2020

Treatment Providers' Perceptions of Effective Sexual Offender Treatment Modalities

Reta Alphin
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Reta L. Alphin

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Karel Kurst-Swanger, Committee Chairperson,
Public Policy and Administration Faculty

Dr. Stephen Morreale, Committee Member,
Public Policy and Administration Faculty

Dr. Olivia Yu, University Reviewer,
Public Policy and Administration Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

Treatment Providers' Perceptions of Effective Sexual Offender Treatment Modalities

by

Reta L. Alphin

MPA, Walden University, 2005

BA, Evangel University, 1995

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Social and Behavioral Sciences

Walden University

May 2020

Abstract

The treatment of sex offenders is a controversial public policy issue, yet the research on what treatment providers perceive to be effective treatment modalities is limited. Using von Bertalanffy's systems theory as the theoretical foundation, the purpose of this quantitative study was to examine and evaluate the treatment providers' perceptions of effective treatment modalities. Data were collected from 101 treatment providers located within 6 states in the Midwest through a researcher developed survey. Data were analyzed using descriptive statistical analysis. A total of 55 treatment modalities were examined, which were condensed into 5 categories. Findings indicated that the psychoeducational modality was perceived to be the most effective while medication was perceived to be the least effective. The positive social change implications stemming from this study include recommendations for sex offender treatment to implement treatment plans using psychoeducational treatment modalities as their primary treatment option to see if this study's results can be replicated. Implementation of these plans may reduce sex offender recidivism and provide additional guidance to treatment providers.

Treatment Providers' Perceptions of Effective Sexual Offender Treatment Modalities

by

Reta L. Alphin

MPA, Walden University, 2005

BA, Evangel University, 1995

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Social and Behavioral Sciences

Walden University

May 2020

Dedication

This dissertation is dedicated to my children, Chase and Brooklynn. I hope the completion of this project has instilled in them a love for learning and the importance of education. And to my husband Gene who patiently supported me through this long and arduous journey.

Acknowledgements

Thank you Dr. Karel Kurst-Swanger, my dissertation chairperson, whose support and guidance were invaluable and whom without, I would not have completed this dissertation. And to my committee member Dr. Stephen Morreale for his assistance and feedback. And, lastly to the URR review committee member Dr. Oliva Yu. Without the help from each of you, this journey would not have been possible.

Table of Contents

List of Tables

Chapter 1: Introduction to the Study

Introduction

Sex offender treatment is perhaps one of the most difficult and controversial areas of intervention in criminal behavior. Treatment providers are inundated with a wide range of emotions from not only society but also from the offender (Stinson & Becker, 2013). Even after treatment, the release of sex offenders back into society brings about an aura of fear and anger. Dealing with the safety of the community and with the rehabilitation of sexual offenders is a challenge facing criminal justice systems and legislators. In the United States, more than 600,000 people return from prison to the community each year and, because of that, the establishment of public policy to assist with sex offender rehabilitation is critical (Hunter, Lanza, Lawlor, Dyson, & Gordon, 2015).

It is imperative that a continued investment be made in sex offender treatment. In 2013, statistical data showed that there were 79,770 instances of rape reported to law enforcement (Federal Bureau of Investigation, 2013). It is estimated that 90% of rapes that occur within the United States are not reported to the police (Federal Bureau of Investigation, 2013). Additionally, statistics show that only 28.3% rapes and other sexual assaults are reported to law enforcement. It is estimated that the number of sexual assaults is 10 times greater than statistical data show (Chon, 2014). It is also estimated there are 170,000 plus persons on probation or parole for a sexual offense (Meloy,

Understanding how providers perceive treatment effectiveness for various types of modalities could elevate the understanding of the complex nature of sex offender treatment. In the review of sexual offender treatment modalities literature, there appears

to be a gap in assessing if there is a relationship between the type of treatment modality and the providers' perception of treatment. Very little research has been conducted on what types of treatment providers perceive to be effective. This area of research is still in its infancy stages. However, it is hopeful that this research can be beneficial to not only treatment providers but also to policymakers and to the offenders receiving the treatment. The purpose of this quantitative study was to increase the knowledge of effective sex offender treatment by examining treatment provider perceptions of various treatment modalities.

Over the past few decades, the research has shifted from what works to what works under which circumstances (Woessner & Schwedler, 2014). Because of this shift, there is a gap in the research that I intended to help close. Tewksbury (2011) posited that there is a lack of data regarding how officials perceive sex offender treatment policies. Additionally, despite the growth of treatment programs, few researchers have evaluated how the treatment providers perceive the programs' effectiveness (Rehfuss, Underwood, Enright, Hill, Marshall, Tipton, West, & Warren 2013). Call and Gordon (2016) posited that understanding factors that influence providers' perceptions toward sex offender management is important as "the available research investigating perceptions towards sex offender policies among professionals consider few predictive factors and limit the focus to demographic characteristics" (p. 836). Because research on exploring clinicians' view of effective treatment modalities is in the infancy stages, this study helped to close that gap and contribute to the treatment providers' effort on expanding or implementing public policy that could continue to effect treatment success and community safety.

To have an efficient sex offender treatment program and public policy that emulates a successful sex offender treatment plan, it is important for policymakers to be aware of what types of treatment providers perceive to be effective in treating sex offenders. Examining the relationship between the treatment modality and the provider's perception of effectiveness will contribute to the body of knowledge and the developing research. Studying those who are involved with the everyday issues that face treatment providers helps in gaining an understanding of what works.

Chapter 1 is organized into several categories. The first category is the background of sexual offender treatment. In this section, the history of sex offender treatment is discussed. Next, the problem statement of this research talks about how, although there are many theories on why offenders commit deviant sexual acts and there are many types of treatment, very little is known about which of the treatment options providers perceive to be effective. Understanding what treatment categories may affect the providers' perception of treatment is important to produce an effective treatment plan. Persons responsible for creating sex offender treatment plans need data on the providers' perception of what is effective to support and create new policies or encourage the use of a specific treatment.

The purpose of the study is the next category where I explain why the research of this study is important and how I attempted to find the desired information. Next the theoretical framework of the systems theory is discussed. The nature of the study is also discussed followed by a definition of terms that are used in this study. Because there are many different types of treatment, the treatment modalities are categorized into five

categories, and each category is explained in further detail. Lastly assumptions, limitations, and significance of the study are examined, followed by a summary of the entire chapter.

Background

The United States has struggled with how to rehabilitate sex offenders. In the 1930s, approximately half of the states enacted sexual psychopath laws. The common theme during that time was that sex offenders suffered from a mental illness and could be cured. The theme changed in the 1960s, and within the 20 years following, most states had done away with sexual psychopath laws (Miller, 2010).

By 1960, 26 states had special statutes dealing with how to treat sexual psychopaths. (Miller, 2010). The 1970s brought a shift toward more determinative sentencing, and court decisions came about claiming that sex offenders' rights were violated with the current methods of treatment. (Miller, 2010). By the 1990s, Washington became the first state to enact a new form of commitment that required lower prison sentences and required offenders to be in protective custody if they were deemed dangerous. (Miller, 2010). Today there are 20 states as well as the federal government that have enacted commitment statutes aimed at violent sex offenders (Miller, 2010).

Little research has been conducted from the point of view of the clinician. Research on what affects the providers' perception is also limited. Using a quantitative research approach, I sought to fill a gap in this research. A survey method was used to obtain data of how providers perceive the effectiveness of various treatment modalities.

The types of treatment are defined within this chapter as well as an explanation of the forms of treatment that were surveyed.

Problem Statement

Evaluating the effectiveness of treatment modalities is difficult. Sex offender treatment research has begun to address the important role of the clinician in determining treatment effectiveness. The focus of this research was to examine the providers' perception of what treatment modalities are effective.

How a provider interacts with an offender can be a determining factor in the success of treatment (Stinson & Becker, 2013). In a study conducted of a sample from the Westchester County Sex Offender Program in New York, researchers compared the differences in how the probation officers and clinicians perceived the effectiveness of treatment of sex offenders. The researcher's hypothesis was that the probation officers would be more likely to perceive offender progress in treatment than the clinicians would. Marino (2009) posited that the more positive view of the perception of effective treatment, the more likely the providers would see effective treatment.

Researchers have found that workers can play a critical role in the effectiveness of program outcomes in a variety of settings, such as probation, parole, and law enforcement. Lea, Auburn and Kibblewhite (1999) conducted a study on the perceptions and experiences of sex offender treatment providers and concluded that this type of research is necessary, and the providers' perceptions influence the practice of treatment. The authors also stated that there is limited research in the area of professional attitudes toward the perception of treatment. Hogue (1993) also suggested that the attitudes of

professionals when working with clients affect their work. In this study, I sought to build upon that limited knowledge.

Using what providers perceive to work could be helpful in strengthening future treatment models and approaches, thereby making a safer society. In this study, I sought to identify clinicians' perceptions of effective treatment modalities across 55 different treatment approaches and to see if there was a relationship between the different types of treatment and the providers' perception of effective treatment of sex offenders. The study adds to the body of research literature exploring the clinicians' role in the treatment process. My goal was to obtain data using a survey that would identify what treatment options are perceived to be the most and least effective in treating sex offenders.

Purpose of the Study

The purpose of this quantitative study was to see if there was a relationship between providers' perception of treatment effectiveness and treatment modalities. Because the research of how clinicians view effective treatment is in its infancy stages, I sought to examine the clinicians' view of what treatment modalities are effective and to analyze the relationship between treatment and how they perceive a treatment's effectiveness. This research can aid in the understanding of how clinicians view treatment and help identify treatment modalities that could be more effective in sex offender treatment. The analysis conducted contributes to the research and to the treatment providers' effort to provide the potential for social change.

The rankings of the effectiveness of treatment were the dependent variables. The independent variables consisted of the type of treatment, broken into five categories, and

were compared with the dependent variables to see if the type of treatment affected how the providers' ranked their perception of the treatment effectiveness. The perception of each treatment modality category was measured by a Likert scale. The answers revealing the results of the survey based upon the five categories of treatment were compared, and a mean for each category of treatment was calculated. The means from the five independent variables were analyzed using the Kruskal Wallis test. There was one analysis done of all five means to see how the perceptions of each category were affected by the type of the treatment. The Kruskal Wallis analysis was used to see if there were any significant differences in the mean of each category of treatment or to see if the ratings of the treatment categories were affected by the types of treatment. The use of SPSS software allowed me to compare the variables using the Kruskal Wallis test. Understanding the relationship between each of the independent variables and the dependent variables was important and necessary to uncover what providers perceive to be effective sex offender treatment.

Research Questions and Hypotheses

Research Questions

To determine if, for each treatment modality used, the providers perceive a difference in the effectiveness of the treatment, the overarching question of this study was as follows: What is the relationship between the type of treatment modality and the provider's perception of effective treatment?

The above literature leads to the following research question:

1. For each set of modalities commonly used in sex offender treatment, do the providers perceive a difference in effectiveness?

Hypotheses

$H_{1:}$ Treatment providers rank the five treatment categories differently.

$H_{0:}$ Treatment providers do not rank the five treatment categories differently.

Independent and Dependent Variables

The dependent variables were the average scores of effectiveness of treatment. The independent variables consisted of the type of treatment and were broken down as a nominal variable with five categories of treatment. The five categories of treatment were assigned a number as follows:

1. Psychoeducational,
2. Behavioral,
3. Psychotherapeutic,
4. Cognitive behavioral, and
5. Medication.

The answers from the five categories of treatment were compiled, and a mean was established for each category. The mean from each category was analyzed using the Kruskal Wallis test. The Kruskal Wallis test showed the comparison of the five means from the five categories of treatment. The Kruskal Wallis test was used to examine differences in the groups of the ratings of the treatment groups. The independent variables were analyzed using the Kruskal Wallis test to see if their presence affected the opinions of the providers when ranking their perception of treatment modalities. A

Kruskal Wallis analysis is a ranked based nonparametric analysis that is used to see if there are differences between two or more groups of independent variables or an ordinal variable. In this research, the Kruskal Wallis analysis was used to see if there was any difference in the rankings of treatment effectiveness of the five categories of treatment.

The null hypothesis was that there is no difference in the effectiveness rankings of the types of treatment from the survey that was sent to the treatment providers based on the independent variables. The hypothesis suggested that the independent variables influence how the providers rank the effectiveness of treatments. Table 1 outlines the independent and dependent variables of this study.

Table 1

Table of Variables

Independent Variable	Dependent Variables
Type of Treatment	Averaged score of effectiveness of treatment

Theoretical for the Study

von Bertalanffy's systems theory is a management theory that provided the theoretical basis for this research. Systems theory is attributed to von Bertalanffy, who began publishing research in the field in the 1960s (Mele, Pells, & Polese, 2010). von Bertalanffy was an Austrian theoretical biologist and philosopher and defined a system as a complex of interacting (Mele, Pells, & Polese, 2010). The purpose of this research was to understand the treatment providers' perception of the five categories of treatment,

representing 55 different treatment modalities, and to identify whether the type of treatment affects the ratings of the effectiveness of the treatment.

Systems theory allows a researcher to understand components and dynamics of client systems in order to develop better strategies, interpret systems issues, and, ultimately, find the right fit between the individuals and environments (Friedman & Allen, 2014). Systems theory explains patterns or, in this current research, a pattern in the survey answers showing what providers perceive to work. By including systems theory within this research, a foundation was laid to allow for patterns to emerge in the answers of the providers.

Nature of the Study

A quantitative research approach was the nature of the study. Data were collected by a survey from a large sample. Creswell (2009) defined descriptive survey research as the method to use to generalize findings of what the sample thinks or perceives. A quantitative analysis was used to analyze the providers' perception of the five categories of treatment and to identify whether the types of treatment, independent variables, affect that perception.

Definition of Terms

The following are operational definitions of terms that are used throughout this study:

Caseload: The number of clients or patients the sex offender treatment provider is treating at one given time is the definition of the variable of caseload (Collins & Nee (2010)

Education: Years of education are what type of training or schooling the provider has had, what licensure, and the number of years the provider has worked with treating sex offenders (Vaughn, 1992).

Length of treatment: The length of treatment is defined as how long the specific method of treatment is for the sex offender.

Perception: The fact or knowledge acquired through the senses; mental product obtained (Landau, 1997).

Program setting: Providers work in different settings: some in private offices, some in nonprofit agencies, and others in public facilities. The definition of program setting is in what venue the provider treats sex offenders.

Treatment modality: A treatment modality is the method in which treatment is administered to the sex offenders.

Years of experience: The length of time as a treatment provider was answered by years of experience, that is, how many years has the provider used a type of treatment to attempt to treat sex offenders (Miller, 2016)?

Types of Treatment

When discussing sexual offenses, there are varying types of treatment options. In this section, I explain the types of treatment options available. The treatment options were placed into five subgroups: psychoeducational, behavioral, psychotherapeutic, cognitive-behavioral, and medication.

Psychoeducational

Psychoeducational treatment is performed by a therapist and is done in a classroom setting. Its purpose is to educate the offender, but this form of treatment is used in conjunction with other treatment for its use to be successful (Clark & Duwe, 2015).

Behavioral

Behavioral treatment includes treatment such as impulse control, plethysmograph, verbal satiation, masturbatory satiation, orgasmic reconditioning, minimal arousal conditional, masturbatory training, aversive techniques, behavior modification techniques, coordinated community supervision, community supervision, and biofeedback (Clark & Duwe, 2015).

Psychotherapeutic

Psychotherapeutic treatment treats the nervous system and mental disorders using psychological techniques. Types of psychotherapeutic treatment includes individual counseling, intimacy relationship skills, journal keeping, autobiography, victim restitution, hypnosis, group counseling, psychodrama/drama therapy, eye movement desensitization and reprocessing, empty chair, psychodynamic therapy, and family systems therapy (Witt, Greenfield, Hiscox 2008).

Cognitive-Behavioral

Cognitive behavioral forms of treatment include victim empathy, stress management, fantasy work, thinking errors, reality therapy, rational emotive therapy,

relapse prevention, relapse contracts, homework, assault cycle, and cognitive behavioral therapy (Witt, Greenfield, Hiscox 2008).

Medication

Medication is another form of treatment and includes Provera/Depo-Provera, Androcur (Cyproterone Acetaine), Lupron, major and minor tranquilizers, Lithium Carbonate, Anafranil, and Buspar desires (Prentky, 1997; Miller, 1998; and Stalans, 2004).

Assumptions

There are certain assumptions that can and should be defined when using a quantitative research approach. In this quantitative study, in following those assumptions, I used a deductive process to test a hypothesis by obtaining and analyzing statistical data. I built this study around the assumption that the treatment providers were efficient in their ability to perform rehabilitation programs within their organizations and that their answers and input in the survey were unbiased and adequately measure providers' perception of effective treatment. The research paradigm of this study was the positivist paradigm. As noted in Goduka (2012), positivism is rooted in the objectivist world view and acknowledges that knowledge is only gained from data from experienced observers, or, in this study, knowledge is taken from experienced treatment providers. Of the three types of philosophical assumptions, an ontological assumption was most suited for this quantitative research study and that fits with the positivist research paradigm because it is based upon facts that are gathered through direct experience or observation. Thus, one of the assumptions of this study was that all participants would have experience in treating

offenders. A positivism research paradigm has a hypothesis, and from that hypothesis the researcher seeks to see if there is a relationship between two variables. Positivists believe that observation and measurement are the core of the research Goduka (2012).

Scopes and Delimitations

The scope of this quantitative research involved surveying treatment providers within the United States who worked directly with treating sex offenders. I attempted to discover if there was a relationship between a type of sex offender treatment and the providers' perception of treatment effectiveness. The participants of this study were chosen from a list of treatment providers within the United States. The participants were chosen without regard to their years of education, gender, age, or treatment facility employed in. The delimitations in this research included exploring the perceptions of treatment providers currently working in the treatment of sex offenders and currently working in the United States. I originally chose providers within the Midwest as that is the area of the United States I have lived in and am most familiar with.

Potential generalizability could have existed due to limiting providers within a specific region of the United States. Additionally, the response rate from the surveys could be seen as a factor in potential generalizability.

Limitations

The following factors may influence the outcome of the study:

1. The use of a survey to obtain the desired data rather than using an experimental design.
2. The potential of a limited number of cooperative providers.

3. The limitation of a sample of providers within the Midwest of the United States.

Using a survey sent to treatment providers of varying ages, education, and types of treatment and modalities, I attempted to glean survey answers from various providers that could represent the providers in other areas of the United States other than the Midwest and thus address potential limitations.

Significance of the Study

Part of uncovering what the providers' perception is of effective treatment is seeing what affects their perception. Upon completion of the analysis of treatment providers' perceptions of effective treatment, recommendations for a rehabilitation program that will promote successful rehabilitation among sex offenders are plausible. The survey answers indicated what treatment providers perceived to be the most effective in treating sexual offenders by comparing their rating of the treatment effectiveness of each treatment modality with the type of treatment category. The knowledge gleaned from this research can be beneficial for policymakers. In addition, it could provide an opportunity for sexual offenders to reenter society with less fear of recidivism for themselves and their potential victims. Most importantly, the significance of this study can be reflected in the form of social change. As sexual offenders are rehabilitated in an effective manner, they can be reintroduced into society as productive citizens, and the stigmatism associated with being a convicted sexual offender will be lessened with the assurance that the treatment plan was effective enough to reduce or eliminate a re-offense.

Summary and Conclusions

Sex offender recidivism is a societal problem that can potentially be assessed and evaluated by researching and finding what particular type of treatment affects the providers' perception of effective treatment. There is a knowledge gap as it pertains to treatment providers' perceptions of effective treatment and how treatment should be administered to offenders. The research of how the type of treatment affects the rankings of the effectiveness of the treatment is in the infancy stages, and this study is a preliminary study that can pave the way into future research efforts. The background of sex offender treatment is important to this study as noted above so that the reader is aware of what types of treatment have been and are now being used. The focus of this research was to find what providers perceive to work and to what extent, if any, is a provider's perception of effective treatment affected by a treatment modality. The systems theory was the theoretical foundation used to discover patterns or a treatment that the treatment providers perceived to be effective. Systems theory is the study of systems with the goal of discovering patterns. In this study, the management theory called the systems theory was the theoretical framework and was applied to see what patterns arose when comparing the systems or the methods of treatment with the perceptions gathered from the survey answers. Chapter 2 is a review of peer-reviewed journals and literature published within the past 5 years. A review of not only the theories behind the sex offender's behavior but a synopsis of the types of treatment is completed in Chapter 2 as well as the history of the sex offender treatment. Additionally, I discuss the research questions and their connection with systems theory.

Chapter 2: Literature Review

Introduction

Although many treatment options are available and there are many theories that try to explain why a person would commit a sexual offense, there is a lack of research and theory on how providers perceive the programs' effectiveness. In this study, I sought to close the gap on the lack of literature and build on the developing research by studying what the providers' ratings of the effectiveness of treatment are compared with the type of treatment modality. The literature related to this topic under discussion and discussed in detail in Chapter 2 includes the systems theory and three areas of literature that are relevant to my research question as follows:

1. Literature related to sex offender behavior,
2. Literature related to treatment modalities, and
3. Literature related to the role of the therapist.

