social reasons. Therapists may believe that they may be equated with their clients by the public, if they do not express a

severe stance against these offenses (Idisis & Edoute, 2017). A participant in Elias and Haj-Yahia's (2016a) study expressed difficulty in accepting the clients' behaviors.

As stated earlier, feelings of anger and disgust over sex offenders' actions may persist with the therapists even as they leave their offices, which would often leave them pondering over this moral dilemma. MacDonald et al. (2017) expressed the inevitability of this dilemma, as therapists might empathize with the victims of sex offenders. However, MacDonald et al. suggested that reflection and reframing would allow therapists to overcome these feelings. Participants in the present study also expressed how they overcame this moral dilemma by concentrating on the positive effect of their treatment. They reframed this dilemma to become a moral responsibility to rehabilitate offenders, thereby decreasing victimization in the community. Elias and Haj-Yahia (2016b) echoed these findings, as their participants shared conflicting feelings about treating perpetrators and the social commitment to protect potential victims at the same time. Although some professionals can successfully reframe their perspectives to overcome this struggle, others are not so successful and may be troubled by cognitive dissonance in these conflicting moral dilemmas (Elias & Haj-Yahia, 2016b).

Allan (2018) presented the *Universal Declaration of Ethical Principles for Psychologists*, which lists the ethical principles that all psychologists abide by. These principles included respect for people and their own human dignity, justice, fidelity, care, and responsibility (Allan, 2018). These principles were found to be accepted worldwide. Therapists can then look to the care principle in justifying their treatment of offenders, as this treatment would optimally benefit the community (Allan, 2018). These findings

indicated the struggle of reframing and overcoming the moral dilemma of treating sex offenders might be difficult but still possible for clinical professionals.

Theme 8: Speaking With Colleagues

The remaining number of themes fell under the category of clinical professionals' ways and strategies in which they overcame negative feelings, emotions, and biases. The first strategy involved speaking with colleagues for advice or simply for support. Due to the emotional burden of their work with sex offenders, the participants relied on their colleagues to keep these emotions in check and to ensure their treatments and reactions to their clients remained ethical. The emotional burden that the participants of this present study pertained to might lead to "compassion fatigue" (MacDonald et al., 2017). Compassion fatigue is experienced by therapists who have empathized with suffering clients so much that they undergo secondary traumatization, which may compromise their abilities to care or provide any more compassion. To avoid compassion fatigue, therapists share some of this burden with their colleagues to alleviate the risk of secondary traumatization (MacDonald et al., 2017).

Several professionals who worked with sex offenders from other studies have also reported how colleagues and fellow counselors helped them deal with occupational stress (Parsonson & Alquicira, 2019; Phillips et al., 2016). At times, even conversations with friends and significant others helped ease therapists' burdens (Elias & Haj-Yahia, 2016a); however, some therapists feel too much shame about their work that they refuse to share details about it with others who would not understand or who might find it awkward (MacDonald et al., 2017). For this reason, colleagues would be the best people with

whom to share burdens. Participants from this present study, as well as Elias and Haj-Yahia's (2016a), reported how colleagues and superiors provided good insights regarding the shared cases, which they otherwise would not have considered.

Theme 9: Being an Expert in the Field

Aside from the external support provided by colleagues, participants of this study relayed how their own experiences and expertise allowed them to overcome their negative emotions regarding sex offender treatments. They noted how the years in their work allowed them to feel less emotionally influence or, at least, have those emotions in check during treatment. Although this finding might be a manifestation of compassion fatigue (MacDonald et al., 2017), it helped these professionals deal with their stress. Another explanation, aside from compassion fatigue, would be the accumulated knowledge gained through the years in the field. Therapists in previous studies have stated that the knowledge they had accumulated allowed them to view sex offenders in more functional and positive perspectives, rather than purely negative ones (Day et al., 2014; Elias & Haj-Yahia, 2016a, 2016b; Rosselli & Jeglic, 2017).

In MacDonald et al.'s (2017) study, the positive effects of real experiences were found to be more helpful than training alone. Elias and Haj-Yahia (2016a) stated that experience with different types of sex offenders allowed therapists to understand their needs, urges, and motives more, which helped in making precise diagnoses. Parsonson and Alquicira (2019) found that therapists held more personalized observations as they grew more experienced. Their study was the only one displaying contradictory results, suggesting that more experience led to greater internal impact on the therapist (Parsonson

& Alquicira, 2019), as opposed to this and other previous study's findings that experience in the field actually lessens internal impact. However, they did note that therapists, like their clients, were individuals who differed from each other; hence, how they deal with and learn from their experiences may also differ (Parsonson & Alquicira, 2019). Therefore, therapists must find the most optimal ways to learn from their experiences and gain expertise.