Theories attempting to explain sex offender behavior were studied and are discussed such as biological, learning, sociological, psychosocial, psychodynamic, and cognitive distortion theories. Types of treatment modalities that are discussed include prison programs, life skills programs, faith-based programs, academic programs, risk need responsivity, behavioral and cognitive behavioral treatment programs, victim empathy, community-based programs, post release programs, and medical treatment programs. The role of the therapist is discussed next and is the area that I primarily focused on by questioning what treatment providers perceive to be effective treatment.

This study contributes to the body of literature of practitioners' efforts of showing how the type of treatment can affect the providers' rankings of effective treatment.

Literature Search Strategy

The information gathered to complete this literature review was obtained through searches of various databases, peer reviewed articles, and research studies. Databases searched included but were not limited to Academic Search Premier, PsychArticles, PsychInfo, ProQuest, EBSCOhost, SociIndex, SAGE, and the United States Department of Justice. The following search terms were used, although this is not an exhaustive list: *sex offender, recidivism, corrections, treatment, prison, perception, treatment provider, therapy, victim empathy, cognitive behavior, faith based, rehabilitation, education,* and *relapse prevention*. Peer-reviewed articles were searched within the years of 2010 to 2016. Articles from years earlier than 2010 were included in some instances due to the lack of literature found on the systems theory and based upon their contribution or importance in establishing a foundation for this research project. Dissertations of similar studies were also reviewed to exhaust all literature on the topic.

Theoretical Foundation

Because the research on how providers perceive treatment modalities and their effectiveness is limited, I sought to increase the understanding of providers' perception of effective treatment. I explored the providers' perceptions of effective treatment by comparing their ratings of treatment effectiveness with the five categories of treatment modalities. The theoretical framework of this study was the use of the systems theory. A cross-sectional research approach was used with surveys conducted of a sample of

providers located within the United States. Upon receipt of the surveys, I identified common themes or relevant statements within the surveys. The common themes were analyzed and studied to see if there was a particular treatment that ranked higher than another as to its effectiveness.

Prior research has been conducted on treatment plans and rehabilitation methods for sexual offenders. There are many theoretical positions on what causes people to engage in deviant sexual behavior. Theories include biological, learning, feminist, sociological, and psychopathological (Faupel, 2015). It is important to understand what causes the behavior before trying to determine what the most effective treatment is. Additionally, by reviewing the various types of theories of criminal behavior, the reader gets a better understanding of why specific treatment methods may have been instituted. Despite the research on treatment plans and methods of rehabilitation, there is little research on treatment providers' perceptions of effective treatment and if a particular type of treatment affects their perception. Literature regarding the use of systems theory in the study of treatment of sex offenders and how providers perceive effective treatment is also limited. The goal of learning treatment providers' perceptions of what works is to ultimately provide guidelines for public policy implementation and contribute to the providers' efforts on further research into types of treatment that rank high by the providers as to their effectiveness.

Research discussing the impact of the providers' efforts in treatment is still in the infancy stages. Studies on the best practices in treating sex offenders are few. Additionally, researchers have suggested that therapists are faced with many challenges

(Clarke, 2011). A theoretical understanding of sexual perpetrators and their behavior is still developing (Hickey, 2012). I attempted to help develop a better understanding of what treatment providers perceive to be effective in treating that behavior and how a treatment modality might affect the providers' effectiveness ranking.

Systems theory was the framework for this study. Systems theory is credited to Bertalanffy. The systems theory framework emphasizes the relationship between individuals—treatment providers—and society in general. The intent of the systems theory framework was to bring the perceptions of the treatment providers together with society in providing society the treatment that works. By including systems theory within this research, a foundation can be laid that allows for patterns to emerge in the answers of the providers. Scheela (2001) stated,

> Professional negative impacts of this work focused on the 'system,' society's attitudes, the media, and the consequences of failure. The negative impacts of "the system" involved lack of funding, legalities that made it difficult to remove the offender from the home, and difficulty with communication between agencies. (p. 757)

History and Background

Perhaps due to the devastating impact a sexual offense has on its victim, individuals who commit such crimes are considered one of America's primary criminological concerns. This concern has led to state and federal legislation attempting to rehabilitate sex offenders (Strecker, 2011).

Prior to the 20th Century, sex offenders were viewed as persons with a medical condition. Then a sex offense was viewed as a behavioral challenge. In the 1950s, laws began to be implemented that regulated sexual behavior (Terry, 2006). Deviant sexual behavior began to be a societal challenge in the 1970s (Terry, 2006). The first psychopathic laws as a response to deviant sexual behavior were passed in the 1930s. These laws required the sexual offender to be confined to a mental hospital for identifying, predicting risk, and administering treatment for the sexual psychopaths (Farkas & Stichman, 2002). These types of laws were criticized and, thus, came to be ignored or repealed in the 1960s (Terry, 2002). Prior to the 1960s, sex offender treatment primarily included psychoanalytic or group psychotherapy. The behavioral approach to treatment was introduced in the 1960s and promoted the evaluation of the benefit of cognitive-behavioral treatment (Marshall & Serran, 2000).

Into the 1970s, treatment for sexual offenders was primarily done with behavioral modification treatment plans. The belief was that the behavior of sex offenders could be modified through the teaching of sex offenders on how to have better social skills. Learning social skills would cause the sex offenders to obtain sexual gratification through normal relationships rather than through deviant behavior (Mann, 2004). In the 1980s, the addition into treatment plans of attempting to eliminate cognitive disorders was implemented (Mann, 2004). Within the United States, Sexual Offense Specific Treatment emerged as a form of psychotherapy treatment within the 1980s. This caused a great need and demand for treatment providers, and the treatment providers' role changed (D'Orazio, 2013).

In the 1980s, sexual offense specific treatment emerged and was included within the psychotherapy treatment of sexual offenders. In addition, during the 1980s, relapse prevention treatment was developed. Its development came about through the idea that addiction was a byproduct of a biological disease and relapse prevention treatment addressed the tendency to relapse to an addiction—a sexual offense addiction (D'Orazio, 2013). It was also during this time that the shift began from the psychoanalysis aspect of treatment to behaviorism. Behavioralists Abel and Becker are credited for making popular cognitive behavioral therapy (D'Orazio 2013).

The implementation of the sex offender registry was in 1994 and required sex offenders to register upon their conviction of a sex crime (Terry, 2011). All 50 states have registration requirements for convicted sex offenders. Megan's Law brought about the initial registration requirements in 1994 and was instituted to protect society from sex offenders. This law was created after Megan Kanka was molested and murdered by a sex offender living in her neighborhood. The perpetrator had a history of sexually abusing children, but because he was not required to register or let anyone in his neighborhood know he had a criminal history of sexual offending, Megan's parents were unable to warn her to stay away from his house. After Megan's Law was instituted in New Jersey, all other states enacted their own version of Megan's Law (Terry, 2011).

Sex offender registration and community notification are primarily state level legal issues. The state laws require sex offenders to register with local law enforcement. However, current studies have revealed little decrease in the recidivism rates with the registration practice (Meloy, Boatwright, & Curtis, 2013). The Adam Walsh Child

Protection and Safety Act of 2006 was created to supervise and manage sex offenders within a community. It sets national standards for registration. Additionally, this Act requires states to evaluate the risk of sex offenders based upon the type of offense committed (Terry, 2011).

The Jacob Wetterling Crimes against Children and Sexually Violent Registration Program was a federal statute that required each state to enact a registry for sex offenders or lose part of their funding for law enforcement (Terry & Furlong, 2004). After discovering loopholes within the Jacob Wetterling Act and Megan's Law, lawmakers instituted the Adam Walsh Child Protection and Safety Act in 2006. This Act gave specific instructions to states on how they had to implement and manage sex offender registry guidelines. This Act also allowed for public release and access of sex offender information to the public (Terry & Furlong, 2004). Lastly, this Act required each state to have a public website allowing the public to have access to sex offender information on the registry (National Center for Missing & Exploited Children, 2008).

In 1994, Congress passed the Jacob Wetterling Crimes against Children and Sexually Violent Offender Act (42 U.S.C. Section 14071) also known as the Wetterling Act. This Act required all states to implement a sex offender registration program by September 1997. Under this Act, sex offenders were required to register for 10 years following their release from prison or upon their conviction of a sex crime. In addition, the offender was required to keep law enforcement appraised of any address changes. This law was named after Jacob Wetterling, an 11-year-old boy who was kidnapped in 1989. Following this law and after the death of Megan Kanka who was murdered by a

sex offender living on her street, Congress passed another Act, which was added to the Wetterling Act as section e. This required all states to have community notification programs that allow public access to information about sex offenders residing in the community (National Center for Missing & Exploited Children, 2008). Megan's Law was designed so parents would be able to advise their children who in the community they should avoid and who was dangerous. It was created to raise the awareness of sex offenders in the community. Additionally, the purpose of the law was to reduce the possibility of the sex offender reoffending because everyone would know he or she was a sex offender, making it harder to lure a victim (U.S. Department of Justice, 2003).

A final provision to the Jacob Wetterling Act was called the Pam Lychner Act and this Act required state law enforcement to submit sex offender data and fingerprints to the FBI. The FBI established a national database of sex offenders to track their whereabouts. Also, this Act amended the Jacob Wetterling Act by requiring the state registration requirement to be 10 years to life rather than 10 years depending upon the number of prior crimes and type of crimes committed (Medical University of South Carolina, 2008).

In 2005, Florida instituted the "Jessica's Law, which required more stringent tracking of sex offenders. However, the most stringent tracking law was the passage of the Sexually Violent Predator Law which was first established in the State of Washington prior to 19 other states adopting similar policy (Lamade, Gabriel, & Prentky, 2011).

Mandatory Registering

The United States has developed numerous policies to protect society from sex offenders. One such policy is mandatory registering (Lieb, Kemshall, & Thomas, 2011).

The Jacob Wetterling Act was established in 1989 because of an 11-year old boy, Jacob Wetterling, being abducted while riding his bike with his friends. After his abduction and with the urging of his mother, Congress passed a law requiring mandatory registration of sex offenders. This law became known as the Jacob Wetterling Crimes against Children and Sexually Violent Offender Registration Act (Missouri State Highway Patrol).

Following the 1989 enactment of the Jacob Wetterling Act, Megan's Law was created which amended the 1989 Act. In 1996, Megan's Law dealt primarily with allowing states to use and disseminate personal and private information to the public for the purpose of locating an abducted child. This was the result of a seven-year old girl named Megan being raped and murdered by a pedophile who had been convicted twice of sexually abusing children (Missouri State Highway Patrol).

Three Australian studies were conducted in 2014 and in which the research attempted to find out the views of practitioners on registration. Treatment providers were interviewed. Many of the providers saw the mandatory registration policy as unfair and over inclusive. The consensus of those interviewed was that community notification through registration was counter-rehabilitative (Day, Carson, Boni, & Hobbs, 2014).

Tracking Law

The tracking law was enacted in 1996 as another amendment to the Wetterling Act. It was entitled the Pam Lychner Sexual Offender Tracking Law. The purpose of this law was to allow law enforcement officials to be able to track sex offenders from one

geographical location to another. In addition, this law required a sex offender to register as a sex offender for the rest of his or her life (Missouri State Highway Patrol, 2009).

While these laws provide a means to monitor treatment of sexual offenders, they have also been regarded as a continual punishment for sex offenders. In addition, the use of mandatory registering and tracking of sexual offenders as a means of reducing recidivism is also questioned.

Various theorists have studied sex offender behavior and possible reasons as to why he or she would reoffend. Theories, as outlined below, discuss varying causes of the behavior. To be effective in their treatment and be able to perceive what works in treatment, knowing the theories behind the behavior is beneficial.

Sex offender typology can be broken down into theoretical explanations. Single factor explanations cover biological and behavioral theories and multifactor theories include integrated theory, confluence model, relapse prevention, self-regulation model and pathways model (Center for Sex Offender Management, 2015).

To better understand the role of the treatment provider and to better understand the potential whys of sex offender behavior, it is important to discuss the various theories for criminal behavior to which treatment modalities are developed. Utilizing the knowledge gained from studying the varying theories of sex offender behavior, treatment modalities were born. Thus, the importance of studying them and simulating them into this research study.

Biological Theories

Some researchers posit that certain biological factors contribute to persons engaging in sex offending. Hormones, high testosterone levels, and specific physical characteristics play a role in why sex offenders offend (Center for Sex Offender Management, 2015).

Biological theories were prevalent as far back as 2,000 years ago. Biological theorists suggest there is a connection with a biological characteristic and deviant behavior. Such theorists included Earnest Hooton who believed criminals could be distinguished by the color of their eyes or shape of their ears. Hooton conducted a study of ten thousand males who had been convicted of a crime to see if there was a connection between physical features and criminal behavior. His study found that physical attributes could be contributed to deviant behavior (Hooton, 1939).

Another biological theorist was Cesara Lombroso who posited people were born criminals. Persons who were criminals were people who had not quite evolved to the humanity stage and did not experience guilt for their deviant behavior. Lombroso believed criminals had distinguishing characteristics about them such as receding foreheads, prominent chins, long arms, or sloping shoulders. In addition, Lombroso believed that sex offenders had full lips and did not develop close relationships or friendships (Ferrero-Lombroso, 2004).

Learning Theories

Learning theories suggest that criminal behavior is learned rather than genetic as the biological theories suggest. Behaviorism is one type of a learning theory. Behaviorists

believe that individuals can be conditioned to learn to be sex offenders. Their behavior is a learned characteristic (Center for Sex Offender Management, 2015). Behaviorists believe that external stimuli cause good or bad behavior. Gene Abel began behaviorist theory research and posited that it was a condition that could be treated (Abel, Blanchard, & Becker, 1978).

He explained his theory with a three-part explanation. First, that sexual offenders have a disturbed developmental history. Second, the offender has disinhibitions present that cause the deviant behavior and, lastly, sex offenders have deviant sexual fantasies. A combination of these three parts results in a deviant sexual behavior (Abel, Blanchard, & Becker, 1978).

Sociological Theories

Sociological theories posit that society plays a part in deviant behavior. Emile Durkheim was one sociological theorist who believed there were two types of society. One type was mechanical solidarity, which is where society has laws that keep people from violating what is considered the norm of society. The other type of society was organic solidarity, which results in a disruption or conflict in society, which he terms as anomie. Durkheim also believed that crime was a necessary part of society. Without it, society would have a break down. His theory of anomie is one of the beginning sociological theories of criminal behavior (as cited in Burkhead, 2006).

Robert Merton was a sociological theorist who created the Strain Theory to explain deviant behavior. Strain theory posits that there are pressures in society that cause people to engage in deviant behavior. Social pressures are the strains per Merton. He

believed there were two components to the social structure. The first being goals that everyone in society wanted to accomplish and the second was the defining of the way those goals could be met. The strain theory suggests that when there is a proper balance between the two components there is social stability. When there is not a proper balance, there is social confusion. The result of social confusion is deviant behavior, which can be found in sex offenders (Merton, 1938).

Psychosocial Theories

A psychosocial theory posits that deviant sexual behavior is caused by responding to external factors. Many sex offenders lack proper social skills, so the misreading of a social cue often occurs. External factors that contribute to deviant sexual behavior per a psychosocial theory are being a victim of sexual abuse as a child or being affected by pornography.

Psychodynamic Theories

Sigmund Freud's theory on sexual deviant behavior suggests that sexual perversions are the result of regression back to the four stages of sexual development. He believed that those individuals who were involved in exhibitionism, voyeurism, and pedophilia were caused by the inadequate development of the sexual stages. Freud also believed that a relationship between a mother and her son was different in sex offenders than in non-offenders. When the mother makes the son into her spouse rather than her son, incest is initiated which results in deviant sexual behavior at a later point in the son's life (Freud, 1953).

Richard von Krafft-Ebing claimed that deviant sexual behavior was a result of psychopathological attributes in a person. He believed that sex was for procreation and only for procreation. He posited that any sexual behavior that was not primarily for procreating was a perversion and those individuals were not only mentally ill, but were a threat to society (Krafft-Ebing, 1995).

Cognitive Distortion Theory

Cognitive distortions in sex offenders are beliefs that violate what is the norm. Gene Abel is widely accepted as the first researcher to use cognitive distortions. Cognitive distortions are beliefs that people have developed due to a mismatch between their sexual interests and what they perceive as societal norm. These beliefs may be reinforced by deviant behavior. Abel also posited that these beliefs and behavior can become a habit and be harder to break over time (Ciardha & Ward, 2013). A study conducted of 125 incarcerated sex offenders enrolled in a residential sex offender treatment program concluded that the majority of those within the program committed the deviant behavior due to a lack of control over events in their life and the deviant behavior allowed them to experience sensations of power and control (Wood, Wilson, & Thorne, 2015).

Overview

A sex offender is a type of criminal that requires not only punishment, but also treatment. Sex offenders are among the most difficult offenders to treat. The State of Utah is said, of persons incarcerated, to lead in having the highest percentage of sex

offenders (Bench & Allen, 2013). In addition, the varying types of sexual offenses require different methods of treatment and punishment to be effective.

During the past few decades, treatment discussion has evolved from what works to what works when and for whom (Woessner & Schwedler, 2014). Many of the treatment plans used include cognitive behavioral treatment and, in some instances, the treatment provider deals with issues such as low self-esteem, relationship building, empathy, and anti-social behavior (2014). Treatment programs have evolved over the last half of the century and, of course, the primary goal of the evolution of treatment is to see less recidivism (Jung & Gulayets, 2011). Types of treatment will be discussed to give the reader an understanding of the types of modalities currently used.

Types of Sexual Offender Treatment

The treatment of sex offenders has been in the spotlight over the past two decades (Collins & Nee, 2010). Problems facing treatment providers and policymakers include how to develop programs that are effective and how to educate the public about such programs. The evaluation of treatment plans being used is another element treatment providers and policymakers deal with to provide credible information to the public (Schneider, Bosley, Ferguson, & Main, 2006). Reviews of literature on the types of treatment used by providers reveal little about what single treatment is the most effective (Corson, 2010).

Prison Programs

Incarceration is a form of treatment that is used in some instances for sex offender treatment. One of the variables discussed in Chapter 3 is the type of setting and prison

systems/programs will be analyzed to see how, if any, it affects the provider's perception of what is effective treatment. Sex offenders represent one-quarter of the United States prison population. Prison not only provides a place for the sex offender to receive treatment, but it protects society while the offender is incarcerated. There are conflicting theories on whether prison is effective or ineffective in reducing recidivism of sex offenders.

Correctional officers are primary contacts for treatment within the prison systems. As such, their perceptions are important to developing a sex offender public policy. A qualitative analysis was conducted of 15 correctional officers in 2013 and which showed that the perception of the correctional officer has been linked to an inmate's willingness to participate in treatment. The study revealed that the correctional officers' attitude had a direct effect on the inmate's treatment outcome (Greineder, 2013).

A 2011 study that was conducted to evaluate the effectiveness of prison based treatment compared a group of 95 inmates who received treatment with 67 persons who had completed treatment as well as 28 who had not completed treatment with a group of 64 inmates who had not received treatment. The results showed that the offenders who had completed prison-based treatment were less likely to be re-arrested for a sexual offense. Additionally, the study showed that those that were re-arrested and that had had treatment went a longer period between prison and reoffending (Perez & Jennings, 2012).

Another study conducted in 2015 consisted of inmates in a federal prison in Austria and revealed that sex offender recidivism was lower when sex offenders were treated for their offense in a prison system. Six years upon release, the study showed that

the rate of recidivism was six percent. In addition, the study showed that first time offenders were less likely to reoffend than those that had been convicted multiple times (Rettenberger, Briken, Turner, & Eher, 2015).

For child molesters and rapists, a three-tiered approach to rehabilitation is suggested. Tier one would be intensive treatment for moderate to high-risk sex offenders and they would be housed in maximum or minimum-security facilities. Marshall, Marshall, & Kingston (2011) proposes that the imprisoned sex offenders should be housed separate from other inmates. When housed with other types of offenders, the treatment process can be deficient in the therapeutic aspect of the rehabilitation process. Tier two of the proposed model would accommodate the lower risk offenders and the offenders who have successfully completed tier one. Tier three would take place when the offender is released from prison and would provide community-based programs and after care (Marshall, Marshall, & Kingston, 2011).

Prison systems have various treatment programs available or required. Faith-based prison programs, academic and vocational education, risk-responsivity, behavioral treatment, and cognitive-behavioral treatment plans can be involved in the treatment of sex offenders during their incarceration. The purpose of incarceration is to decrease the offender's risk for reoffending.

One type of treatment found within some of the federal correctional institutions is the prison based residential sex offender treatment program. There are admission criteria for this type of program. The offender must have a conviction of a sex offense, 36 months' minimum of a sentence left to serve, no additional pending criminal charges, be

psychologically stable, and have shown a desire to change. The residential treatment program encompasses psychosexual assessment, educational programs, group programs, anger management, victim empathy, intimacy skills, and ways to prevent relapse. The average time of enrollment in this form of treatment is 20 months.

Life Skills Programs

Life skills is another area of treatment that some prisons provide for sex offenders. Many prisoners lack a high school education, have unstable employment histories, as well as suffer from chemical dependencies. These issues result in high recidivism rates if not treated and the offenders are not given direction on how to better themselves in all areas. A large portion of life skills programming within prison systems is done with cognitive behavioral treatment and how-to re-program offenders to think and act differently. Social skills, anger management, communication skills, relationship building skills, as well as chemical dependency assistance all fall within the scope of life skills programs (Clark & Duwe, 2015).

Faith-Based Prison Programs

Within the United States prison systems, chaplains are available for the inmates for spiritual guidance or religious counseling. In addition, some prisons offer worship services and workshops to assist with the religious aspect of the inmates' lives. The benefits of religious involvement in treatment are numerous. Research suggests that involvement in a faith-based prison program gives increased levels of hope and purpose to offenders (Duwe & King, 2012).

A recent study conducted to evaluate the effectiveness of the InnerChange Freedom Initiative examined recidivism outcomes among 732 offenders that were released from Minnesota prisons. The results of the study showed that recidivism drastically decreased if the offender participated in the InnerChange faith-based prisoner program (2012).

Academic and Vocational Education

Evidence suggests there is a need for inmate educational programs and that the prison systems are not keeping up with that need. Ex-inmates face many obstacles upon their release from prison and, due to the obstacles, many inmates find themselves returning. Research linking lower recidivism rates to education has been promising. Those who have completed some type of post-secondary training or degree while incarcerated have less recidivism (Palmer, 2012).

A study conducted in the Minnesota state correctional facilities sought to evaluate prison based educational programs and study the outcome of recidivism for those who went through an educational program. The study found that earning a secondary degree while incarcerated did not influence recidivism. However, those who obtained a post-secondary educational during their prison term showed not only less recidivism, but higher paying job upon release (Duwe & Clark, 2014).

Risk-Need-Responsivity

The risk-need-responsivity model for treatment of sex offenders is a risk management approach to treatment. The risk principle refers to variables that have been shown to increase the potential for re-arrest. For example, a risk would be prior criminal

history. The needs principle refers to areas that the offender needs assistance with such as housing, education, job skills, and mental and chemical dependency treatment. The responsivity principle refers to the ability to respond to those needs. Researchers have suggested that the risk need responsivity model should be implemented into all reentry programs (Hunter, Lanza, Lawlor, Dyson, & Gordon, 2015).

The risk principle suggests that the intensity of the treatment intervention should be matched to the risk level of the offender. Treatment should be longer and more frequent for higher risk offenders. Research showed that the treatment is most effective when the treatment level is matched with the risk level of the offender (Yates, 2013).

The need principle posits that the treatment and intervention should target the needs of the offenders or their specific risk factors. In particularly, two of the main needs per research that should be addressed are the sexual deviant behavior and the antisocial lifestyle (Yates, 2013). The responsivity principle's role is to connect the offender with the treatment. Variables such as language, culture, personality, and learning styles should all be taken into consideration. (Yates, 2013).

Literature discussing effective treatment and what is perceived to be effective treatment suggests that using the risk, need and responsivity principles will lead to effective treatment. The risk aspect of this treatment suggests that treatment is more effective when it is matched to an offender's risk. The need principle suggests that needs are more effective than the actual treatment intervention. And responsivity says that the treatment is more effective when the treatment intervention is matched with the offender's learning style (Seto, Kingston & Stephens, 2015).

The responsivity aspect of this treatment refers to the methods and features of the provider that help to improve the offender's ability to have beneficial treatment (Levenson & Prescott, 2014).

Behavioral Treatment Programs

Behavioral treatment for sex offenders became a primary treatment option in the 1970s. This form of treatment was used as a primary determinant of sexual offenses. Behavioral treatment is based upon conditioning principles and the purpose is to reduce sexual deviancy by replacing inappropriate thoughts or fantasies with an aversion stimulus. Covert sensitization treatment and masturbatory reconditioning techniques are part of behavioral treatment (Walton & Chou, 2014).

Cognitive-Behavioral Treatment Programs

Although public policy and society demand that sex offenders be treated by confinement, many times a sex offender will spend a large part of his or her life in the public. Because of this, cognitive behavioral therapy is a form of treatment that is used to manage sex offenders (Schaffer, Jeglic, Moster, & Wnuk, 2010). Most sex offender treatment is done in group formats and tends to be cognitive in nature (Jennings & Deming, 2013). Researchers have found that sex offender treatment, in particularly, cognitive behavioral treatment, reduces recidivism. In addition, studies show that cognitive behavioral treatment is the most cost-effective form of treatment. Cognitive behavioral treatment is currently the most used psychosocial treatment for sex offenders (Schaffer, Jeglic, Moster, & Wnuk, 2010). Most of treatment for adult sex offenders is cognitive in nature and done within group formats (Jennings & Deming, 2013).

Cognitive programs are based in part on the premise that the offending behavior was caused by improper thinking. Consequently, cognitive skills programs will seek to enhance self-control, problem solving, critical reasoning, interpersonal perspective, and social and moral decision making (Haeseltine, Sarre, & Day, 2011). Cognitive behavioral therapy has a long history. Documentation has shown its use since the late 19th century and the same tactics are used within behavioral therapy today (Schaffer, Jeglic, Moster, & Wnuk, 2010).

Cognitive behavioral treatment combines two psychotherapies to not only address the actions of the offender, but the thoughts and beliefs as well. The cognitive component of the treatment focuses on the attitudes that cause the offender to have the dysfunctional thinking that ultimately leads to the offenses. This area of the cognitive behavioral treatment emphasizes ways the sex offender can learn new skills and develop characteristics and new thinking habits that will cause him or her to cease from the deviant behavior. The behavioral aspect of the cognitive behavioral treatment helps the offender to develop new skills and actions that will help them change their pattern of behavior (Kim, Benekos, & Merlo, 2015).

Thinking for a Change is a cognitive-behavioral program created by the National Institute of Corrections and helps offenders develop interpersonal communication skills, change thought patterns and assist with decision making skills. Studies have shown that persons who participate in this program while incarcerated have a lower recidivism rate than those who do not. A study compared 121 felony offenders who had participated with

96 who had not. After six months to 2 ½ years of follow up, 23% of the persons who had participated in the Thinking for a Change had re-offended (Clark & Duwe, 2015).

Another cognitive-behavioral that is used to treat offenders is the Lifestyle Change Program. This program is led by a psychologist and lasts for approximately a year. This program was created to help develop decision making skills and positive lifestyle changes within the offenders. This type of program also poses systems issues that this research seeks to close the gap on the lack of studies comparing the provider's perception of effective treatment with some of the systems issues that the providers face. Studies conducted showed that inmates who had completed at least one phase of this program had lesser recidivism rates than those who did not (Clark & Duwe, 2015).

Jennings & Deming (2013) posit that a group environment supports behavior change and assists with social interaction, social awareness, self-esteem, empathy, and management of deviant thoughts.

Victim Empathy Intervention

Victim empathy is interchangeably referred to as empathy, awareness, or remorse. Empathy can be defined as a cognitive and emotional understanding of the experience the victim went through because of the offense and causes a compassionate response to the victim. Victim empathy intervention requires the offender to write an apology to the victim and frame the apology in such a manner as to show progress in his or her ability to move toward empathy and to understand the impact his behavior had on the victim(s) (Mann & Barnett, 2012). Offenders in Sand Ridge Civil Commitment Center in Wisconsin were surveyed about the necessity and importance of victim empathy

treatment for sex offenders. Victim empathy was rated as the second most important treatment element (Mann & Barnett, 2012).

Community-Based Programs

There is more awareness of the need for community-based programs. More offenders are receiving community-based treatment orders. Thus, the need for community-based programs has increased. Additionally, overcrowding of correctional facilities necessitates the need for community-based sex offender treatment (Collins, Brown, & Lennings, 2010). Collins, Brown, & Lennings, (2010) also posits that, due to the overcrowding and research conducted on recidivism rates after community-based treatment, the recognition of the need for aftercare support and treatment is more prevalent.

Post-Release

There is more of an awareness of the need for aftercare support and treatment than there was in years past. There is a need to treat offenders who re-enter society due to the potential risk they pose to society. Although there has not been much study or research conducted on after-care, post-release sexual recidivism was linked to the lack of aftercare treatment in one study. But what has been researched and written shows that aftercare is essential to the successful treatment of sex offenders (Collins, Brown, & Lennings, 2010). Prisoner reentry is a process all individuals have to go through following incarceration and there are many barriers for offenders to overcome such as employment, housing, substance abuse, mental health issues, previous criminal history, and family difficulties. Because it is such a critical stage of the successful treatment process, there is

a great need for programs that will help integrate and facilitate persons reentering society (Hunter, Lanza, Lawlor, Dyson, & Gordon, 2015).

A study of released offenders explored the post-release employment and recidivism. This study consisted of 6,561 offenders who had been released from the Indiana Department of Corrections. This was a five-year study that represented more than 43% of the total offenders released from the Indiana Department of Corrections. Analysis of the offender's characteristics was part of the data analysis as well as post-release recidivism. The findings of this study showed that sex offenders were less likely to re-offend if they were employed following their release. The results of the five-year study showed that correctional education increased employability following prison and decreased recidivism. Educated offenders were less likely than uneducated offenders to reoffend (Nally, Lockwood, Ho, & Knutson, 2014).

Medical Treatment Programs

Medical castration is a form of medical treatment that is used in the treatment of sex offenders. SSRI are chemicals used to help offenders with compulsive or addictive behavior such as inappropriate sexual acts. It has been suggested that SSRIs reduce sexual fantasies, desire, and sexual deviant behavior in its patients. Additionally, a testosterone lowering medication is another form of medical treatment that is used to treat sex offenders. Forms of TLM are cyproteroneacetat, medroxyprogestoerone acetate, and luteinizing hormone-releasing hormone. Additionally, the use of naltrexone is used for compulsive sexual behavior (Briken, 2012).

The use of antiandrogens as a chemical form of castration shows to be effective for some sex offenders in reducing deviant sexual fantasies. The two chemicals licensed for use in chemical castration within the United States are Medroxyprogesterone acetate (MPA) and Depo-Provera. In Europe and Canada, Cyproterone Acetate (CPA) is used. CPA is a synthetic steroid and works by reducing sexual urges in males. It comes in the form of tablets or a slow release injection (Thibaut, 2011).

The use of CPA has shown to cause a reduction in recidivism even after its use has been discontinued (Harrison, 2007). Medroxyprogesterone acetate (MPA) is one form of medication that is used to reduce symptoms of inappropriate sexual desires (Prentky, 1997; Miller, 1998; and Stalans, 2004). In addition, serotonin reuptake inhibiters are also used in place of antiandrogen drugs. Studies have shown that these antidepressants work to cause a delay in the sexual drive. These studies also show that they have had favorable treatment response with the use of serotonin reuptake inhibitors (Greenberg & Bradford, 1997 and Briken, 2012). Other forms of pharmaceutical drugs used are Triptorelin and Leuprorelin. Both medications stimulate the release of LH and cause a temporary flare of testosterone levels. After the initial dose to stimulate, the continued use of either of these drugs result in a lowering of testosterone levels within two to four weeks (Thibaut, 2011).

Therapist and Treatment Provider's Role: Application of Systems Theory

The therapist is key to seeing positive changes in sex offenders. The relationship between the treatment provider and the offender are paramount to success (Marshall, Marshall, Serran, & O'Brien, 2011). Individuals who work with sex offenders are charged with the awesome responsibility to make several important decisions regarding

these individuals, most having to do with various types of risk. (Schwartz, 2002). Understanding and identifying factors that contribute to successful treatment is critical and essential to policy making decisions. The following research question was asked in this research project:

For each set of modalities commonly used in sex offender treatment, do the providers perceive a difference in effectiveness?

To date there has been little research conducted to get the providers' perception of what works (Kimonis, Fanniff, Borum, & Elliott, 2011). Little research also exists on how treatment providers view the change process in the offenders they treat and how the change affects them as agents of change. A study was conducted that explored the therapists' perceptions of how they view their role in treatment. The survey was conducted with a sample of four treatment providers. They were asked questions such as how they viewed their role, their views on how a sex offender could be treated, how they can measure whether someone is being changed or treated successfully, and the good and bad of their treatment plan. The theme that arose from that survey suggested that the heterogeneity of sex offenders and the identity they presented, had an influence on how successful change was in an offender (Collins & Nee, 2010).

A study conducted by Collins & Nee (2010) suggested that treatment was impacted by the time constraints the treatment providers had on them to get through their caseload in a specific amount of time. The constraint was a system issue facing the practitioners in this study and providers felt their perception of how effective their treatment was affected by that systems issue. In the study conducted by Collins & Nee

(2010), four treatment providers were interviewed to see how they perceived their effectiveness as mediators of change. Among the variables the providers said affected their perception were the environment of the place of treatment and 'systematic issues' (p. 324).

Marshall and Serran (2000) posit that there is great significance in the level of education and training the treatment provider has and how effective the treatment is for the sex offender. They also posit that by the therapists receiving proper training and education, the treatment is more likely to be effective. Sex offenders who do not get successful treatment or who do not complete treatment have a higher rate of reoffending (Grady, Howe, & Beneke, 2013). The role of the treatment provider is critical. A qualitative study was completed in which four providers with a combined experience of 78 years were analyzed. From this study conducted by Grady, Howe, & Beneke, (2013), eight themes emerged that influenced the treatment providers' selection of treatment for offenders. Those themes included the whole picture, logistical factors affecting admission, post-acceptance factors, and behavioral patterns over time, outside support, quality of referral, overt signs of interest, and overt negative signs. These eight themes were looked for when deciding if the offender was going to be a successful candidate for treatment (2013). The themes of this theory correlate with systems theory as each of the factors outlined in this study as the eight themes are systems issues that could potentially affect the effectiveness and long-term success of treatment as well as the perception providers put on effective treatment.

Creating effective treatment programs is paramount to decreasing the recidivism rate. Treatment plans must be created so that the offender has the ability and desire to successfully complete treatment. Part of a successful treatment for sex offenders includes the role of the therapist or treatment providers. In addition, to providing the treatment plan and outline, the therapist must help the offenders want to engage in treatment and give them a desire and a belief that their behavior should and can change through treatment. Engagement, empathy, warmth and motivation have been found to be a help in the treatment of sex offenders (Levenson & Prescott, 2014).

One of the first hurdles a treatment provider faces is that of denial. Many sex offenders deny that their act was their fault, that it was as bad as it was portrayed to be, or that it even happened. Denial is a daily reality for treatment providers and one that providers must address. A study conducted in a prison in England set out to explore what treatment providers' perceptions were and what implications there are in the types of treatment given to sex offenders. A qualitative methodology was used and was conducted to gain an understanding of what providers perceived to work, in particularly in the case of deniers. The study sought to delve into the personal accounts and experiences of the providers to get a better understanding of what works (Blagden, Winder, Gregson, & Thorne, 2011).

Psychotherapy suggests that therapists contribute to the process of therapeutic change. Additionally, in a study by Drapeau (2005), it was reported that offenders believed that their therapists or treatment providers had the most significant impact on their treatment. Research has focused on the content of the treatment rather than on the

actual processes conducted by the providers (Sandhu & Rose, 2012). Because of this there is a gap in the literature which my study seeks to fill.

Punishment and rehabilitation are sought after in the rehabilitation of sex offenders. Is it possible to have both be successful? Ward & Salmon (2009) posits that punishment involves creating states such as guilt, remorse, blame, and responsibility, while rehabilitation offers well-being, support and belonging.

Studies have shown that the response of the treatment providers to the offenders plays a role in the successfulness of the treatment plan. Displaying features such as empathy, warmth, encouragement, and directiveness all play a role in how the goals for the treatment are met. In addition, when these attributes are displayed, the offenders successfully achieve their goals (Marshall, 2005; Marshall, Serran, Fernandez, Mulloy, Mann, & Thornton, 2003; Marshall & Serran, 2004; Marshall, Serran, Moulden, Mulloy, Fernandez, Mann, & Thornton, 2002.; Harkins & Beech, 2007, and Drapeau, 2005). Additional studies showed that when there was expressiveness and togetherness exhibited in a group setting during treatment there was additional success in the treatment. Without those characteristics, treatment gains did not take place (Beech & Fordham, 1997 and Beech & Hamilton-Giachritsis, 2005).

A pilot study conducted of 24 sexual offenders regarding their thoughts on the importance of therapists' style and attitude during treatment showed that the offenders believed that the style, offender's perception of the therapist, and the bond between the therapist and the offender were important in administering successful treatment (Drapeau, 2005). In addition, a non-confrontational approach to treatment and a supportive type of

relationship between the offender and the therapist produced the most positive results among sex offenders (Drapeau, 2005; Fernandez, 2006; Kear-Colwell & Pollock, 1997; Preston, 2000; Garland & Dougher, 1991; Andrews & Banta, 2004, Ginsberg, Mann, Rotgers, & Weekes, 2002; Mann, Ginseberg, & Weekes, 2002; and Beech & Fordham, 1997).

An extensive study of therapists' role and outcome of sex offender treatment was conducted by Marshall, et al (2003). The purpose was to observe several therapy groups with different therapists and see if there were features of the therapists that could be identified and if those traits found in the therapists produced changed in treatment. The study consisted of 12 two-hour video tapings of treatment sessions from seven prisons. Each therapist being viewed had been given extensive training on being a therapist and all of the offenders being treated for this study were adult males who had victimized a child or an adult female.

The therapist features that produced the most significant changes in the treatment outcome included empathy, warmth, and rewarding. In addition, asking direct questions of the offenders resulted in beneficial changes in the treatment. The features that negatively affected the treatment outcome included a confrontational style of treating the offender (2003).

In addition to the characteristics displayed by the treatment providers, the treatment providers can teach the offenders how to set goals and to set up a plan utilizing the offenders' interests and abilities to make them a productive citizen of society and have less of a chance to recidivate. After setting goals, the offenders' weaknesses can be

worked on to enhance the chance of successful treatment (Marshall, Marshall, & Serran, 2006).

A study conducted of 158 treatment providers who work with juvenile sex offenders explored the factors that predict treatment success. In this study, a survey was given to treatment providers to try to understand what factors contribute to successful treatment. Per the researchers of this study, this study was an attempt to close a gap between understanding what is effective treatment (Kimonis, Fanniff, Borum, & Elliott, 2011).

Fallon (2012), utilizing Tuell's (2003) survey, conducted research to see what treatment providers perceive to be effective treatment among juvenile sex offenders. 64 participants participated in the survey and the results showed that out of the 55 treatment modalities listed in the survey, 23 ranged in the effective to mostly effective range, 12 were in the somewhat effective to effective, 12 were in the somewhat effective and eight of the treatment modalities listed under medication were in the not effective to somewhat range. The treatment modalities listed among the somewhat effective to mostly effective included communication skills, assertiveness training, psychodrama, individual counseling and eye movement desensitization and reprocessing (EMDR).

Recidivism

'Will they do it again' is a question asked by researchers and treatment facilities regarding sex offenders and their potential in recidivating. Are sexual offenders more likely to recidivate than other criminals? What happens when they are released back into

society? These questions raise plenteous discussion within society (Wilson, Stewart, Stirpe, Barrett, & Cripps, 2000).

Sex crimes are crimes against not only society, but on their victims and the victims' families. Consequently, treatment programs that decrease the opportunity or desire to reoffend are critical. Although varying models of treatment have been implemented, recidivism is still a paramount concern.

Recidivism is a gauge for policymakers and sexual offender treatment personnel to see how effective their treatment programs and legislation are. Concerns for future victims lead to legislation being implemented to protect society. Additionally, most sexual offenders will return to society upon completion of some sort of treatment plan. Knowing the causes of recidivism is of paramount importance to protecting society. In addition to the danger sexual offender recidivists pose, there is the immense cost to society in recidivism. Coupled with the financial cost to society by recidivism in the investigation and imprisonment aspects, there is the cost of emotional damage to victims, fear for future victims, and the physical impact sexual offenders have on their victims. The reduction of reoffending among sex offenders has been recognized as one of the most important goals in treatment planning (Heilburn, Nezu, Keeney, Chung, & Wasserman, 1998). Policymakers and treatment providers must continually advocate for more research and the enhancement of quality sex offender treatment to prevent future sex offenses (Levenson & Prescott, 2014).

Voice From Offenders

In addition to the importance of researching the perceptions of treatment providers as to what works, studies have been conducted on how offenders view treatment and what the offenders believe is beneficial to effective treatment. It is widely accepted that for a sex offender to have effective treatment, it is important for that person to feel involved in and responsible for successful treatment (Collins, Brown, & Lennings, 2010).

A study conducted in 2009 (Levenson & Prescott) surveyed 44 committed sex offenders in Wisconsin. The results of the 44 surveyed offenders showed expectantly higher accolades and positive sentiment toward their treatment providers. The negative comments from this survey suggested that they felt the providers were at times judgmental.

In a study conducted in an outpatient therapy facility, those surveyed reported being satisfied with their treatment programs and were positive about the effectiveness of the treatment they received. Offenders ranked victim empathy and accountability as the most important aspects to their treatment (Levenson, Prescott & Jumper, 2014).

A study was conducted of sex offenders by asking the offenders how they perceive the treatment process, the program of treatment and their treatment provider. The sample was obtained from The Illinois Department of Human Services Treatment and Detention Facility. A survey was given to the sample. The result of the study showed that the offenders thought the accountability, victim empathy, and relapse prevention

were the most beneficial treatment plans while the least helpful treatment topics were life skills and human sexuality (Levenson, Prescott, & Jumper, 2014).