Theme 10: Practicing Self-Care

Most participants agreed that practicing self-care was important in the field. The participants in the present study enumerated several strategies that helped to relax them or to ease their emotional burdens. These included having a healthy lifestyle, exercising, practicing mindfulness, turning to spirituality and religion, pacing and proper scheduling of sessions, and even the simple act of fidgeting with items during sessions. Several past studies have also stated that healthy eating, getting enough sleep, and exercising can lower the effects of compassion fatigue or burnout (Bach & Demuth, 2018; Elias & Haj-Yahia, 2016a; Mayorga, Devries, & Wardle, 2015; Nissen-Lie et al., 2015). As Mayorga et al. (2015) stated, even 10-minute intervals of exercise are effective, so these can easily be done by busy professionals.

Researchers have reported proper scheduling of clients to alleviate stress (Elias & Haj-Yahia, 2016a). As a participant in the present study stated, clients have different issues that cause different levels of stress and exhaustion. Not setting "difficult" clients up for consecutive sessions may help reduce burnout. Another participant suggested cutting the session if client shows too much antagonism or aggression. This would reduce

not only the stress from the session, but also the risk of danger. Elias and Haj-Yahia's (2016a) participant also suggested setting the most difficult clients up last, so that the negative emotions do not linger throughout the day.

In terms of spirituality and religion, not all therapists and clients alike practice them, but for those who do, it appeared to help them overcome negative emotions as well. As stated by this present study's participant, "it helps me find peace, if I'm praying for my clients." Faith-based support and communities have actually been found by previous studies to help not just the therapists, but the clients themselves (Dum, Socia, Long, & Yarrison, 2019; Thomas et al., 2015). These types of strategies may not work for everyone but are worth considering for those who practice religion. Other self-care strategies presented by past studies include meditation, problem-solving together with the client, and continual reflection of social work values (Mayorga et al., 2015; Nissen-Lie et al., 2015; Parsonson & Alquicira, 2019). These self-care practices, along with those enumerated by the present study's participants, were deemed important in keeping clinical professionals emotionally healthy whilst dealing with sex offenders.

Theme 11: Focusing on the Job

This last theme displayed how focusing on the job, specifically the positive and professional aspects of the job, may also help in overcoming negative emotions. The idea of "making a difference" was prominent in the present study's participants, as they worked to lessen sexual offenses in their communities. This sentiment was shared by participants in Bach and Demuth's (2018) study, who stated that despite the distress caused by their jobs, they perceived its importance in making their communities a much

safer place. Conversely, in Elias and Haj-Yahia's (2016b) study, participants recognized their "social mission" to help society through sex offender treatment, but 52.63% of their participants expressed a desire to leave the field. In their other study, Elias and Haj-Yahia's (2016a) participants relayed the loss of quality of life that they experienced in the field. This shows how the job itself can be very draining and take its toll on therapists.

These differences in perspectives may be attributed to the differences between the professionals themselves. Some may not find it as easy to focus on the positive sides of the job. Participants in the present study have shared some particular strategies to help them focus, such as compartmentalizing and removing the lens of sexual offense to see the clients as whole human beings. Compartmentalizing has also been proven to be effective as a self-care strategy by Parsonson and Alquicira (2019). Conversely, Blagden et al. (2016) shared the result that treating sex offenders as regular human beings allowed professionals to cultivate constructive relationships with them. With these strategies, clinical professionals can focus better on the positive aspects of their jobs.

Limitations of the Study

As stated in Chapter 1, the qualitative nature of this study posed as a limitation for the small number of participants. Even though much depth was acquired regarding the subject matter, these results might only represent the small number of participants; therefore, the generalizability of the findings were not ensured. Clinical professionals who worked in other settings or other types of professionals who worked with sex offenders might not share the same attitudes and beliefs as the present study's participants. This limitation was evident in the minute differences of findings shared by

this study and other previous works (see Baum & Moyal, 2018; Church et al., 2011; Day et al., 2014; Parsonson & Alquicira, 2019; Ward & Durant, 2013).

The sampling strategies, purposive and snowball sampling, contributed to the limitation on generalizability, as the sample selected might not be representative of the general population. Furthermore, the assumption that these clinical professionals would be completely honest and disclose all relevant information was not totally guaranteed. Hence, the insights provided by the participants in this study developed several recommendations for future studies discussed in the next section.

Recommendations

I used grounded theory to examine the attitudes of clinical professionals who worked with sex offenders, and I arrived at a framework revealing the complex workings of the phenomenon. As Church et al. (2011) purported, the attitudes and beliefs of clinical professionals regarding sex offenders represent more than simple "positive" and "negative" sides, hence the complexity of the proposed framework. Thus, this framework needs to be further examined using quantitative methods to raise its empirical value. A quantitative study with a larger sample size will increase the generalizability of this framework.