Summary

Sexual deviant behavior is a serious challenge within society and requires an effective treatment plan. Research suggests that comprehensive treatment programs or a combination of treatment methods are more effective than those, which are limited in nature (Hall, Shondrick, & Hirschman, 1993). Recidivism has been shown to be less when offenders are or have been involved in a rehabilitation plan (Hanson, et al, 2002). Prison programs are one form of treatment used to treat sex offenders. One-fourth of the United States prison population is made up of sex offenders. One study suggests there is an increase in recidivism when sex offenders are incarcerated versus another form of treatment (Gendreau, Goggin, & Cullen, 1999 and Gendreau, Goggin, Cullen, & Andrews, 2000).

Within the prison system, there are other forms of treatment available to sex offenders. One form is faith-based programs. Faith-based programs offer worship services to the prisoners and based upon the results of the studies reviewed, the recidivism rate is lower in inmates who participate in this type of program (Early, 2005; U.S. Department of Justice, 2003; Johnson, 2004; and Camp, Klein-Saffran, Kwon, Daggett, & Joseph, 2006). An educational program is another avenue an inmate can pursue while incarcerated. The benefits from an educational program include psychological, societal, and moral (Vaughn, 1992). Educational programs offer the

inmates a chance to learn basic life skills as well as pursuing higher educational opportunities.

Behavioral treatment programs are often used in conjunction with other forms of treatment. Behavioral treatment theories posit that deviant fantasies are a result of learning and reinforcement and can be changed by changing the offenders' behavior (Heilbrun, Nezu, Keeney, Chung, & Wasserman, 1998; Marshall & Barbaree, 1978; and Stalans, 2004). Included within behavioral treatment plans are cognitive-behavioral treatment programs. Cognitive-behavioral treatment for sex offenders has proven to be the most effective form of rehabilitation (Marshall & Barbaree, 1990 and Gendreau, Goggin, & Cullen, 2000). Cognitive-behavioral theories suggest that attitudes or beliefs of the offenders have a direct influence on their negative behavior. The goal of cognitive-behavioral treatment is to replace the inappropriate behavior with positive behavior (Marshall, Anderson, & Fernandez, 1999; Yates, Goguen, Nicholaichuk, Williams, & Long, 2000).

Post-release programs are perhaps the most critical aspect of a sex offender treatment plan. The purpose of post-release programs is to gradually reintroduce the offenders back into society. Having the necessary skills, housing, employment, and social relationships are included within the plan to reintroduce the offenders back to society (Carich & Stone, 2001 and Aylward, 2006).

Medical treatments to offenders include surgical and chemical castration. The use of antiandrogens to perform chemical castration upon an offender has been shown effective for some sex offenders. Surgical castration has been used but has resulted in

negative feedback from special interest groups (Besharov, 1992). Although chemical castration does have side effects, some studies suggest its use reduces the rate of recidivism in sex offenders (Grossman, Martis, & Fichtner, 1999).

Lastly, the attitudes and characteristics of the therapists administering the treatment play a role in how successful the treatment is. Displaying empathy, warmth, encouragement, and directiveness are important in how the treatment goals are met (Marshall, 2005; Marshall, Serran, Fernandez, Mulloy, Mann, & Thornton, 2003; Marshall & Serran, 2004; Marshall, et al, 2002; Harkins & Beech, 2007, and Drapeau, 2005).

Just as there are varying types of sexual offenses, there are various treatment plans currently in effect within the treatment facilities. This literature review has given a synopsis of the types of treatment plans along with examples of studies showing results of studies of those treatment plans. The literature review includes reviews from peer reviewed journals within the past five years. Farkas (2014) posits that studies that have surveyed counselor's perceptions, illustrate how research can be beneficial to the treatment. She also explains that, "The explication, testing, and corroboration of research findings have the potential to advance our knowledge and enhance our understanding of 'what works'?" (Farkas, p. 392). Additionally, she proposes that studies that tell us what works allow us to use what works in future rehabilitation and corrections (2014).

The themes that resound from the literature review are that without successful treatment, recidivism is high. However, there are few studies that have been done to assist in finding what successful treatment or if a particular type of treatment affects

providers' perception of successful treatment. By comparing the five categories of treatment with how the providers perceived their effectiveness, this study attempted to close that gap.

As shown in Chapter 3, the purpose of this research was to analyze the results of the survey to see if the independent variables affected the ratings of the treatment effectiveness. The variables are discussed more in depth and detail within Chapter 3. The methodology of this study is discussed, and the findings are analyzed to see if the types of treatment has an effect on how a provider perceives a treatment. The information included in Chapter 3 is the discussion of the problem statements, hypothesis and the sample population.

Chapter 3: Research Method

Introduction

The purpose of this quantitative study was to see if there is a relationship between the type of treatment and the providers' rankings of the effectiveness of treatment. Treatment providers have been working directly with sex offenders for years, and their opinions and perceptions of what is effective can be beneficial to the future success of treatment.

In this chapter, I discuss the research methodology, data collection and analysis, and research design that were used in this study to measure the success of treatment programs for sexual offenders. I evaluate the treatment providers' perceptions of treatment modalities currently being used by ranking the perceived effectiveness of the treatment modalities and comparing them with the types of treatment to see if there is a correlation. The assessment of treatment providers' perspectives on effective treatment modalities added to this body of research. Babbie (1995) posited that being in the actual treatment process itself is an important mechanism for learning what works in the treatment of sexual offenders. Additionally, Babbie suggested that experience and education are important in the effective treatment of sex offenders as practitioners that are not experienced or that are untrained may miss or ignore serious behavioral issues.

Research Design and Rationale

To achieve the purpose, I took a quantitative approach. The sample survey is a method of data collection (Lodico, Spaulding, & Voegtle, 2010). A cross-sectional

survey design was used because the information was gathered at one time and not over a long period of time.

In this study, the independent variables were the five categories of treatment: psychoeducational, behavioral, psychotherapeutic, cognitive behavioral, and medication. The dependent variables were the subjective rankings of the five categories or the perceived effectiveness of the five categories of treatment surveyed.

A Kruskal Wallis analysis was performed to determine any association between perceptions and each of the independent variables. Study participants rated each of the 55 treatment methods, which were broken down into five types, on a 5-point Likert scale, 1= *not effective*, 2 = *somewhat effective*, 3 = *uncertain*, 4 = *mostly effective*, and 5 – *effective*. Time constraints did arise in some instances because some of the persons who were invited to do the survey did not respond in a timely manner. Resource constraints were minimal as the cost of emailing a survey link and gathering the data were very low.

Descriptive survey research is a method of data collection to compare perceptions from a large sample (Lodico et al, 2010). Creswell (2009) defined descriptive survey research as the method to use to generalize findings of what the sample thinks or perceives. A quantitative design "provides a numeric description of trends, attitudes, or opinions" by studying a sample of the population (Creswell, 2003, p. 153). Causal-comparative research attempts to show cause and effect among the variables and therefore would not have been an appropriate means of measurement. Additionally, experimental research was not suitable for this study as the sample population is subjected to experimental treatment. Correlational descriptive quantitative research was

the means of measurement most suitable for this study as I examined the relationship between two or more variables (see bcps.org, 2015). This quantitative study was nonexperimental in nature, and no intervention took place.

Independent and Dependent Variables

After receiving an introductory solicitation email and after agreeing to complete the survey, providers had the option to click on a link to the Survey Monkey site to take the survey. Surveys are used in the hope of finding results that portray an accurate representation of what a larger population of sex offender treatment providers perceive to work. Knowing what treatment methods are most effective in treating sex offenders is important for a safer society, not only for the public but for the offenders as well. A Kruskal Wallis analysis was conducted to determine if the independent variables, types of treatment, affected the rankings of the effectiveness of treatment, which were the dependent variables.

Methodology

Population

The original intended target population for this study was clinicians who provide sex offender treatment-in three Midwestern States. However, due to the lack of responses from those three Midwestern States, the target population was increased to providers within the United States. The sampling design used a search via the Internet to identify sex offender treatment providers within the states of Illinois, Minnesota, and Nebraska. The providers surveyed came from lists of approved providers gathered from each state's approved sex offender treatment providers' list. From the providers listed, a survey

questionnaire was sent to the providers along with a request to participate in the study. The list of providers from Minnesota came from the Minnesota Department of Human Services. The list of approved treatment providers for Nebraska came from the Department of Health and Human Services, Division of Behavioral Health. The Illinois sample came from the Sex Offender Management Board Approved Provider List. There were approximately 416 providers from the three states chosen. The intended population size for this research was the 416 providers gathered from the list. Due to the lack of respondents from the states originally chosen, the Institutional Review Board approval was requested and approved to open the study up to other providers within the United States. Surveys were sent to 899 providers in states scattered throughout the United States and based upon contact information that was publicly available.

Sampling Method and Sample Size

A total of 101 treatment providers returned the survey. Data collection began on March 13, 2018 and ended on August 14, 2018. An IRB approved survey was sent to 899 sex offender treatment providers throughout the United States. Pursuant to the IRB approval, all responses received from the survey were received anonymously. No identifying mechanisms were placed on the survey in order for the respondents to respond anonymously. A reminder email was sent on June 23, 2018 to the first 628 surveys sent. July 18, 2018 a reminder message was sent, and a final reminder was sent on August 14, 2018 to the last providers who had been sent a survey. The sample of 899 all received two requests to participate. One-hundred and one total responses were received, but only 95 were fully completely and six were partially completed. A CI of 4

and a CI of 95% were used. Sample power analysis was used through SPSS with a *p* value of .05. An alpha level of .05 was used to avoid Type II error. Participants were asked to fill out a survey containing questions relating to their perception of the five categories of treatment and how systems issues affect those perceptions.

Procedures for Recruitment, Participation, and Data Collection

Recruiting took place by emailing providers asking them to participate in a survey. The names of the providers were gathered from a provider list from each state that the sample was taken from. The data collected for this study were taken from the results of the survey emailed to respective sexual offender treatment organizations.

An initial email was sent to each provider, requesting them to participate in the survey and advising them that the reason they were chosen to participate is they had been identified as a person who provides sex offender treatment. If the participant chose to participate in the survey, they clicked on a link that took them to the survey in Survey Monkey. Participants were informed of confidentiality and potential benefits from participation.

The purpose of the research was introduced in the letter along with how the survey would be given as well as step-by-step instructions on completing the survey. In addition, participants were informed that they would have access to my findings upon completion of this research project. A follow up email was sent 2 weeks after the initial survey had been sent. Due to an initial poor response, additional surveys were sent via email to providers in Iowa and Kansas and, after an IRB revision, sent to providers

throughout the United States. Surveys were conducted via electronic service by a sample of the treatment providers within the United States.

Data collection began on March 13, 2018 and ended on August 14, 2018. An IRB approved survey was sent to 899 sex offender treatment providers throughout the United States. Pursuant to the IRB approval, all responses received from the survey were received anonymously. No identifying mechanisms were placed on the survey in order for the respondents to respond anonymously. A reminder email was sent on June 23, 2018 to the first 628 surveys sent. July 18, 2018 a reminder message was sent, and a final reminder was sent on August 14, 2018 to the last providers who had been sent a survey. The sample of 899 all received two requests to participate. One-hundred and one total responses were received, but only 95 were fully completely and six were partially completed.

Survey emails were sent with a link to the Survey Monkey where the survey instrument was made available. Some treatment facilities had more than one provider. In this case, an email was sent to each provider. Upon the return of the survey, the provider's participation in the study was completed.

Instrumentation

A survey questionnaire was used to collect data on the perceived effectiveness of treatment modalities among a sample of treatment providers. The instrument used in this study was based upon an instrument created by Tuell (2003) but was modified to meet the research questions of this study. Permission was granted from Tuell for the use of the survey (see Appendix D). Tuell's survey was used to assess how treatment providers

viewed treatment effectiveness but did not assess how the various types of treatment affected the providers' view of effective treatment. Tuell's sample consisted of sexual offender treatment providers within the state of Ohio as well as counselors, therapists, and psychologists. Various treatment options were also surveyed, and demographic information was collected first to see if there was any relationship between the demographics and a treatment method. The survey items Tuell chose were treatment modalities that had been identified as used in sex offender treatment. The treatment modalities are classified into one of five treatment areas: psychoeducational, psychotherapeutic, cognitive-behavioral, behavioral, and medication. Tuell tested the consistency of the treatment modality categories with the use of Cronbach's coefficient alpha for each of the categories. Scores above .60 (psychoeducational and behavioral, psychotherapeutic, and medication) were consistent. Tuell's findings were based on 56 participants who completed the survey. The responses indicated that cognitive behavioral treatment modalities were the most effective. Psychoeducational and psychotherapeutic were also perceived to be equally important with behavioral treatment following. Medication as a form of treatment ranked the lowest as to what the providers perceived to be the most effective (Tuell, 2003). While Tuell focused on juvenile offenders, in this study, I sought to discover the perceptions of what works for sex offenders in general.

In a follow up study conducted by Fallon (2012), Fallon used Tuell's survey to assess the effectiveness of the categories of treatment on adult male offenders. Both Tuell and Fallon utilized the survey designed by Tuell to assess treatment effectiveness, however, this study specifically focused on how the treatment providers rank the

categories of treatment in Tuell's survey and how systems issues might affect that perception.

Variables and Hypothesis

The dependent variable is the rankings of the treatment effectiveness. The perception or rankings were measured on a five-point Likert scale. The independent variables consisted of the five types of treatment. The level of measurement of the independent and dependent variables is shown in Table 2.

Table 2

Operational Definition of Independent and Dependent Variables for Hypothesis Testing

Variable	Definition	Level of measurement
Independent variable	Types of treatment	Nominal
Dependent variables	The average score of effectiveness of treatment	Ordinal

Validity and Reliability of the Study

Validity of this study was tested by the ability to replicate or generalize the findings from this research study to another program or sample. Reliability was shown by eliminating any personal bias of the researcher and of the persons being administered the survey design. Cronbach's coefficient alpha was used in Tuell's initial survey (2003) to examine the reliability of the five types of treatment that will be analyzed in the survey.

The purpose of using Cronbach's coefficient alpha provided information as to the internal consistency of the five categories of treatment.

Data Analysis Plan

The purpose of this study was to investigate sex offender treatment providers' perceptions of effective treatment. The 55 treatment modalities listed in the survey were consolidated into five categories for easier analysis. Descriptive statistical analysis was used to show the frequency of categories of treatment chosen. The purpose of the data analysis was to see what providers perceive to be effective treatment and to further see what systems issues may affect their perception. Data analysis began once the surveys were returned from the treatment providers.

The survey listed 55 types of treatment. The 55 types of treatment were further broken into five sub-categories. The five categories were psychoeducational, psychotherapeutic, cognitive-behavioral, medication, and behavioral. The responses received from the survey were analyzed using descriptive statistics. Descriptive statistics are used to describe the basics of the data and provide summaries about the sample (Trochim, 2006).

A table was created showing the mean and the standard deviation of the 55 treatment modalities. The mean and standard deviation was done with the use of SPSS. The table shows the ranking of each treatment modality based on the mean of how the provider perceives the effectiveness of each treatment modality using the scale that 1 = Not effective 2 = Somewhat effective 3 = Uncertain 4 = Mostly effective 5 = effective.

The results show the average in which the providers rated the treatment and the standard deviation among the answers.

To see which of the five categories of treatment rank higher in effectiveness according to the providers, the survey answers were analyzed using frequency analysis. Frequency analysis is a descriptive statistics analysis that deals with the number of occurrences a specific category was chosen. First the mean was established for each of the five categories of treatment. The data showed how many in the sample and how the sample ranked in each category of treatment. The mean showed what the average answer is for each category of treatment. Once the mean for each category was obtained, the median was obtained by putting the mean of each category in numerical order and finding the average of the answers. Finally, the mode was calculated to see which category appeared most frequently in the survey answers. A table was created showing the rank order of the categories and an overall rank of the survey answers. After ranking the scores of each category, standard deviation was conducted. The answers were placed into a table which lists the category, the number, the mean, the standard deviation, the median and the minimum and maximum of the range. SPSS was used to analyze the data.

A Kruskal Wallis analysis was conducted to see what, if any, relationship there is between the perception and each of the independent variables. A Kruskal Wallis analysis allows for the testing of the relationship between a nominal independent variable measured with more than two groups and dependent variable measured at the ordinal level. A similar study conducted analyzing the treatment providers' perceptions of the most utilized treatment modalities in the treatment of adult male sex offenders used

multiple regression to determine the association of the independent variables of age, education, and years of experience and the treatment modalities (Miller, 2016). An alpha level of .05 was used to avoid the possibility of Type II errors.

For the dependent variable, which is the ranking of the treatment methods, or the providers' perception of what it effective, ordinal level of measurement was used. Ordinal data are used for ranking purposes and not for numerical value (Davies & Mosdell, 2006). Perception is difficult to capture since it cannot be overtly measured or validated. Because of the difficulty in measuring perception, the most common way to measure perception is through a Likert Scale. The answers obtained from the Likert Scale were averaged to produce a numerical score. The answers from the five categories of treatment were ranked. Likert Scales are economical and allow a researcher to glean information easily (Ho, 2017). A Kruskal Wallis analysis was the test conducted to see if the independent variables have a significant impact on the dependent variable. The analysis was used to compare the five means created from the answers given and scored from the survey answers.

Research Questions and Hypotheses

To determine the correlation between the type of treatment and the provider's perception of effective treatment, the literature led to the following research question:

1. For each set of modalities commonly used in sex offender treatment, do the providers perceive a difference in effectiveness?

H_1 Treatment providers rank the five treatment categories differently.

H_0 The anticipated null hypothesis is that the treatment providers do not rank the five treatment categories differently.

Data collected from the answers gathered from surveys were ranked based upon the means of each of the categories of treatment listed on the survey (psychoeducational, psychotherapeutic, cognitive-behavioral, medication, and behavioral). To achieve this purpose, a quantitative research method was conducted. Data were analyzed using frequencies, mean, standard deviations, and correlation. A mean was obtained for each item within the respective categories. In addition, a mean for each treatment category was obtained. Rank order was established based upon the means of the categories. A Kruskal Wallis analysis was conducted on the five means (the mean from each of the five categories of treatment). The purpose of this analyses was to not only see the rankings of the treatment modalities but allow the researcher to see the differences in the averaged rankings of the types of treatment.

The independent variables consisted of the five categories of treatment commonly used in sex offender treatment. The dependent variables are the ratings of the treatment modalities or the perceived treatment effectiveness by sex offender treatment providers and will be measured by the Likert Scale. The responses from the survey listed what modalities among the list of treatments are perceived to be the most beneficial to effective sex offender treatment. The five independent variables were analyzed using a Kruskal Wallis analysis. The independent variables were analyzed to see if their presence affected the opinions of the providers when ranking their perception of treatment modalities.

Threats to Validity

Threats to external validity include could the results of this study and the responses received from the providers in the sample selected be replicated in another sample of providers in another part of the country? Additionally, varying levels of education and demographics of the providers may not allow the study to be generalized to the providers with differing education.

Internal validity threats that are a potential in this study are: do the different independent variables affect the variation of the dependent variables? Or can the variation of the dependent variables be affected by other things other than one of the independent variables? Because of the nature of the study and the goal to be able to replicate the results in other areas, internal validity of this study is critical.

External threats also might include future research of the professionals chosen in the sample as their answers may differ in varying times of their training and profession. History, compensation, and maturation are not threats in this study as the survey is conducted anonymously and participants are not compensated for their time. Also, due to the sample being of people from a specific profession and with specific characteristics, the study may not be replicable to other professionals.

Ethical Procedures

Upon completion and approval of the IRB application, data were collected via surveys. The surveys collected were confidential as no personal information of any offender was sought. Therefore, there were no ethical concerns for this study. IRB

approval was obtained, allowing distribution of surveys to the sample population. IRB approval number is 03-01-18-0098685.

Data collected from the surveys were sent and received electronically and stored in Dropbox. The data was kept confidential and, other than the researcher, no one had access to the survey answers. Data will be kept for a minimum of five years.

Summary

To achieve the goal of this research, a quantitative descriptive correlational research design was used. The data collected from the survey designs were the large contributor to the findings for this study. The findings from the data were analyzed and discussed in the following chapter of this study. Recent years have shown the introduction of public policies relating to sex offenders and treatment. The policies range from identifying causes of the offenses, types of treatment requirements, as well as setting policies that will create a safe environment for the public (Day, Carson, Boni, & Hobbs, 2014). It is the hope of this researcher to have data available following the analysis that would allow policymakers to create a successful treatment plan for sex offenders.

In Chapter 4, the results of the data collection and analyzing are discussed and future recommendations are made based upon the findings. The chapter is intended to provide guidelines for a model rehabilitation treatment plan. The plan's intent is to see a reduction in recidivism and promote positive and effective rehabilitation for sexual offenders.

Chapter 4: Results

Introduction

The purpose of this study was to increase the knowledge of effective sex offender treatment by examining the relationship between the type treatment modality and the provider's perception of effective treatment. Purpose of this study was the research question that for each set of modalities commonly used in sex offender treatment, do the providers perceive a difference in effectiveness? Upon receiving IRB approval (03-01-18-0098685), I commenced the quantitative research to examine the relationship between the treatment modalities and the providers' perceptions of effectiveness. The research questions and hypothesis and null hypothesis are listed below.