Each category from the framework may also be examined specifically to ensure their credibility. For example, an experimental study using addiction treatments on sex offenders may be administered to investigate its effectiveness. Other types of treatment, such as the GLM (Thomas et al., 2015; Yates, 2013), may be examined next to addiction treatment, to find out which framework works better. Large scale quantitative surveys can

be conducted on clinical professionals regarding the moral dilemma or internal struggles that they have faced in their jobs and which strategies have worked for them to overcome these. Future researchers can use the Universal Declaration of Ethical Principles for Psychologists when examining clinical professionals' attitudes regarding the moral dilemma of treating sex offenders (Allan, 2018).

Implications

The insights provided by the clinical professionals in this study imparted several implications for different social levels. On a micro level, the findings show that clinical professionals' views on sex offenders are not merely "positive" or "negative" but a complex web, as seen in the framework, influenced by several factors ranging from moral dilemmas to social responsibility. This finding indicates that contrary to the negative public, the experiences of clinical professionals allow them to treat sex offenders with more objectivity. Less experienced clinical professionals may draw from these findings to reflect on their own internal struggles and moral dilemmas. Indeed, this present study's finding that the participants have reframed and considered it a moral responsibility to treat sex offenders and lower victimization rates in society may encourage clinical professionals in their own struggles. The strategies provided by the participants in this study such as speaking with colleagues and practicing self-care may be applied by other clinical professionals as well, to find which strategy works for them to alleviate the burden of negative emotions from their work.

On a meso level, the finding that clinical professionals saw the human side of sex offenders and that they were damaged people who made mistakes indicates that the

communities wherein they reside may also adapt this kind of perspective. As shared by the participants, it is natural to feel anger or fear when one encounters a sex offender, but those feelings should be held in check as one interacts with them to understand where they are coming from. Organizations who work with sex offenders may also adapt this perspective along with the strategies presented in the findings. Safety measures, such as those shared by the participants, should be held, but not to the extent that treatment and reintegration into the community are hindered.

On a macro level, the findings indicate that society or the general public should also reflect on their attitudes toward sex offender treatment. As the participants of this study stated that they were doing their best to "make a difference" in society, so should society aim to make a difference by being more open to sex offender rehabilitation and reintegration. Policy makers should also exert more effort on informing communities about low sex offender recidivism rates, and about reintegration programs, along with safety measures they may enforce. Policies on clinical professionals' self-care should also be enforced, as they mostly undergo compassion fatigue and burnout. The findings of this study imply that several strategies may be effective in overcoming these, and a policy enforcing these strategies would be helpful for those professionals who are not aware and are struggling.

Regarding the methodological implications of this study, the qualitative nature allowed for a deeper understanding of clinical professionals' attitudes toward sex offenders. The use of grounded theory allowed for the categorization of findings, to arrive at the proposed framework. This proposed framework, grounded on the themes

found in this study, may be applied by researchers and practitioners alike in their works to extend the knowledge about sex offender treatment further.

Conclusion

Sex offenders represent a condemned group of people by society in general, even though they have lower recidivism than other types of offenders (Rosselli & Jeglic, 2017). Clinical professionals who worked with them may also share some feelings of disgust and fear regarding them, but these professionals hold more complex attitudes toward them and their treatment. The findings from this study indicated a complex framework in which clinical professionals considered several factors in treating sex offenders. This framework could be distributed into five categories. The first category, the attitudes and beliefs of clinical professionals, displayed how these professionals might initially feel anger and disgust toward their clients but would set these feelings aside and see the "human" side of their clients. The second category, treatment of sex offenders, showed how clinical professionals treated sex offenders just like any other client of theirs, with an emphasis on keeping themselves safe throughout the treatment. The third category, framework used to balance their obligations to the profession and the client with negative images and views of sex offenders, revealed how professionals usually applied a framework similar to addiction treatment in treating sex offenders. The fourth category explored the internal struggles and moral dilemmas that clinical professionals must overcome to provide the best treatment that they could, through reframing their perspectives into a moral responsibility to save potential victims from future offenses. The last category described the strategies that clinical professionals used to overcome the

negative emotions that they felt when treating sex offenders. These included speaking with colleagues, being an expert in the field, practicing self-care, and focusing mainly on the positive aspects of the job. These findings showed that professionals dealing with sex offenders were influenced by several factors, which then made up the complex web that was the theoretical framework proposed by the study. This study displayed the advocacy of clinical professionals who work with sex offenders in treating, rehabilitating, and reintegrating these sex offenders.

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Appendix: Guiding Questions for Interview

1. What emotions, images, feelings emerge when you discover that a new client is a sex offender?
2. How to cope with these emotions?
3. When you meet a sex offender for the first time do you do anything different than you would when meeting with a client that has another mental disorder?
4. When you provide treatment for a sex offender what emotions or feelings do you experience?
5. How do these emotions impact your ability to treat sex offenders?
6. How does providing treatment to sex offenders impact you internally? Do you experience moral or ethical dilemmas? If so, what is your experience?
7. If you experience negative feelings toward these clients, how do you cope with them during a clinical session?
8. How do negative emotions about the clinical encounter impact you after providing service?
9. What wisdom could you impart to a clinician that has never worked with sex offenders in practice?