Chapter 4 is divided into the introduction of the study and its intent, research questions and hypothesis, data collection, treatment and fidelity, results, and summary. The data collection for the research study is presented and includes the timeframe of the survey, the use of Survey Monkey to collect the data, and an analysis of the data obtained from the surveys sent to providers through the use of Survey Monkey. The results of the statistical analyses are also included.

Research Questions and Hypothesis

For each set of modalities commonly used in sex offender treatment, do the providers perceive a difference in effectiveness?

$H_{1:}$ Treatment providers rank the five treatment categories differently.

H_0: The treatment providers do not rank the five treatment categories differently.

Data Collection

All data were collected in accordance with the approved by the Walden IRB. Following IRB approval, surveys were sent on March 13, 2018 to sex offender treatment providers in the states of Illinois, Minnesota, and Nebraska. The list of providers from Minnesota came from the Minnesota Department of Human Services. The list of approved treatment providers for Nebraska came from the Department of Health and Human Services, Division of Behavioral Health. The Illinois sample came from the Sex Offender Management Board Approved Provider List. There were approximately 416 providers from the three states chosen. The three states originally were chosen due to living within the Midwest and those states being in close proximity. However, after finding limited providers' email addresses of providers in the three states originally chosen to send a survey and a lack of responses received from the original three states, I submitted a change of procedure to IRB on April 29, 2018 and received permission on May 9, 2018 to expand my survey to all 50 states. All 50 states were chosen in an attempt to reach enough of an audience to obtain sufficient survey results for this study.

Response Rates

Data collection began on March 13, 2018 and ended on August 14, 2018. An IRB approved survey was sent to 899 sex offender treatment providers throughout the United States. Pursuant to the IRB approval, all responses received from the survey were received anonymously. No identifying mechanisms were placed on the survey in order for the respondents to respond anonymously. A reminder email was sent on June 23, 2018 to the first 628 surveys sent. July 18, 2018 a reminder message was sent, and a final

reminder was sent on August 14, 2018 to the last providers who had been sent a survey. The sample of 899 all received two requests to participate. A total of 101 responses were received, but only 95 were fully completely and six were partially completed. Based on the number of respondents to the survey, the CI reached was 95%. Using the 101 responses received and dividing the number of responses by the 899 surveys sent out, the response rate for this study was 11%.

Results

Data were transferred directly from Survey Monkey to an excel spreadsheet. Upon exporting it to an excel spreadsheet, the data were uploaded to SPSS for statistical analysis. Descriptive statistical analysis was used to show the frequency of categories of treatment chosen. I calculated the mean and standard deviation, and I created a table showing the rankings of each treatment modality. A frequency test was conducted using SPSS to calculate the frequency of the answers rating the effectiveness of each of the 55 treatment options as set forth Appendix G.

Appendix G shows the frequency of answers received for each of the five ratings of the Likert scale for each of the 55 treatment modalities. It also shows the percentage of the responses for reach modality. Of the 55 individual treatment modalities, cognitive behavioral received the most responses of *effective* from the respondents. Sixty-one and 9/10% of the respondents said that they perceived cognitive behavioral therapy to be effective. Thirty-two percent said that this form of treatment was *mostly effective*, and there were no respondents who perceived cognitive behavioral therapy to be *not effective*.

Each of the medication options received low effective responses, indicating that most providers are unsure of the effectiveness of medication as a treatment option. For instance, only 4.2% perceived Provera/Depo-Provera to be effective in treating sex offenders, 4% stated that Lupron was effective, and the other forms of medication ranked at 1 and 2% perceived effectiveness.

Additionally, the 55 treatment options were placed into the five categories of treatment, and a frequency analysis was conducted on those five categories to see if there was any difference in treatment providers' perceptions of effective treatment. The results are set forth in Table 3.

Table 3

Distribution of Perceived Rating for Each of the Five Treatment Categories

Variable	Frequency *(f)*	Percentage *(%)*
Psychoeducational (*N* = 89)		
Not effective	2	2.2
Somewhat effective	5	5.6
Uncertain	18	20.2
Mostly effective	50	56.2
Effective	14	15.7
Behavioral (*N* = 89)		
Not effective	1	1.1
Somewhat effective	17	19.1
Uncertain	36	40.4
Mostly effective	32	35.9
Effective	3	3.4
Psychotherapeutic (*N* = 89)		
Not effective	0	0
Somewhat effective	5	5.6
Uncertain	47	52.8
Mostly effective	36	40.4
Effective	1	1.2
Cognitive behavioral (*N* = 93)		
Not effective	0	0
Somewhat effective	4	4.3
Uncertain	24	25.8
Mostly effective	49	52.7
Effective	16	17.2
Medication (*N* = 93)		
Not effective	7	7.5
Somewhat effective	13	13.9
Uncertain	69	74.2
Mostly effective	3	3.2
Effective	1	1.1

As shown in the table, the category that ranked the highest in perceived effectiveness was psychoeducational. The category that respondents were most uncertain about was the medication category. The cognitive behavioral forms of treatment were perceived higher than all the other categories except the psychoeducational, which could be interpreted that the types of treatment that seek to change the behavior of or seek to reeducate offenders on how to behave are perceived to be the most effective.

Following the frequency analysis, the mean and standard deviation of the 55 treatment modalities were calculated, and the results are presented in Appendix F. Cognitive behavior's mean was 4.49, with the minimum being 2 and the maximum being 5. Cognitive behavioral therapy ranked the highest. Hypnosis had the lowest mean at 2.42, with the minimum of 1 and the maximum of 5.

Table 4 shows the mean and standard deviation of the five categories of treatment, which again shows the psychoeducational category ranking the highest in the perceived effectiveness with a mean of 44.0816. The category receiving the lowest mean was medication with a mean of 21.5000.

Table 4

Mean, Median, Minimum, Maximum, Standard Deviation of the Ratings for the Five Treatments

	N	Minimum	Maximum	Mean	Std. Deviation
Psychoeducational	98	10.00	60.00	44.0816	9.52985
Behavioral	97	16.00	60.00	37.5670	8.55729
Psychotherapeutic	97	21.00	60.00	40.3299	6.59185
Cognitive behavioral	97	22.00	55.00	42.2062	7.35547
Medication	96	1.00	40.00	21.5000	5.94714
Valid N (listwise)	*96*				

The Kruskal Wallis test was conducted on each of the categories to examine the differences in the types of treatment. Kruskal Wallis was chosen because the researcher wanted to see if there were differences between the five categories of treatment. Due to the length of the results from the 55 categories, the results of the 55 sub-categories are set forth in Appendix F. The Kruskal Wallis analysis was conducted on the five categories of treatment using the Independent K Sample method since there were multiple samples. The results showed there were differences in the results thus rejecting the null hypothesis that providers perceived no difference in the five categories of treatment. $\chi^2(15, N = 5281) = 1364.325$, $P = .000$. Additionally, a Chi-Square analysis was conducted and is set forth in Table 5 along with additional analyses.

The research question was that for each set of modalities commonly used in sex offender treatment, do the providers perceive a statistically significant difference in effectiveness? The survey results show that of the five categories of treatment psychoeducational ranks the highest in treatment providers' perception of effective treatment (Mean = 44.0816), proving the hypothesis that treatment providers rank the five treatment categories differently. The null hypothesis was rejected. Psychoeducational modalities include social skills training, communication skills, assertiveness training, conflict resolution, values clarification, sex education, dating skills, anger management, sex roles, positive social sexuality, vocational training and job seeking skills. All treatment methods that educate the offender on ways to manage their temptations to reoffend.

Post hoc analyses were conducted, which included the Friedman analysis. In addition to finding the median of the five categories of treatment, the mean rank analysis was conducted, which showed psychoeducational as ranking the highest in the providers' perceived effectiveness. Also as verified in other analyses conducted and discussed in this research project, medication ranked the lowest in the five categories of treatment. Psychoeducational form of treatment is perceived by the sample size to be the most effective form of treatment. Psychotherapeutic and cognitive behavioral were very similar in scores ranking as the second and third highest form of perceived effective treatment.

A Kendall's W analysis was conducted and ranked the providers' perception of the five categories of treatment in the same way as the Friedman analysis again showing that there were differences in how the providers perceived the different categories of treatment. The sample size was 96 and a mean was conducted of the five categories of treatment. This analysis showed that psychoeducational forms of treatment were perceived more effective than the other categories. The mean of psychoeducational was 4.08 followed by cognitive behavioral with 3.73. Eighty-four and 3/10 percent of the respondents perceived psychoeducational treatment to be the most effective. It also confirmed the findings that medication was perceived to be the least effective form of treatment with a mean of 1.10. Psychotherapeutic and cognitive behavioral categories were ranked close to the same in perceived effectiveness. Kendall's W = .548 which represents the respondents do perceive the five categories of treatment's effectiveness differently. The Kendall's W output is laid out in Table 5 below.

Table 5

Kendall's W Output

Ranks		Test Statistics	
	Mean Rank	N	96
Psychoeducational	4.08	Kendall's W[a]	.548
Behavioral	2.89	Chi-Square	210.507
Psychotherapeutic	3.20	df	4
Cognitive Behavioral	3.73	Asymp. Sig.	.000
Medication	1.10		

a. Kendall's Coefficient of Concordance

Following the mean and median analysis of the five categories of treatment, a Chi-Square analysis was conducted as shown in Table 6 below. The five categories of treatment were analyzed using descriptive statistics and crosstabs. Perception and each category were compared using nominal measures to see their effect size of Cramer's V and Phi. The results showed $\chi^2(15, N = 5281) = 1364.325, P = <.01$.

Table 6

Chi-Square Statistical Results and Symmetric Measure of Cramer's V (N = 5281)

	Value	df	Asymptotic Significance
Chi-Square	1364.325	6	.000
Cramer's V	.254		.000

Because the variables have multiple categories, the appropriate measure of the effect size would be Cramer's V. Cramer's V = .254 and shows the category of treatment does have an impact on the provider's perception of effective treatment and, therefore, the null hypothesis is rejected. Psychoeducational, psychotherapeutic and cognitive behavioral ranked higher than behavioral and medication. However, because Cramer's V results showed .254, the null hypothesis that providers perceived no difference in how effective treatment was is rejected.

Summary/Conclusion

Chapter 4 provided the data results from the analysis. Data collected and analyzed were used to answer the research question that for each set of modalities commonly used in sex offender treatment, do the providers perceive a difference in effectiveness? The data were gathered and reviewed to examine the connection between a treatment modality and a provider's perception of its effectiveness. Data were collected according to the IRB guidelines and no personal data were compromised. Data will be stored in Dropbox securely for five years as outlined in the IRB application.

The initial data analysis results showed that the independent variables affected the dependent variable, or the providers' perceived effectiveness of treatment. The results showed in favor of hypothesis one which stated the providers would perceive the different treatment modalities differently. This study showed that of the five categories of treatment, psychoeducational ranked the highest. The responses helped to answer research questions for each set of modalities commonly used in sex offender treatment - Do the providers perceive a difference in effectiveness?

The answer chosen the most for psychoeducational was mostly effective, which represents 84.3 % of responses for that category. A bit more than 2.2% of the responses for psychoeducational was ranked on the Likert Scale as a 2 or not effective. Cognitive behavioral ranked the second highest of the five categories of treatment showing 82.8% of the treatment providers' answers were mostly effective.

Post hoc analyses were conducted, including the Friedman analysis as well Kendall's W analysis. All test results showed that the providers ranked their perceived effectiveness of the five categories of treatment differently. With these results, the null hypothesis that the treatment providers do not perceive a difference in the effectiveness of the five treatment categories differently is rejected.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to increase the knowledge of effective sex offender treatment by examining the relationship between the type of treatment modality and the provider's perception of effective treatment. Knowledge of how providers perceive sex offender treatment and what treatment modalities providers perceive to be the most effective is limited. In an effort to increase the knowledge of providers' perceptions, a survey was administered, which asked the sex offender treatment providers what treatment types and modalities providers felt were most effective.

In this chapter, I outline the purpose of the study, my findings and interpretation of the findings, limitations, the implications of the study, and how it may affect positive social change. The results are discussed, along with future research and policy implementation recommendations.

The research was guided by one research question, which was as follows: For each set of modalities commonly used in sex offender treatment, do the providers perceive a difference in effectiveness? The hypothesis was that treatment providers would rank their perception of the five treatment categories differently and the null hypothesis was that the treatment providers would not rank their perception of the five treatment categories differently. Through this research, I intended to expand the knowledge for future sex offender treatment providers.

Interpretation of Findings

I rejected the null hypothesis, resulting in the conclusion that providers do rank their perception of effective treatment differently for each treatment type. This correlates with Grady, Howe, & Beneke, (2013), who posited that there are eight themes that affect how providers perceive effective treatment. The themes of this theory correlate with systems theory. Each of the factors outlined in this study as the eight themes are systems issues that could potentially affect the effectiveness and long-term success of treatment as well as the perception providers put on effective treatment.

In this study, I showed that of the five categories of treatment, psychoeducational ranked the highest in perceived effectiveness. The responses helped to answer research question for each set of modalities commonly used in sex offender treatment: Do the providers perceive a difference in effectiveness?

The answer chosen the most for psychoeducational was *mostly effective*, which represents 84.3% of responses for that category. Two point two percent of the responses for psychoeducational was ranked on the Likert scale as a 2 or *not effective.*

The perceived effectiveness of a cognitive behavioral modality was ranked the second highest of the five categories of treatment, showing 82.8% of the treatment providers' answers were *mostly effective*. This correlates somewhat with (Schaffer, Jeglic, Moster, & Wnuk, 2010) who posited that cognitive behavioral treatment is currently the most used psychosocial treatment for sex offenders. Additionally, this particular finding confirms Jennings and Deming (2013) who considered that most sex offender treatment is done in group formats and tends to be cognitive in nature. Jennings

and Deming also found that sex offender treatment, in particular, cognitive behavioral treatment, reduces recidivism. In addition, studies have shown that cognitive behavioral treatment is the most cost-effective form of treatment (Jennings and Deming 2013).

The most common answer for the medication category was *uncertain,* at 95.7% of the responses received for that particular category. Ranking third out of the five categories was psychotherapeutic, with the most common answer being *mostly effective*, which ranked at 98.9% of responses received for that category of treatment. This correlates with a study conducted by Fallon (2012) who, using Tuell's (2003) survey, showed that the medication categories listed in the survey received responses of *noneffective* to *somewhat effective*.

Tuell's (2003) responses were similar in nature to the current study. Tuell indicated that cognitive behavioral treatment modalities were the most effective. Psychoeducational and psychotherapeutic were also perceived to be equally important with behavioral treatment following. Medication as a form of treatment ranked the lowest as to what the providers perceived to be the most effective (Tuell, 2003).

The results of this study support the theoretical framework of systems theory. As noted earlier in this study, systems theory allows the researcher to understand components and dynamics of client systems in order to develop better strategies, interpret systems issues, and, ultimately, find the right fit between the individuals and environments (Friedman & Allen, 2014). This study helped narrow down the multiple treatment categories used by treatment providers, which allows the providers to focus on the systems and strategies that they perceive to work. After reviewing the results of the

surveys that questioned which of the 55 treatment modalities were perceived most effective, the modalities that were ranked the highest should be capitalized on in future treatment plans. By using the data gleaned from the surveys and using it to develop better strategies, interpret treatment issues, and finding the right fit for the offenders, the results fall into the theoretical framework of systems theory.

This study's survey results provided a better understanding of what practices to recommend for treatment policy. By analyzing the data gathered from the surveys, the treatment types that ranked the highest in perceived effectiveness could be implemented in future treatment plans in various treatment venues.

As stated by Grady, Howe, & Beneke, (2013), sex offenders who are not successfully treated have a higher chance of reoffending. The findings from this study and future studies can help to uncover systems issues that affect the outcome of treatment. Systems theory allows a researcher to understand components and dynamics of client systems in order to develop better strategies, interpret systems issues, and, ultimately, find the right fit between the individuals and environments (Friedman & Allen, 2014). Systems theory explains patterns and, in this particular study, the patterns that emerged showed that treatment modalities that fall within the psychoeducational category are perceived to be the most effective. Grady, Howe, & Beneke, (2013), posited that offenders that do not have successful treatment are more likely to reoffend. They also posited that there were themes that affected a treatment providers choice of treatment (Grady, Howe, & Beneke, 2013), The respondents of this survey suggested that choosing psychoeducational treatment assisted in limiting the issues that could affect a sex

offender's treatment outcome. In addition, based upon the results of this study, most respondents perceived treatment with medication as an area they were uncertain of its effectiveness or did not feel it was effective.

The results were tabulated from a survey sent to sex offender treatment providers. The responses were analyzed to see which category of treatment was perceived to be the most effective. In reviewing the responses, the category psychoeducational ranked the highest. Of the responses received in this category, over 84% ranked this category as the most effective. Cognitive behavioral ranked a close second. Both categories lean toward changing the behavior of the offender so that they have the ability to refrain from reoffending. Psychoeducational methods include treatment methods such as social skills training, communication skills, anger management as well as others. The purpose of this survey study was to determine treatment categories that providers perceived to be effective. After determining the categories providers perceived to be effective, to implement them into future treatment plans to protect society and rehabilitate sex offenders.

Limitations of the Study

The main limitation of my study was the number of responses received from the survey. Although 899 surveys were sent to providers, only 101 responses were received. Due to this response rate, the results of this study represent the perceptions of a small percentage of sex offender treatment providers. While the limited data may have limited effect, they do provide new knowledge of provider perception.

Also, due to the number of different types of settings the providers work in, the response rates could have been affected. Additionally, the requested answers to the surveys were ratings based upon a Likert scale and did not allow the respondents to further elaborate or explain their answers. Perhaps the addition of open-ended questions could have yielded qualitative data. However, I used an existing survey instrument in this research study. This caused limitations in the study.

Implications

As laid out in Chapter 1, sex offender treatment is perhaps one of the most difficult and controversial areas of intervention in criminal behavior. Treatment providers are inundated with a wide range of emotions from not only society but also from the offender (Stinson & Becker, 2013). Even after treatment, the release of sex offenders back into society brings about an aura of fear and anger. The providers' responses proved the hypothesis that providers rank the categories of treatment effectiveness differently.

Multiple data analyses were completed on the 101 responses received. The first analysis completed was a mean and standard deviation of all the 55 treatment modalities. The results of this analysis showed that of the 55 modalities, cognitive behavioral received the most effective responses. This correlates with Tuell's (2003) study. However, when a frequency analysis was completed of the five categories, the category psychoeducational ranked the highest overall with providers' perceived effectiveness. This differs from Tuell's (2003) survey in which the providers ranked cognitive behavioral treatment modalities as the most effective. In the current study, cognitive behavioral forms of treatment ranked second highest in perceived effectiveness.

Kendall's W analysis showed $W = .548$, which also confirmed there were differences in the respondents' perceived effectiveness of treatment for the five categories.

The results of this study provide insight into how providers' perceptions of treatment effectiveness could provide future public policy and information. Due to the ranking of the category psychoeducational as the highest perceived effective treatment, future treatment plans could be created that would include more of the psychoeducational modalities to more effectively treat sex offenders. The results of this study reveal that the providers perceive the treatment modality of psychoeducational to be the most effective treatment modality, and this could be implemented into future policy and treatment plans. The results from this study help to enhance the existing but limited research on sex offender treatment providers' perceptions of effective treatment. The expansion of the current literature could lead to plans and treatment approaches that may assist in lower recidivism rates in sex offenders.

The psychoeducational category of treatment includes such treatment options as social skills, communication skills, assertiveness training, conflict resolution, anger management, vocational training, job seeking skills, among others. All of these areas are beneficial to the offender reentering society as a productive citizen. Tuell (2003) research showed that treatment modalities commonly used included psychoeducational intervention and was a recommended form of treatment due to its address of issues such as social skills, need for anger management, and need for long term management of sexual deviancy.

Using the data gathered from the providers as to what treatment modality and what treatment category they perceive to be the most effective in treating sex offenders, a treatment plan could be instituted at sex offender treatment facilities that capitalize on that treatment category. Developing an understanding of what is perceived to work is important in developing future public policies and treatment plans. Koon-Magnin (2015) claimed that legislation resulting from perceptions of sex offender treatment plans would be well received. Sex offenders and sex offender treatment providers are involved with many other organizations other than just the treatment facility he or she is treating with. In analyzing what treatment is the most deceived to be the most effective, potentially could cause policy changes in other entities such as court systems, counseling centers, victim advocacy centers, and insurance providers. Even after treatment is finished, the sex offender may be involved with many different agencies. This involvement will have an effect on future public policy and sex offender treatment laws and legislation. As stated previously in this study, studying the perceptions of effective treatment is in its infancy stages. Using the results of this study and future studies has the potential to initiate future legislation that will impact not only sex offenders, but future treatment providers and facilities.

Future Research

A follow up study or studies should be conducted to analyze the implementation of treatment category perceived to be most effective to see if it continued to be perceived as such and, if so, could be further implemented into treatment plans. Duplicating this study with a larger sample size could add more validity and reliability to the survey

results. Follow-up studies similar in nature and with an expanded sample will reveal the true implications of how measuring perceptions of treatment providers will have a long-term effect on successful sex offender treatment and rehabilitation. It is suggested that adding a few open-ended questions could yield illuminating views from practitioners.

Future studies should be conducted testing the treatment categories to compare the results with this present study to see if there are similarities. As posited by Lea, and Kibblewhite, this research is necessary because "perceptions influence practice." (1999). In doing so, the results could be compiled, and treatment plans conducted that could be implemented on a larger scale with the ultimate goal to be to see sex offenders treated successfully and recidivism decreased. Future studies, with a greater response rate, could be compared to see if there is any difference in the findings of the studies.

Additionally, follow-up studies to include interviews of the sex offender treatment providers could result in more data that could reveal which treatment modalities rank the highest according to providers. By obtaining this information and comparing it with the current study, more focused treatment plans could be considered.

Recreating a study and using that study's data to revise or reshape treatment modalities is a way potential future social change could be implemented from this study. However, evaluating the outcomes of those revised treatment plans takes time to see if results are meaningful or not.

Conclusion

The purpose of this study was to increase the knowledge of effective sex offender treatment by examining the relationship between the type of treatment modality and the

provider's perception of effective treatment. Since the research of how treatment providers view effective sex offender treatment is in its infancy stages, the purpose of this study was to examine the providers' view of treatment modalities and to analyze the relationship between the treatment and the providers' perception of treatment. The goal was to give future treatment providers and plans a measure to use to provide positive treatment and, ultimately, lead to positive social change in the area of sex offender treatment.

Overall the results did not support the null hypothesis that there would be no difference in treatment providers' perceptions of the effectiveness of modalities. The results showed that of the five treatment categories psychoeducational ranked the highest in perceived effectiveness. Psychoeducational treatment modalities include such treatment options as social skills training, communications skills, sex education, among others.

In order to decrease the fear in society of sex offenders being released without being assured of them having received successful rehabilitative treatment, it is imperative that future studies be conducted focused on this area and the results of the studies. As suggested in this study, it should be considered in the development of public policy and treatment plans.

The knowledge gleaned from this research is beneficial for policymakers and would serve a dual purpose. If policymakers would utilize the data obtained from this study as well as data from future studies, policies and treatment plans could be put into effect that would provide an opportunity for sexual offenders to reenter society with less

fear of recidivism for themselves and their potential victims. As sexual offenders are rehabilitated in an effective manner, they can be reintroduced into society as productive citizens and the stigmatism associated with being a convicted sexual offender will be lessened with the assurance that the treatment plan was effective enough to reduce or eliminate a re-offense.

Potential for Social Change

The focus and goal of this research study was to effect positive social change within, not only the sex offender treatment field, but within society. This study answered the research question of providers perceived effective treatment. It provides a guideline for policymakers to use in implementing new policies.

Although there were some limitations to the study, more research is necessary and important to continue to increase the knowledge of what works in treating sex offenders, this study has contributed to the body of literature and added knowledge that could cause positive social change.

The data on what providers perceive to be effective treatment modalities is limited. Further study of this topic would be beneficial and important to the future treatment of sex offenders and to the safety of society.

Psychoeducational types of treatment ranked the highest and a plan should be put into place allowing more psychoeducational treatment plans to be put into use. Implementing psychoeducational modalities into more treatment plan would potentially lead to social change and more effective treatment of future sex offenders.

The responses to the psychoeducational category of treatment showed that, of the 101 respondents, 50 perceived this form of treatment to be mostly *effective*. 14 perceived it to be *effective* and only two perceived this treatment modality as *not effective*. One form of treatment found within prison system is life skills. Life skills' treatment includes, among other forms, anger management. This correlates with the providers' perception that psychoeducation treatment modalities are *most effective*. Social skills, anger management, communication skills, relationship building skills, as well as chemical dependency assistance all fall within the scope of life skills programs (Clark & Duwe, 2015). A study conducted in Minnesota correctional facilities correlates with this study's findings as it showed that being involved in an educational program while incarcerated reduced the risk of recidivism in sex offenders (Duwe & Clark, 2014).

Likewise, this study showed that medication was not perceived as an effective form of treatment. Survey results showed that the providers were uncertain of the effectiveness of medication in treating sex offenders. This correlates with the limited literature and research studies completed on medication and the treatment of sex offenders. A future study should focus on adding medication to the treatment plans and/or singling out providers who focus on medication as their primary source of treatment. This would allow researchers to evaluate medication on its own and in a more structured study.

The research on providers perceptions of effective treatment is limited. However, this study identified approaches to effective treatment responses. As noted in Lea, and Kibblewhite (1999) research on providers' perceptions of effective treatment is necessary

"perceptions influence practice." Although past literature is limited and the results of this current study cannot be tied back to many findings, the intent of this study was accomplished by surveying providers and analyzing their perceptions of treatment effectiveness.

This research study was completed with the goal to find specific treatment modalities that are perceived to work the best in treating sex offenders and to take those modalities and introduce them to future treatment plans and future public policies in an effort to change the fear and risk of more than 600,000 people returning from prison to the community each year (Hunter, Lanza, Lawlor, Dyson, & Gordon, 2015) to confidence that the best treatment program possible has been created and is being utilized.

References

Abel, G. G., Blanchard, E. B., & Becker, J. V. (1978). *An integrated treatment program for rapists.* New York, NY: Grune & Stratton.

Allen, I. E., & Seaman, C. A. (2007, 07). Likert scales and data analyses. *Quality Progress, 40,* 64-65. Retrieved from https://ezp.waldenulibrary.org/login?qurl=https%3A%2F%2Fsearch.proquest.com%2Fdocview%2F214764202%3Faccou

Aylward, A. (2006). Successful transitions from institution to community: Reentry and the Washington State sex offender treatment program. *Corrections Today*, *68*(7), 76-77,82-83,106.

Babbie, E. R. (1995). *The practice of social research* (7th ed.). Washington, D.C.: Wadsworth.

Babbie, E. R. (2008). *The basics of social research* (4th ed.). Belmont, CA: Thomson/Wadsworth.

bcps.org, (2015).

Beech, A. R., & Fisher, D. (2002). The rehabilitation of child sex offenders. *Australian Psychologist, 37,* 206-215.

Beech, A. R., & Fordham, A. S. (1997). Therapeutic climate of sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment*, *9*(3), 219-237. doi: 10.1177/107906329700900306

Beech, A. R., & Hamilton, C. E., (2005). Relationship between therapeutic climate and treatment outcome in group-based sexual offender treatment programs. *Sexual*

Abuse: A Journal of Research and Treatment, *17*(2), 127-140. doi: 10.1007/s11194-005-4600-3

Beech, A. R., & Harkins, L. (2012). DSM-IV paraphilia: Descriptions, demographics and treatment interventions. *Aggression and Violent Behavior*, *17*(6), 527-539. doi: 10.1016/j.avb.2012.07.008

Bench, L. L., & Allen, T. D. (2013). Assessing sex offender recidivism using multiple measures: A longitudinal analysis. *The Prison Journal*, *93*(4), 411-428. doi: 10.1177/0032885513500765

Besharov, D. J. (1992). Sex offenders: Is castration an acceptable punishment? *ABA Journal*, *78*(7), 42-44.

Blagden, N., Winder, B., Gregson, M., & Thorne, K. (2011). Working with denial in convicted sexual offenders: A qualitative analysis of treatment professionals' views and experiences and their implications for practice. *International Journal of Offender Therapy and Comparative Criminology*, *57*(3), 332-356. doi: 10.1177/0306624X11432301

Briken, P. (2012). Medical treatment of sexual offenders and men who are at risk of sexual offending. *Institute for Sex Research and Forensic Psychiatry-Center for Psychosocial Medicine*, *15*(1), 52-55.

Burkhead, M. D. (2006). *The search for the causes of crime*. Jefferson, NC: McFarland & Company, Inc., Publishers.

Call, C., & Gordon, J. A. (2016). Support for current sex offender management policies: A national survey of the perceptions of professionals. *American Journal of*

Criminal Justice, 41, 834-851.

Calley, N. G. (2012). Juvenile offender recidivism: An examination of risk factors. *Journal of Child Sexual Abuse*, *21*(3), 257-272. doi: 10.1080/10538712.2012.668266

Camp, S. D., Klein-Saffran, J., Kwon, O. K., Dagget, D. M., & Joseph, V. (2006). An exploration into participation in a faith-based prison program. *Criminology and Public Policy*, *5*(3), 529-550.

Carich, M. S., & Stone, M. H. (2001). Aftercare for medium and hardcore sexual offenders. *Journal of Individual Psychology*, *57*(1), 60-67.

Center for Sex Offender Management. (2015). Center for Sex Offender Management. https://cepp.com/expertise/sex-offenders

Center for Sex Offender Management. *Glossary of terms used in the management and treatment of sexual offenders* (1999). Center for Sex Offender Management. https://vawnet.org/material/glossary-terms-used-management-and-treatment-sexual-offenders

Chon, D. S. (2014). Police reporting by sexual assault victims in western and in non-western countries. *Research on Violence Against Women*, *29*(8), 859-868. doi: 10.1007/s10896-014-9644-z

Ciardha, C. O., & Ward, T. (2013). Theories of cognitive distortions in sexual offending: What the current research tells us. *Trauma, Violence, & Abuse*, *14*(1), 5-21. doi: 10.1177/1524838012467856

Clarke, J. (2011). Working with sex offenders: Best practice in enhancing practitioner

resilience. *Journal of Sexual Aggression, 17*(3), 335-355. doi: 10.1080/13552600.2011.583781.

Clark, V. A., & Duwe, G. (2015). An outcome evaluation of a prison-based life-skills program: The power of people. *International Journal of Offender Therapy and Comparative Criminology, 59*(4), 384-405. doi: 10.1177/0306624X13509444

Collins, E., Brown, J., & Lennings, C. (2010). Quantitative review of community treatment with sex offenders: Perspective of the offender and the expert. *Psychiatry, Psychology and Law, 17*(2), 290-303. doi: 10.1080/13218710903421282

Collins, S., & Nee, C. (2010). Factors influencing the process of change in sex offender interventions: Therapists' experiences and perceptions. *Journal of Sexual Aggression, 16*(3), 311-331. doi: 10.1080/1355260090349753

Corson, J. A. (2010). Applied psychophysiology and cognitive and behavioural therapy in the treatment of sex offenders, *Biofeedback, 38*(4), 148-154. doi: 10.5298/1081-5937-38.2.04

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions,* Thousand Oaks, CA: Sage Publications.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approach* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA; Sage.

Davies, M. M., & Mosdell, N. (2006). *Practical research methods for media and cultural*

studies: Making people count. Edinburgh, United Kingdom: Edinburgh University Press.

Day, A., Carson, E., Boni, N., & Hobbs, G. (2014). The management of sex offenders in the community: From policy to practice. *Australian Journal of Social Issues*, *49*(3), 249-264. Retrieved from http://hdl.handle.net/10536/DRO/DU:30069129

D'Orazio, D. (2013). Lessons learned from history and experience: Five simple ways to improve the efficacy of sexual offender treatment. *International Journal of Behavioral Consultation and Therapy*, *8*(2), 2-7. Retrieved from https://eric.ed.gov/?id=EJ1017930

Drapeau, M. (2005). Research on the processes involved in treating sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 17*(2), 117-125. doi: 10.1177/107906320501700203

Duwe, G., & King, M. (2012). Can faith-based correctional programs work? An outcome evaluation of the InnerChange Freedom Initiative in Minnesota. *International Journal of Offender Therapy and Comparative Criminology, 57*(7), 813-841. doi: 10.1177/0306624X12439397

Duwe, G., & Clark, V. (2014). The effects of prison-based educational programming on recidivism and employment. *Prison Journal*, *94*(4), 454-478. doi: 10.1177/0032885514548009

Early, M. L. (2005). The role of non-profits in the rehabilitation of prisoners. *Criminal Justice Ethics*, *24*(1), 2-59. Retrieved from https://www.prisonfellowship.org/images/content/prison_fellowship/documents/jo

hn%20jay%20criminal%20justice%20article%20mle_rev3.pdf/

Fallon, M. K. (2012). *Treatment providers' perceptions of treatment effectiveness with female juvenile sex offenders* (Doctoral dissertation). University of Cincinnati, ProQuest Dissertations Publishing. 3554311.

Farkas, M. A. (2014). The potential of research to inform theory, policy, and practice. *International Journal of Offender Theory and Comparative Criminology*, *58*(4), 391-393. doi: 10.1177/0306624X14522392

Farkas, M. A., & Stichman, A. (2002). Sex offender laws: Can treatment, punishment, incapacitation, and public safety be reconciled? *Criminal Justice Review*, *27*(2), 256-262. doi: 10.1177/073401680202700204

Faupel, S. (2015). Etiology of adult sexual offending. *Sex Offender Management Assessment and Planning Initiative*, 1-7. Retrieved from https://www.smart.gov/pdfs/EtiologyofAdultSexualOffending.pdf.

Fernandez, Y. M. (2006). Focusing on the positive and avoiding negativity in sexual offender treatment. In W. L. Marshall, Y. M. Fernandez, L. E. Marshall, & G. E. Serran (Eds.), *Sexual offender treatment: Controversial issues* (pp. 187-197). Chichester, NH: Wiley.

Ferrero-Lombroso, G. (2004). Criminal man. In J. Jacoby (Ed.), *Classics of criminology* (3rd ed., pp 141-156). Long Grove, IL: Waveland Press, Inc. (Original work published 1911)

Freud, S. (1953). *Three essays of the theory of sexuality, The complete psychological works of Sigmund Freud*. London, England: Hogarth.

Friedman, B., & Allen, K. N. (2014). *Essentials of clinical social work*. Thousand Oaks, CA: Sage Publications.

Galek, K., Flannelly, K.J., Greene, P.B., & Kudler, T. (2011). Burnout, secondary traumatic stress, and social support. *Pastoral Psychology*, 6(5), 633-649. doi: 10.1007/s11089-011-0346-7

Garland, R.. J. & Dougher, M. J. (1991). Motivation intervention in the treatment of sex offenders. In W. Miller & S. Rollnick (Eds.), *Motivational Interviewing: Preparing people to change addictive behavior* (p. 303-313). New York, New York: Guilford Press.

Ginsberg, J .L. D., Mann, R. E., Rotgers, F., & Weekes, J. R. (2002). Motivational interviewing with criminal justice populations. In W. Miller & S. Rollninck (Eds.), *Motivational interviewing: Preparing people to change addictive behavior* (p. 333-246). New York, New York: Guilford Press.

Goduka, N. (2012). From positivism to indigenous science. *Africa Insight*, 41(4), 123-138.

Grady, M. D., Howe, A .R. S., & Beneke, E. (2013). Increasing retention rates in sex offender treatment: Learning from expert clinicians. *Sexual Addiction & Compulsivity*, 171-191.

Greenberg, D. M. & Bradford, J. M. W. (1997). Treatment of the paraphilic disorders: A review of the role of the selective serotonin reuptake inhibitors. *Sexual Abuse: A Journal of Research and Treatment*, 9, 349-360. doi: 10.1177/107906329700900407

Greineder, B. (2013). Correctional officers' perceptions of sexual offenders in the United States: A qualitative analysis. *International Journal of Criminal Justice Sciences*, 8(1), 24-35.

Grossman, L. S., Martis, B., & Fichtner, C. G. (1999). Are sex offenders treatable? A research overview. *Psychiatric Services*, 50(3), 349-361.

Hall, G. C. N. (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology*, 63(5), 802-809.

Hall, G. C. N., Shondrick, D. D., & Hirschman, R. (1993). Conceptually-derived treatments for sexual aggressors. *Professional Psychology*: *Research and Practice*. 24, 62-69.

Hanson, R. K. (2000). Will they do it again? Predicting sex-offense recidivism. *Current directions in psychological science*, 9(3), 106-109.

Harkins, L. & Beech, A.R. (2007). A review of the factors that can influence the effectiveness of sexual offender treatment: Risk, need, responsivity, and process issues. *Aggression and Violent Behavior*, 12(6), 615-627. doi: 10.1016/j.avb.2006.10.006

Harrison, K. (2007). The high-risk sex offender strategy in England and Wales: Is chemical castration an option? *The Howard Journal*, 46(1), 16-31. doi: 10.1111/j.1468-2311.2007.00451.x

Heilburn, K., Nezu, C. H., Keeney, M., Chung, S. & Wasserman, A. L. (1998). Sexual offending: Linking assessment, intervention, and decision-making. *Psychology, Public Policy, & Law*, 4(1/2), 138-174.

Hickey, N. (2012). CBT for sex offenders: too good to be true? A reply to Ho and Ross. *Criminal Behavior and Mental Health*, 22(1), 11-13. doi: 10.1002/cbm.1820

Ho, G.W.K. (2017). Examining perceptions and attitudes: A review of Likert-type scales versus Q-Methodology. *Western Journal of Nursing Research*, 39(5), 674-689. doi: 10.1177/0193945916661302

Hooton, E. A. (1939). *Crime and the man*. Cambridge, Massachusetts: Harvard University Press.

Hogue, T. E. (1993). Attitudes towards prisoners and sexual offenders. In N. K. Clark & G. M. Stephenson(Eds.),Sexual offenders: Context, assessment and treatment (pp.27-32). Leicester:BPS

Hunter, B. A., Lanza, A. S., Lawlor, M, Dyson, W., and Gordon, D. M.. A strengths based approach to prison re-entry: The fresh start prisoner re-entry program. *International Journal of Offender Therapy and Comparative Criminology,* 60(11), 1-17. doi: 10.1177/0306624X15576501

Jamieson, S. (2008). Likert Scale. In S. Boslaugh & L. McNtt (Eds), *Encyclopedia of Epidemiology*. (p 603-605). Thousand Oaks, CA: SAGE Publications, Inc. doi: http://dx.doi.org.ezp.waldenulibrary.org/10.4135/9781412953948.n261

Jennings, J.L. & Deming, A. (2013). Effective utilizing the “behavioural” in cognitive-behavioral group therapy of sex offenders. *International Journal of Behavioral Consultation and Therapy*, 8(2), 7-13.

Johnson, B. R. (2004). Religious programs and recidivism among former inmates in prison fellowship programs: A long-term follow-up study. *Justice Quarterly*,

21(2), 329-354. doi: 10.1080/07418820400095831

Jung, S. & Gulayets, M. (2011). Using clinical variables to evaluate treatment effectiveness in programmes for sexual offenders. *Journal of Sexual Aggression*, 17(2), 166-180. doi: 10.1080/13552601003802238

Kansas v. Hendricks, 117 U.S. 2072. (1997).

Kear-Colwell, J., Polluck, P. (1997). Motivation or confrontation: Which approach to use with child sex offenders? *Criminal Justice and Behavior*, 24(1), 20-33. doi: 10.1177/0093854897024001002

Kim, B., Benekos, P. J., & Merlo, A. V. (2015). Sex offender recidivism revisited: Review of recent meta-analysis on the effects of sex offender treatment. *Trauma, Violence, & Abuse*, 17(1), 1-13. doi: 10.1177/1524838014566719

Kimonis, E., Fanniff, A., Borum, R., & Elliott, K. (2011). Clinician's perceptions of indicators of amenability to sex offender—specific treatment in juveniles. *Sexual Abuse: A Journal of Research and Treatment*, 23(2), 193-211. doi: 10.1177/1079063210384278

Koon-Magnin, S. (2015). Perceptions of and support for sex offender policies: Testing Levenson, Brannon, Fortney, and Baker's Findings. *Journal of Criminal Justice*, 43(1), 80-88.

Lamade, R., Gabriel, & Prentky, R. (2011). Optimizing risk mitigation in management of sexual offenders: A structural model. *International Journal of Law and Psychiatry*, 34(3), 217-225. doi: 10.1016/j.ijlp.2011.04.008

Landau, S. I. (2000). *The new international Webster's concise dictionary of the English*

language. Naples, Florida: Trident Press International.

Laws, D. R. (1990). A conditioning therapy of the etiology and maintenance of deviant sexual performance and behavior. In W.L. Marshall & H.E. Barbaree (Eds.), *Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender,* (p. 209-229).

Lea, S., Auburn, T., & Kibblewhite, K. (1999). Working with sex offenders: The perceptions and experiences of professional and paraprofessionals. *International Joursnal of Offender Therapy and Comparative Criminology*, 43(1), 103-119. doi: 10.1177/0306624X99431010

Lester, S. (1999). An introduction to phenomenological research. *Stan Lester Developments, Taunton*, 2(1), 1-4.

Levenson, J. & Prescott, D. S. (2014). Déjà vu: from Furby to Langstrom and the evaluation of sex offender treatment effectiveness. *Journal of Sexual Aggression*, 20(3), 257-266. doi: 10.1080/13552600.2013.867078

Levenson, J., Prescott, D. S. & Jumper, S. (2014). A consumer satisfaction survey of civilly committed sex offenders in Illinois. *International Journal of Offender Therapy and Comparative Criminology*, 58(4), 474-495. doi: 10.1177/0306624X12472956

Lieb, R., Kemshall, H., & Thomas, T. (2011). Post-release controls for sex offenders in the U.S. and UK. *International Journal of Law and Psychiatry*, 34(3), 226-232. doi: 10.1016/j.ijlp.2011.04.006

Lodico, M., Spaulding, D., & Voegtle, K. (2010). *Methods in educational research:*

From theory to practice. San Fransisco, CA; Jossey-Bass.

Mann, R.E., Ginseberg, J. I. D., & Weekes, J. R. (2002). Motivational interviewing with offenders. In M. McMurran (Ed.), *Motivating offenders to change: A guide to enhancing engagement in therapy* (p. 87-102). Chichester, New Hampshire: Wiley.

Mann, R. E. (2004). Innovations in sex offender treatment. *Journal of Sexual Aggression*, 10(2), 141-152. doi: 10.1080/1355260042000261751

Mann, R. E., Hanson, R. K., Thornton, D. (2010). Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment.* 22, 191-217. doi: 10.1177/1079063210366039

Mann, Ruth E. & Barnett, Georgia D. (2012). Victim empathy intervention with sexual offenders: Rehabilitation, punishment, or correctional quackery? *Sexual Abuse: A Journal of Research and Treatment*, 25(3), 282-301. doi: 10.1177/1079063212455669

Marino, K. M. (2009). Probation management of sex offenders: An analysis of co-facilitators' perceptions of offender progress in treatment. *Criminal Justice Review*, 34(3), 382-403. doi: 10.1177/0734016808328671

Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment*, 17(2), 109-117. doi: 10.1177/107906320501700202

Marshall, W. L., Anderson, D., & Fernandez, Y. M. (1999). *Cognitive behavioural*

treatment of sexual offenders. Toronto, Ontario: John Wiley & Sons.

Marshall, W. L. & Barbaree, H. E. (1990). Outcome of comprehensive cognitive-behavioral treatment programs. In W. L. Marshall, D. R. Laws & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender* (p. 363-385). New York: Plenum Press.

Marshall, W. L. & Fernandez, Y. M. (2003). *Phallometric testing with sexual offenders: Theory, research, and practice.* Brandon, Vermont: Safer Society Press.

Marshall, W. L., Marshall, L. E., & Kinston, D. A. (2011). Are the cognitive distortions of child molesters in need of treatment? *Journal of Sexual Aggression,* 17(2), 118-129. doi: 10.1080/13552600.2011.580572

Marshall, W. L., Marshall, L. E., Serran, G. A., & O'Brien, M. D. (2011). *Rehabilitating Sexual Offenders: A Strength Based Approach*, Washington, D.C. APA Books.

Marshall, W. L. & Serran, G. A. (2000). Improving the effectiveness of sexual offender treatment. *Trauma, Violence, & Abuse,* 1(3), 203-222. doi: 10.1177/1524838000001003001

Marshall, W. L. & Serran, G. A. (2004). The role of the therapist in offender treatment. *Psychology, Crime and Law,* 10(3), 309-320. doi: 10.1080/10683160410001662799

Marshall, W. L. & Serran, G. A. (2006). Strategies in the treatment of paraphilias: A critical review. *Annual Review of Sex Research*, 17(1), 162-182. doi: 10.1080/10532528.2006.10559841

Marshall, W. L, Serran, G. A., Fernandez, Y. M., Mulloy, R., Mann, R .E., & Thornton,

D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behavior change. *Journal of Sexual Aggression*, 9(1), 25-30. doi: 10.1080/355260031000137940

Marshall, W. L, Serran, G. A., Moulden, H., Mulloy, R., Fernandez, Y. M., Mann, R. E., & Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behavior change. *Clinical Psychology*, 9(6), 395-405. doi: 10.1002/cpp.335

Medical University of South Carolina. (2008). Title of the writing

Mele, C., Pels, J. & Polese, F. (2010). A brief review of systems theories and their managerial applications. *Service Science*, (2 ½), p. 126-135. doi: 10.1287/serv.2.1_2.126

Meloy, M., Boatwright, J., & Curtis, K. (2013). Views from the top and bottom: Lawmakers and practitioners discuss sex offender laws. *American Journal of Criminal Justice*, 38, 616-638. doi: 10.1007/s12103-012-9189-8

Merton, R. K. (1938). Social structure and anomie. *American Sociological Review*, 3(5), 672-682.

Miller, J. A. (2010). Sex offender civil commitment: The treatment paradox. *California Law Review*, 98(6), 2093-2128.

Miller, K. L. (2016). Treatment providers' perception of most utilized treatment modalities with adult male sex offenders, ProQuest, Ann Arbor, MI, 1-73.

Miller, R. D. (1998). Forced administration of sex-drive reducing medications to sex offenders: Treatment or punishment? *Psychology, Public Policy, and Law*, 4, 175-

199.

Missouri State Highway Patrol. (2007). Title of the article? Retrieved from http://www.mshp.dps.missouri.gov.

McNabb, D. E. (2002). *Research methods in public administration and nonprofit management Quantitative and qualitative approaches*, Armonk, New York, M.E. Sharpe, Inc.

Nally, J. M., Lockwood, S., Ho, T., & Knutson, K. (2014). Post-release recidivism and employment among different types of released offenders: A 5-year follow up study in the United States. *International Journal of Criminal Justice Sciences*, 9(1), 16-34.

National Center for Missing & Exploited Children. (2008). Retrieved January 16, 2009 from http://www.missingkids.com.

Pais, S. (2001). Therapist issues in working with sex offenders. *Journal of Clinical Activities* 1(4), 89-97. doi: 10.1300/J182v01n04_09

Palmer, G., Boykin, A., Lythgoe, K., Bizzell, D., & Daiss, D. Mental health professionals' perceptions of difficult situations: A brief report on the development of the psychiatric situations scale. *The Internet Journal of Mental Health*, 2(1), 1-7.

Palmer, S. M. (2012). Postsecondary correctional education. *Adult Learning*, 23(4), 163-169. doi: 10.1177/1045159512457918

Paolucci, E. O., Genuis, M. L., Violato, C. (2001). A Meta-analysis of the published research on the effects of child sexual abuse. *The Journal of Psychology*, 135(1),

17-36. doi: 10.1080/00223980109603677

Perez, D. M. & Jennings, W. G. (2012). Treatment behind bars: the effectiveness of prison-based therapy for sex offenders. *Journal of Crime and Justice*, 35(3), 435-450. doi: 10.1080/0735648X.2012.662060

Prentky, R. A. (1997). Arousal reduction in sexual offenders: A review of antiandrogen interventions. *Sexual Abuse: A Journal of Research and Treatment*, 9, 335-347. doi: 10.1177/107906329700900406

Preston, D. L. (2000). Treatment resistance in corrections. *Forum on Corrections Research*, 12, 24-28.

Rehfuss, M. C., Underwood, L. A., Enright, M., Hill, S., Marshall, R., Tipton, P., West, L. & Warren, K. (2013). Treatment impact of an integrated sex offender program as measured by J-SOAP-II. *Journal of Correctional Health Care*, 19(2), 113-123. doi: 10.1177/1078345812474641

Rettenberger, M., Briken, P., Turner, D., & Eher, R. (2015). Sexual offender recidivism among a population-based prison sample. *International Journal of Offender Therapy and Comparative Criminology*, 59(4), 424-444. doi: 10.1177/0306624X15584984

Sandhu, D. K. & Rose, J. (2012). How do therapists contribute to therapeutic change in sex offender treatment: An integration of the literature. *Journal of Sexual Aggression* , 18(3), 269-283. doi: 10.1080/13552600.2011.566633

Schaffer, M., Moster, A., & Wnuk, D. (2010). Cognitive-behavioral therapy in the treatment and management of sex offenders. *Journal of Cognitive Psychotherapy:*

An International Quarterly, 24(2), 92-103. doi: 10.1177/1079063215585731

Scheela, R. A. (2001). Sex offender treatment: Therapists' Experiences and Perceptions. *Issues in Mental Health Nursing,* 22(8), 749-767.

Schneider, J., Bosley, J. T., Ferguson, G., & Main, M. (2006). The challenges of sexual offense treatment programs in correctional facilities. *Journal of Psychiatry & Law,* 34(2), 169-196. doi: 10.1177/009318530603400204

Schwartz, B. (2002). *The sex offender,* Kingston, New Jersey: Civic Research Institute, Inc.

Seidler, K. (2013). Offering an alternative: The challenges of working in a group context in a private practice. *Sexual Abuse in Australia & New Zealand,* 5(1), 25-23.

Serran, G. A. & Marshall, L. E. (2006). In W.L. Marshall, Y. M. Fernandez, L. E. Marshall & G. A. Serran (eds.). *Sexual offender treatment: Controversial issues* (p. 109-124). New York, New York: John Wiley & Sons, Ltd.

Seto, M. C., Kingston, D. A., & Stephens, S. (2015). Sexual Offending. *APA Handbook of Forensic Psychology*, 1, 351-379.

Stalans, L. J. (2004). Adult sex offenders on community supervision: A review of recent assessment strategies and treatment. *Criminal Justice and Behavior,* 31(5), 564-608. doi: 10.1177/0093854804267093

Stinson, J. D. & Becker, J. V. (2013). *Treating Sex Offenders: An Evidence-Based Manual,* New York, New York, The Guilford Press.

Strecker, D. R. (2011). Sex offender treatment in prisons and the self-incrimination privilege: How should courts approach obligatory, un-immunized admissions of

guilt and the risk of longer incarcerations? *St. John's Law Review*, 85, 1557-1594.

Terry, K. J. (2011). Impacts of sex offender notification. *Criminology & Public Policy*, 10(2), 274-282. doi: 10.1111/j.1745-9133.2011.00722.x

Terry, K. J. (2006). *Sexual offenses and offenders: theory, practice, and policy*. Belmont, California: Thomson Learning.

Terry, K. J. & Furlong, J. S. (2004). *Sex offender registration and community notification*: *A Megan's law sourcebook*. Kingston, New Jersey: Civic Research Institute, Inc.

Tewksbury, R. (2011). Community corrections professionals' views of sex offenders, sex offender registration and community notification and residency requirements. *Federal Probation*, 75(3), 45-50.

Thibaut, F. (2011). Pharmacological treatment of sex offenders. *Sexologies*, 20, 166-168.

Trochim, W. M.K. (2006). Descriptive statistics. Retrieved from http://socialresearchmethods.net/kb/statdesc.php.

Tuell, C. J. (2003). Treatment providers' perceptions of effective interventions with juvenile sex offenders (Doctoral Dissertation). University of Cincinnati, Cincinnati, OH.

U.S. Federal Bureau of Investigation (1995).

Vaughn, M. S. (1992). Academic and vocational education for incarcerated adult and juvenile sex offenders: A national study. *Journal of Addictions & Offender Counseling*, 12(2), 47-62. doi: 10.1177/106342660100900405

von Bertalanffy, L. (1968). *General Systems Theory: Foundations, Developments,*

Applications, New York: Braziller.

Walton, J. S. & Chou, S. (2014). The effectiveness of psychological treatment for reducing recidivism in child molesters: A systematic review of randomized and nonrandomized studies. *Trauma, Violence, & Abuse*, 16(4), 1-17. doi: 10.1177/1524838014537905

Ward, T. (1999). Competency and deficit models in the understanding and treatment of sexual offenders. *Journal of Sex Research*, 36(3), 298-305. doi: 10.1080/00224499909552000

Ward, T. (2007). On a clear day you can see forever: Integrating values and skills in sex offender treatment. *Journal of Sexual Aggression*, 13(3), 187-201. doi: 10.1080/13552600701794036

Ward, T., Gannon, T., & Yates, P. M. (2008). The treatment of offenders: Current practice and new developments with an emphasis on sex offenders. *International review of Victimology*, 15(2), 179-204. doi: 10.1177/026975800801500207

Ward, T., Hudson, S., Johnston, L. & Marshall, W .L. (1997). Cognitive distortions in sex offenders: An integrative review. *Clinical Psychology Review*, 17(5), 479-507. doi: 10.1016/s0272-7358(97)81034-3

Ward, T. & Maruna, S. (2007). *Rehabilitation: Beyond the risk paradigm*. London, Ukraine: Routledge.

Ward, T. & Sa lmon, K. (2011). The ethics of care and treatment of sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 23(3), 397-413. doi: 10.1177/1079063210382049

Weston, M., Brewer, K. C., & Peterson, C. A. (2012). ANA Principles: The framework for nurse staffing to positively impact outcomes. *Nursing Economics*, 30(5), 247-252.

Wilson, R .J., Stewart, L. Stirpe, T., Barrett, M., & Cripps, J. E. (2000). Community-based sex offender management: Combining parole supervision and treatment to reduce recidivism. *Canadian Journal of Criminology*, 42(2), 177-188. doi: 10.3138

Witt, P. H., Greenfield, D. P., & Hiscox, S. P. Cognitive/behavioural treatment approaches to the treatment adult sex offenders. *The Journal of Psychiatry and Law*, 36, 245-271.

Woessner, G. & Schwedler, A. (2014). Correctional treatment of sexual and violent offenders: Therapeutic Change, Prison Climate, and Recidivism. *Criminal Justice and Behavior*, 41(7), 862-879. doi: 10.1177/0093854813520544

Wood, P. B., Wilson, J. A., & Thorne, D. P. (2015). Offending patterns, control balance, and affective rewards among convicted sex offenders. *Deviant Behavior*, 36(5), 368-387. doi: 10.1080/01639625.2014.935659

www.doc.mo.gov.

Yates, P. M. (2013). Treatment of sexual offenders: Research, best practices, and emerging models. *International Journal of Behavioral Consultation and Therapy*, 8(3-4), 89-95.

Yates, P. M., Goguen, B. C., Nicholaichuk, T. P., Williams, S. M., & Long, C.A. (2000). *National sex offender programs*. Ottawa, Ontario: Correctional Services of

Canada.

Appendix A:

Appendix A: Provider Demographic Information Sheet

Demographic Information

The following information will assist in this researcher's understanding of the data obtained for this research. Please circle or add your response. Feel free to add any additional information or comments that you feel will assist in this research.

Your Gender: _____ Your Age: _____ Your Race: _____

1. **Number of years working in sex offender treatment: 1-5 5-10 11-15 16+**

2. **Education:** Undergraduate Graduate Post-Graduate

3. **Degree:** _____

4. **Licensure:** No License Counselor Social Worker Psychologist Other

5. **Program setting:** Non-profit Agency Public Facility Private Practice

6. **Program security:** Minimum security Medium security Maximum security

7. **Program referral:** Adjudicated Voluntary

8. **Total number of sex offenders in program: _____**

9. **Average length of stay in treatment for the majority of your clientele:**

   3 months 6 months 1 yr. 2 yrs. 3 yrs.+

10. **Size of your caseload on average in the last 30 days: _____**

11. **Type of training received for the five types of treatment listed in the survey:**

    _____

BY COMPLETING THIS QUESTIONAIRE, I INDICATE MY CONSENT TO PARTICIPATE IN THIS STUDY.

Appendix B: Sex Offender Treatment Survey

Sex Offender Treatment Survey

The following is a survey which has been designed for assessing treatment providers' perceptions of effective sexual offender treatment modalities. Please indicate your perception of effectiveness degree by filling in the appropriate box to the right of each statement. If you have never used a treatment, check box "3 Uncertain". A key is provided with general definitions of each treatment modality. There are no right or wrong answers.

KEY:

1 = Not effective 2 = Somewhat effective 3 = Uncertain 4 = Mostly effective 5 = effective

	Psychoeducational	1	2	3	4	5
1	Social skills training					
2	Communication skills					
3	Assertiveness training					
4	Conflict resolution					
5	Values clarification					
6	Sex education					
7	Dating skills					

8	Anger management					
9	Sex roles					
10	Positive social sexuality					
11	Vocational training					
12	Job seeking skills					
	Behavioral					
13	Impulse control					
14	Plethysmograph					
15	Verbal satiation					
16	Masturbatory satiation					
17	Orgasmic reconditioning					
18	Minimal arousal conditioning					
19	Masturbatory training					
20	Aversive techniques					
21	Behavior modification techniques					
22	Coordinated community supervision					
23	Community supervision					
24	Biofeedback					
	Psychotherapeutic					

25	Individual counseling					
26	Intimacy/relationship skills					
27	Journal keeping					
28	Autobiography					
29	Victim restitution					
30	Hypnosis					
31	Group counseling					
32	Psychodrama/drama therapy					
33	EMDR					
34	Empty chair					
35	Psychodynamic therapy					
36	Family systems therapy					
	Cognitive-behavioral					
37	Victim empathy					
38	Stress management					
39	Fantasy work					
40	Thinking errors					
41	Reality therapy					
42	Rational emotive therapy					
43	Relapse prevention					
44	Relapse contracts					

45	Homework					
46	Assault cycle					
47	Cognitive behavioral therapy					
	Medication					
48	Provera/Depo-Provera					
49	Androcur (Cyproterone Acetane)					
50	Lupron					
51	Major tranquilizers					
52	Minor tranquilizers					
53	Lithium carbonate					
54	Anafranil					
55	Buspar					

(Tuell, 2003)

BY COMPLETING THIS QUESTIONNAIRE, I INDICATE MY CONSENT TO PARTICIPATE IN THIS STUDY

Additional comments or list other issues that arise that could potentially impact the effectiveness of treatment.

Appendix C: Key to Treatment Modalities

Psychoeducational

Social skills training: This is a type of treatment that helps the offender improve his or her social skills so he or she can function normally in society.

Communication skills: Assists the offender in learning how to effectively communicate.

Assertiveness training: Is a form of treatment that helps the offender learn to stand up for him or herself and to learn the balance between being passive and aggressive.

Conflict resolution: A way to find a peaceful and safe solution to a conflict.

Values clarification: Treatment where therapist tries to help the offender develop or become aware of his or her own values or morals.

Sex education: Educating the offender on what a proper sexual relationship is.

Dating skills: Assists sex offenders in learning the proper way to date.

Anger management: Learning to recognize signs that a person is becoming angry and acting to calm down and deal with the anger in a positive manner.

Sex roles: Sex offenders are taught their role in sexual behavior in lieu of illegal behavior.

Positive social sexuality: Dealing with sexuality in a way that is positive and accepted by society.

Vocational training: Training a sex offender in a job skill.

Job seeking skills: Teaching the offender skills in how to find employment.

Behavioral

Impulse control: Training the sex offender to resist the impulses and urges that are inappropriate

Plethysmograph: Instrument used to measure blood flow to a person's genitals when images are presented to him

Verbal satiation: Therapy that uses verbal repetition and auditory exposure to show that the verbal responses may produce responses that are normally associated with objects.

Masturbatory satiation: Use of masturbating to satisfy the sexual desires.

Orgasmic reconditioning: Changing sexual object choice through controlling fantasies.

Minimal arousal conditioning: Offender allowed to masturbate to an appropriate audio tape, but being administered something just as ammonia when doing the same thing to a deviant sexual interest audio tape

Masturbatory training: Skills based intervention using masturbation as a means to satisfy the sexual desire.

Aversive techniques: Offender is exposed to a stimulus while at the same time being subjected to a form of discomfort.

Behavior modification techniques: Behavior is either given positive or negative reinforcement based upon whether the behavior is appropriate or not.

Coordinated community supervision:

Community supervision:

Biofeedback: Training offenders to control their physiological processes.

Psychotherapeutic

Individual counseling: One on one with the offender by the counselor or therapist.

Intimacy/relationship skills: Treatment to teach the offender how to have a proper intimate relationship and skills on how to maintain a proper relationship.

Journal keeping: recording events and solutions to triggers that can cause re-offense.

Autobiography: Self written story of the incidents causing the need for treatment.

Victim restitution: Offender is required to try to compensate his or her victim(s) by paying for counseling, medical expenses, etc.

Hypnosis: Causing offender to become in a state of consciousness so that he or she losses the power to voluntarily act, but, rather, responds to a suggested way of behaving.

Group counseling: counseling with others in treatment.

Psychodrama/drama therapy: Offenders are assigned roles to play within a drama created or designed by the therapist.

EMDR: Eye movement desensitization and reprocessing that attempts to help the offender reduce the effects of disturbing memories and replace them with more suitable coping mechanisms.

Empty chair: An empty chair is placed in front of the offender and he or she is asked to imagine a person in that chair that may have caused the offender heartache or emotional harm. The offender talks to the imaginary friend and expresses his or her feelings toward the imaginary person as a means of unlocking bitterness and anger that has built up within the offender.

Psychodynamic therapy: Focuses on helping the offender understand how influences in the past affect the offender’s present-day behavior.

Family systems therapy: Therapy that includes the offender and his or her entire family.

Cognitive-behavioral

Victim empathy: Offender is asked to be empathic and to put himself or herself in the shoes of the victim to understand how the victim feels.

Stress management: Equips the offender with techniques on how to deal with stress.

Fantasy work: Using fantasy to avoid re-offense.

Thinking errors: Teaching offenders to not change their thinking in such a manner so they do not see how they have hurt others.

Reality therapy: Focuses on problem solving and learning how to make better choices in order to achieve specific goals.

Rational emotive therapy: Focuses on showing the offender how to resolve emotional and behavioral issues.

Relapse prevention: Therapist attempts to have offender set goals for identifying and preventing future sexual offenses.

Relapse contracts: Offender is asked to write a contract that identifies his or her goals for ending inappropriate behavior.

Homework: Assignments to be conducted outside of the normal treatment times.

Assault cycle: Training offender to recognize the cycle of reoffending in an effort to break that cycle.

Cognitive behavioral therapy: Form of psychotherapy used to help change inappropriate behavior.

Medication

Provera/Depo-Provera: Medication used to reduce sexual drive.

Androcur (Cyproterone Acetane): Medication used to inhibit the actions of androgens in an offender.

Lupron: Medication to overstimulate hormones production in that particular part of the body affected shuts down.

Major tranquilizers: Medication used to reduce the offender's sexual drive.

Minor tranquilizers: Medication used in reducing sex drive.

Lithium carbonate: Used to balance moods.

Anafranil: Medication used to help treat obsessive behavior.

Buspar: Medication used to treat anxiety.

Appendix D: Consent to Use Survey

Hi Reta,

This is a response to your request to use my survey documents for your research.

Permission granted.

Best of luck.

Chris

Chris Tuell, Ed.D., LPCC-S, LICDC-CS

Clinical Director of Addiction Services

University of Cincinnati

Dept. of Psychiatry and Behavioral Neuroscience

Lindner Center of HOPE

Appendix E: Rankings and Kruskal Wallis Test Results

Treatment Modality	Rank	N	Mean Rank
	Psychoeducational		
Social skills training	1.000	1	5.00
	2.000	1	2.50
	3.000	1	2.50
	4.000	1	2.50
	5.000	1	2.50
Communication skills	1.000	1	5.00
	2.000	1	1.00
	3.000	1	3.00
	4.000	1	3.00
	5.000	1	3.00
Assertiveness training	1.000	1	4.00
	2.000	1	1.50

	3.000	1	1.50
	4.000	1	4.00
	5.000	1	4.00
Conflict resolution	2.000	1	1.50
	3.000	1	1.50
	4.000	1	3.50
	5.000	1	3.50
Values clarification	2.000	1	1.50
	3.000	1	1.50
	4.000	1	3.50
	5.000	1	3.50
Sex education	2.000	1	3.00
	3.000	1	1.00
	4.000	1	3.00
	5.000	1	3.00

Dating skills	2.000	1	1.00
	3.000	1	3.00
	4.000	1	3.00
	5.000	1	3.00
Anger management	2.000	1	1.00
	3.000	1	3.00
	4.000	1	3.00
	5.000	1	3.00
Sex roles	2.000	1	1.50
	3.000	1	1.50
	4.000	1	3.50
	5.000	1	3.50
Positive social sexuality	2.000	1	1.00
	3.000	1	2.50
	4.000	1	2.50
	5.000	1	4.00
Vocational training	2.000	1	1.50
	3.000	1	1.50

	4.000	1	3.50
	5.000	1	3.50
Job Seeking Skills	2.000	1	1.50
	3.000	1	1.50
	4.000	1	3.50
	5.000	1	3.50
	Behavioral		
Impulse control	1.000	1	1.00
	2.000	1	4.00
	3.000	2	4.00
	5.000	2	4.00
Plethysmograph	1.000	1	3.00
	2.000	1	3.00
	3.000	2	4.50
	5.000	2	3.00
Verbal satiation	1.000	1	3.00
	2.000	1	3.00

	3.000	2	3.00
	5.000	2	4.50
Masturbatory satiation	1.000	1	3.50
	2.000	1	3.50
	3.000	2	3.50
	5.000	2	3.50
Orgasmic reconditioning	1.000	1	3.50
	2.000	1	3.50
	3.000	2	3.50
	5.000	2	3.50
Minimal arousal conditioning	1.000	1	3.00
	2.000	1	6.00
	3.000	2	3.00
	5.000	2	3.00
Masturbatory conditioning	1.000	1	2.50
	2.000	1	2.50
	3.000	2	4.25
	5.000	2	3.75

Aversive techniques	1.000	1	3.50
	2.000	1	3.50
	3.000	2	3.50
	5.000	2	3.50
Behavior modification Techniques	1.000	1	2.00
	2.000	1	2.00
	3.000	2	5.00
	5.000	2	3.50
Coordinated community supervision	1.000	1	2.00
	2.000	1	5.00
	3.000	2	3.50
	5.000	2	3.50
Community supervision	1.000	1	2.00
	2.000	1	5.00
	3.000	2	3.50
	5.000	2	3.50

Biofeedback	1.000	1	1.00
	5.00	2	2.50

Psychotherapeutic

Individual counseling	1.000	1	2.50
	2.000	1	2.50
	3.000	2	3.75
	5.000	1	2.50
Intimacy/relationship skills	1.000	1	2.00
	2.000	1	2.00
	3.000	2	4.50
	5.000	1	2.00
Journal keeping	1.000	1	3.50
	2.000	1	3.50
	3.000	2	2.25
	5.000	1	3.50
Autobiography	1.000	1	4.00

	2.000	1	4.00
	3.000	2	2.75
	5.000	1	1.50
Victim restitution	1.000	1	1.50
	2.000	1	3.50
	3.000	2	2.50
	5.000	1	5.00
Hypnosis	1.000	1	2.50
	2.000	1	5.00
	3.000	2	2.50
	5.000	1	2.50
Group counseling	1.000	1	3.00
	2.000	1	1.00
	3.000	2	4.00
	5.000	1	3.00
Psychodrama/drama therapy	1.000	1	2.50
	2.000	1	2.50
	3.000	2	3.75

	5.000	1	2.50
EMDR	1.000	1	1.00
	2.000	1	2.50
	3.000	2	3.25
	5.000	1	5.00
Empty chair	1.000	1	2.00
	2.000	1	5.00
	3.000	2	3.00
	5.000	1	2.00
Psychodynamic therapy	1.000	1	4.00
	2.000	1	4.00
	3.000	2	1.50
	5.000	1	4.00
Family systems therapy	1.000	1	2.00
	2.000	1	2.00
	3.000	2	3.00
	5.000	1	5.00

Cognitive Behavioral

Victim empathy	1.000	2	1.50
	3.000	1	4.50
	4.000	1	3.00
	5.000	1	4.50
Stress management	1.000	2	2.50
	3.000	1	2.50
	4.000	1	2.50
	5.000	1	5.00
Fantasy work	1.000	2	2.75
	3.000	1	1.50
	4.000	1	4.00
	5.000	1	4.00
Thinking errors	1.000	2	3.00
	3.000	1	3.00
	4.000	1	3.00
	5.000	1	3.00

Reality therapy	1.000	2	2.75
	3.000	1	1.50
	4.000	1	4.00
	5.000	1	4.00
Rational emotive therapy	1.000	2	3.00
	3.000	1	3.00
	4.000	1	3.00
	5.000	1	3.00
Relapse prevention	1.000	2	3.50
	3.000	1	1.00
	4.000	1	3.50
	5.000	1	3.50
Relapse contracts	1.000	2	3.50
	3.000	1	1.50
	4.000	1	5.00
	5.000	1	1.50
Homework	1.000	2	2.00
	3.000	1	5.00
	4.000	1	3.00

	5.000	1	3.00
Assault cycle	1.000	2	2.00
	3.000	1	3.00
	4.000	1	5.00
	5.000	1	3.00
Cognitive behavioral therapy	1.000	2	2.00
	3.000	1	4.50
	4.000	1	2.00
	5.000	1	4.50
		Medication	
Provera/Depo-Provera	1.000	1	2.50
	2.000	1	5.00
	4.000	3	2.50
Androcur (Cyproterone Acetane)	4.000	3	2.00
Lupron	4.000	3	2.00

Major tranquilizers	4.000	3	2.00
Minor tranquilizers	4.000	3	2.00
Lithium carbonate	4.000	3	2.00
Anafranil	4.000	3	2.00
Buspar	4.000	3	2.00

Appendix F: Mean and Standard Deviation of the 55 Treatment Modalities

	N	Minimum	Maximum	Mean	Std. Deviation
Social skills training	97	1	5	3.86	1.070
Communication skills	98	1	5	3.97	1.000
Assertiveness training	98	1	5	3.55	1.123
Conflict resolution	97	1	5	3.88	.992
Values clarification	96	1	5	3.73	1.110
Sex education	96	1	5	3.75	1.161
Dating skills	95	1	5	3.89	1.005
Anger management	97	1	5	3.86	1.109

Sex roles	95	1	5	3.46
1.050				
Positive social sexuality	97	1	5	4.05
.928				
Vocational training	97	1	5	3.31
1.121				
Job Seeking Skills	96	1	5	3.42
1.121				
Impulse control	96	2	5	4.25
.906				
Plethysmograph	96	1	5	2.67
1.211				
Verbal satiation	97	1	5	2.53
.991				
Masturbatory satiation	97	1	5	2.52
1.119				
Orgasmic reconditioning	97	1	5	2.58
1.039				
Minimal arousal conditioning	95	1	5	2.74
1.064				
Masturbatory conditioning	97	1	5	2.84
1.161				

Aversive techniques	97	1	5	2.69
1.341				
Behavior modification techniques	97	1	5	3.95
1.035				
Coordinated community supervision	97	1	5	4.18
1.000				
Community supervision	97	1	5	3.89
1.069				
Biofeedback	93	1	5	3.01
.927				
Individual counseling	95	1	5	4.13
.992				
Intimacy/relationship skills	97	1	5	4.21
.946				
Journal keeping	96	1	5	3.21
1.169				
Autobiography	96	1	5	3.50
1.152				
Victim restitution	97	1	5	3.32
1.151				
Hypnosis	97	1	5	2.42
.934				

Group counseling	97	2	5	4.46
.879				
Psychodrama/drama therapy	95	1	5	2.81
1.003				
EMDR	96	1	5	3.09
1.037				
Empty chair	96	1	5	2.92
1.033				
Psychodynamic therapy	96	1	5	2.94
1.168				
Family systems therapy	95	2	5	3.71
.988				
Victim empathy	97	1	5	3.69
1.219				
Stress management	97	1	5	4.13
1.007				
Fantasy work	96	1	5	3.41
1.175				
Thinking errors	97	2	5	4.42
.876				
Reality therapy	97	1	5	3.57
.934				

Rational emotive therapy	96	1	5	3.50
1.076				
Relapse prevention	96	1	5	4.16
.988				
Relapse contracts	96	1	5	3.19
1.217				
Homework	96	1	5	3.78
1.207				
Assault cycle	97	1	5	4.05
1.121				
Cognitive behavioral therapy	97	2	5	4.49
.792				
Provera/Depo-Provera	96	1	5	2.73
.968				
Androcur (Cyproterone Acetane)	93	1	5	2.84
.648				
Lupron	94	1	5	2.86
.784				
Major tranquilizers	94	1	5	2.55
.850				
Minor tranquilizers	94	1	5	2.62
.818				

Lithium carbonate	94	1	5	2.78	.844
Anafranil	94	1	5	2.74	.702
Buspar	94	1	5	2.81	.807
Valid N (listwise)	*76*				

Appendix G: Frequency of Each of the 55 Treatment Modalities

Variable	Frequency *(f)*	Percentage *(%)*
Social skills training		
Effective	28	34.2
Mostly effective	47	57.3
Not effective	1	1.2
Somewhat effective	3	3.7
Uncertain	3	3.7
Total	82	100.00
Communication skills		
Effective	31	31.6
Mostly effective	49	59.8
Not effective	1	1.1

Somewhat effective	12	1.2
Uncertain	5	5.1
Total	98	97.8

Assertive training

Effective	21	21.2
Mostly effective	37	37.4
Not effective	3	3.1
Somewhat effective	19	19.2
Uncertain	18	18.2
Total	99	99.1

Conflict resolution

Effective	25	25.8
Mostly effective	50	51.5
Not effective	2	2.1

Somewhat effective	11	11.3
Uncertain	9	9.3
Total	97	100

Values clarification

Effective	23	23.9
Mostly effective	46	47.9
Not effective	4	4.2
Somewhat effective	14	14.6
Uncertain	9	9.4
Total	96	100

Sex education

Effective	30	31.3
Mostly effective	34	35.4
Not effective	3	3.1
Somewhat effective	16	16.7

	Uncertain	13	13.5
Total		96	100

Dating skills

	Effective	29	30.5
	Mostly effective	40	42.1
	Not effective	1	1.1
	Somewhat effective	11	11.6
	Uncertain	14	14.7
Total		95	100

Anger management

	Effective	28	28.9
	Mostly effective	48	49.5
	Not effective	4	4.1
	Somewhat effective	13	13.4

	Uncertain	4	4.1
Total		97	100

Sex roles

	Effective	14	14.7
	Mostly effective	38	40
	Not effective	4	4.2
	Somewhat effective	14	14.7
	Uncertain	25	26.3
Total		95	99.9

Positive social sexuality

	Effective	34	35.1
	Mostly effective	43	44.3
	Not effective	1	1
	Somewhat effective	7	7.2

	Uncertain	12	12.4
Total		97	100

Vocational training

	Effective	14	14.4
	Mostly effective	33	34
	Not effective	5	5.2
	Somewhat effective	21	21.7
	Uncertain	24	24.7
Total		97	100

Job seeking skills

	Effective	16	16.7
	Mostly effective	36	37.5
	Not effective	4	4.2
	Somewhat effective	20	20.8

	Uncertain	20	20.8
Total		96	100

Impulse control

	Effective	46	47.9
	Mostly effective	36	37.5
	Not effective	0	0
	Somewhat effective	8	8.3
	Uncertain	6	6.3
Total		96	100

Plethysmograph

	Effective	8	8.3
	Mostly effective	13	13.5
	Not effective	22	23.2
	Somewhat effective	17	17.1
	Uncertain	36	37.5

Total		96	99.6

Verbal satiation

Effective	2	2.1
Mostly effective	8	8.2
Not effective	21	21.7
Somewhat effective	16	16.5
Uncertain	50	51.5
Total	97	100

Masturbatory satiation

Effective	3	3.1
Mostly effective	15	15.5
Not effective	24	24.8
Somewhat effective	20	20.1
Uncertain	35	36.1

Total	97	99.6

Orgasmic reconditioning

Effective	3	3.1
Mostly effective	12	12.4
Not effective	19	19.6
Somewhat effective	21	21.7
Uncertain	42	43.3
Total	97	100.1

Minimal arousal conditioning

Effective	5	5.32
Mostly effective	15	15.8
Not effective	14	14.7
Somewhat effective	22	23.2
Uncertain	39	41.1

Total	95	100

Masturbatory conditioning

Effective	6	6.2
Mostly effective	24	24.7
Not effective	16	16.5
Somewhat effective	20	20.6
Uncertain	31	32.6
Total	97	100

Aversive techniques

Effective	9	9.3
Mostly effective	24	24.7
Not effective	25	25.8
Somewhat effective	22	22.3
Uncertain	17	17.5

Total		97	99.6
Behavior modification techniques			
	Effective	32	32.9
	Mostly effective	44	45.4
	Not effective	1	1
	Somewhat effective	14	14.4
	Uncertain	6	6.2
Total		97	99.9
Coordinated community supervision			
	Effective	45	46.4
	Mostly effective	36	37
	Not effective	1	1
	Somewhat effective	10	10.3
	Uncertain	5	5.2

Total		97	99.9
Community supervision			
	Effective	31	32
	Mostly effective	42	43.3
	Not effective	1	1
	Somewhat effective	16	16.5
	Uncertain	7	7.2
Total		97	100
Biofeedback			
	Effective	6	6.5
	Mostly effective	15	16
	Not effective	7	7.5
	Somewhat effective	12	13
	Uncertain	53	57

Total		93	100
Individual counseling			
	Effective	39	41.1
	Mostly effective	42	44.2
	Not effective	1	1.1
	Somewhat effective	11	11.5
	Uncertain	2	2.1
Total		95	100
Intimacy/relationship skills			
	Effective	43	44.3
	Mostly effective	42	43.3
	Not effective	1	1.0
	Somewhat effective	9	9.3
	Uncertain	2	2.1

Total	97	100

Journal keeping

Effective	14	14.6
Mostly effective	31	32.2
Not effective	4	4.2
Somewhat effective	31	32.3
Uncertain	16	16.7
Total	96	100

Autobiography

Effective	19	19.8
Mostly effective	38	39.6
Not effective	4	4.2
Somewhat effective	20	20.1
Uncertain	15	15.6

	Total	96	99.3
Victim restitution			
	Effective	16	16.5
	Mostly effective	30	30.1
	Not effective	6	6.2
	Somewhat effective	19	19.6
	Uncertain	26	26.8
	Total	97	99.2
Hypnosis			
	Effective	1	1.0
	Mostly effective	2	2.1
	Not effective	25	25.8
	Somewhat effective	10	10.3
	Uncertain	59	60.8

	Total	97	100
Group counseling			
	Effective	62	63.9
	Mostly effective	26	26.8
	Not effective	0	0
	Somewhat effective	8	8.2
	Uncertain	1	1.0
	Total	97	99.9
Psychodrama/drama therapy			
	Effective	5	5.3
	Mostly effective	14	14.7
	Not effective	11	11.6
	Somewhat effective	20	21.1
	Uncertain	45	47.3

Total		95	100
EMDR			
	Effective	10	10.4
	Mostly effective	18	18.8
	Not effective	8	8.3
	Somewhat effective	13	13.5
	Uncertain	47	49.0
Total		96	100
Empty Chair			
	Effective	6	6.3
	Mostly effective	20	20.8
	Not effective	9	9.4
	Somewhat effective	22	22.9
	Uncertain	39	40.1

	Total	96	99.5
Psychodynamic therapy			
	Effective	11	11.5
	Mostly effective	19	19.8
	Not effective	10	10.4
	Somewhat effective	27	28.1
	Uncertain	29	30.0
	Total	96	99.8
Family systems therapy			
	Effective	22	23.2
	Mostly effective	37	38.9
	Not effective	0	0
	Somewhat effective	14	14.7
	Uncertain	22	23.2

	Total	95	100
Victim empathy			
	Effective	27	27.8
	Mostly effective	42	43.3
	Not effective	5	5.2
	Somewhat effective	19	19.6
	Uncertain	4	4.1
	Total	97	100
Stress management			
	Effective	41	42.3
	Mostly effective	42	43.3
	Not effective	1	1.0
	Somewhat effective	12	12.4
	Uncertain	1	1.0

Total		97	100

Fantasy work

	Effective	18	18.8
	Mostly effective	32	33.3
	Not effective	7	7.3
	Somewhat effective	15	15.6
	Uncertain	24	25.0
Total		96	100

Thinking errors

	Effective	58	59.8
	Mostly effective	30	30.9
	Not effective	0	0
	Somewhat effective	8	8.2
	Uncertain	1	1.0

	Total	97	99.9
Reality therapy			
	Effective	18	18.6
	Mostly effective	30	30.1
	Not effective	1	1.3
	Somewhat effective	9	9.3
	Uncertain	39	40.2
	Total	97	99.5
Rational emotive therapy			
	Effective	21	21.2
	Mostly effective	26	27.1
	Not effective	2	2.1
	Somewhat effective	16	16.7
	Uncertain	31	32.3

	Total	96	99.4

Relapse contracts

	Effective	16	16.7
	Mostly effective	26	27.1
	Not effective	7	7.3
	Somewhat effective	26	27.1
	Uncertain	21	21.9
	Total	96	100

Homework

	Effective	32	33.3
	Mostly effective	36	37.5
	Not effective	4	4.2
	Somewhat effective	17	17.7
	Uncertain	7	7.3

Total		96	100
Assault cycle			
	Effective	42	43.3
	Mostly effective	36	37.1
	Not effective	3	3.1
	Somewhat effective	12	12.4
	Uncertain	4	4.1
Total		97	100
Cognitive behavioral therapy			
	Effective	60	61.9
	Mostly effective	31	32
	Not effective	0	0
	Somewhat effective	6	6.1
	Uncertain	0	0

	Total	97	100

Provera/Depo-Provera

	Effective	4	4.2
	Mostly effective	9	9.3
	Not effective	14	14.6
	Somewhat effective	15	15.6
	Uncertain	54	56.3
	Total	96	100

Lupron

	Effective	4	4.3
	Mostly effective	3	3.2
	Not effective	8	8.5
	Somewhat effective	8	8.5
	Uncertain	71	75.5

Total		94	100
Major tranquilizers			
	Effective	1	1.1
	Mostly effective	1	1.1
	Not effective	18	19.1
	Somewhat effective	9	9.6
	Uncertain	65	69.1
Total		94	100
Minor tranquilizers			
	Effective	1	1.1
	Mostly effective	2	2.1
	Not effective	15	15.9
	Somewhat effective	10	10.6
	Uncertain	66	70.2

	Total	94	100
Lithium carbonate			
	Effective	2	2
	Mostly effective	7	7.4
	Not effective	12	12.7
	Somewhat effective	8	8.5
	Uncertain	65	69.4
	Total	94	100
Anafranil			
	Effective	1	1.1
	Mostly effective	1	1.1
	Not effective	10	10.6
	Somewhat effective	7	7.4
	Uncertain	75	79.8

	Total	94	100
Buspar			
	Effective	2	2.1
	Mostly effective	7	7.4
	Not effective	10	10.6
	Somewhat effective	9	9.6
	Uncertain	66	70.2
	Total	94	100