

2020

Mental Health Professionals: Attitudes Toward Sex Offenders And Moral Development

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<http://dx.doi.org/10.25774/w4-tcb9-9f11>

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MENTAL HEALTH PROFESSIONALS: ATTITUDES TOWARD SEX OFFENDERS
AND MORAL DEVELOPMENT

A Dissertation

Presented to

The Faculty of the School of Education
The College of William & Mary in Virginia

In Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

by

Benjamin S. Newman LPC, CSAC, CSOTP

August 2019

Mental Health Professionals: Attitudes toward Sex Offenders and Moral Development

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Approved August 2019 by

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Dedication

To every single person that has supported me during this process. Over the years it has taken me to complete my dissertation I have never had one person suggest I should “quit”. It is easy to keep going when no one is suggesting you should stop.

Thank you for your unrelenting support!

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Acknowledgements

It goes without saying that Dr. Rick Gressard has been one of the most significant influences on my life. For more than a decade, Dr. Gressard has shaped my educational, professional and personal trajectory. Although I have learned countless things from Dr. Gressard one of the most powerful lessons I have received is about mentorship. Dr. Gressard is a mentor that has been unwaveringly supportive, challenging and provides a space for honest reflection. My hope is to repay Dr. Gressard by providing the same patience, safety and support to those I have the privilege to mentor. Thank you for your unrelenting support and the immeasurably positive impact you have had on the course of my life.

My experience at the College of William & Mary would be incomplete without the support and guidance I received from Dr. Victoria Foster. I have found myself uniquely impacted by her lectures on developmental perspectives. Dr. Foster's teaching and guidance has shaped the way I conceptualize clients, supervisees, others and even myself. I learned from Dr. Foster something that I always hoped was true and that is that we are all capable of growth throughout our life time as long as we are committed to the process. Thank you, Dr. Foster, for truly shaping the way I see others and myself.

At several points in my academic career I have received support from an advocate that has made all the difference. Within each of the major intersections in my academic career Dr. Tom Ward has been a common factor. I am fortunate not only to have had Dr. Ward as a teacher but also as an advocate. My hope is to follow the example I have seen Dr. Ward demonstrate and act as an advocate for those

around me. Thank you, Dr. Ward for being the difference maker in several of the most important events in my education.

I have never felt alone on this journey. One person that has always been an unrelenting and determined support is my mom. She has acted as motivator, teacher, mentor, editor and cheerleader throughout the entire dissertation process. Both my mom and dad have been role models throughout my life that demonstrate an exceptional level of work ethic and resilience. To my mom and dad, I do not know how to define unconditional love but I know exactly how it feels. You have both been advocates for me since before I was born and that has made all of the difference.

At some point in this dissertation process I went on a first date with Sarah Elizabeth Destefano, who is now my wife. I can remember telling Sarah on our first date that “my dissertation will be done in six months”. Since lying to Sarah on our first date we have gotten married and had a beautiful daughter. Thank you for knowing that this dissertation would get done even when you had no evidence to support that belief. I don’t know how I have gotten so lucky and I am excited for the rest of my life with you.

On May 11, 2019 Sloane Avery Newman was born and every day since that time she has been an irreplaceable part of my team and life. She has acted as the best type of motivator and distraction. Sloane I love you unconditionally and always.

I would also like to acknowledge the College of William & Mary. Since my first class it has always felt like a privilege to be part of the William & Mary community. Thank you for inspiring me and I hope to have a career that truly honors the education you have provided me.

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MENTAL HEALTH PROFESSIONALS: ATTITUDES TOWARD SEX OFFENDERS AND MORAL DEVELOPMENT

Abstract

Mental health professionals who provide treatment to sex offenders navigate the complex legal, ethics and moral intersections surrounding the population within the professional-personal dialectic. The purpose of this research study was to explore the potential relationship between mental health professional's attitudes toward sex offenders and their level of moral development in order to encourage increasingly effective training and experiential interventions which then may impact treatment outcomes. Research participants included licensed and non-licensed counselors, social workers and psychologists (n = 135). Along with a demographic questionnaire and the Marlowe-Crowne Social Desirability Scale, the Defining Issues Test was used as a measure of moral development and the Community Attitudes Toward Sex Offender Scale evaluated the attitudes of mental health professionals toward the sex offender population. This study identified a statistically significant relationship between a mental health professional's level of moral development and attitude toward sex offenders with 6.2% of the variation in attitudes related to DIT-II N2 scores. Mental health professionals that engaged in greater amounts of self-directed training endorsed less negative attitudes toward sex offenders. No relationship was found between the mental health professional's length of experience, other types of training and attitudes toward sex offenders. The results and limitations identified within this study support further development of this line of research with an emphasis on recruiting a sample with a larger representation of

participants with sex offenders specific credentialing and with the inclusion of additional or alternative assessments related to evaluating attitudes toward sex offenders.

Mental Health Professionals: Attitudes toward Sex Offenders and Moral Development

Chapter One: Introduction

Mental health professionals are part of a social system that is inundated by emotionally laden media coverage, societal myths, and negative attitudes surrounding sex offenders. Statistically less prevalent cases of sexual offenses such as rape-homicide often dominate media coverage (Malinen, 2012). These social influences contribute to the dehumanization and out-group derogation of the sex offender population (Viki, Fullerton, Raggett, Tait & Wiltshire, 2012). Perspective taking of this type fosters a punishment-and-obedience mindset and entitative conceptualization that lumps sex offenders into a single stigmatized group.

Such a moral lens is congruent with Kohlberg's preconventional level of moral development (Kohlberg & Hersh, 1977). In Kohlberg's first two stages of moral development, individuals understand their world based on physical consequences and simplistic ideas of right and wrong (Kohlberg & Hersh, 1977). For example, this type of reasoning is exhibited in some members of the public who support the indefinite incarceration or institutionalization (Davey, 2015; Jenuwine, Simmons & Swies, 2003) of all sex offenders (preconventional reasoning). However, this simplistic response is problematic because it does not consider variations within the sex offender population, the size of the sex offender population and potential costs of such an incarceration approach. Perspectives that take into account the important variations that exist within the sex offender population and numerous complexities associated with the problem of sexual abuse would be more congruent with Kohlberg's higher levels of moral development. The personal values section (A.4.b.) of the 2014 American Counseling

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Association (ACA) code of ethics mandates that counseling professionals understand how their attitudes and personal values can impact the counseling relationship and/or process (ACA, 2014). Each mental health professional has different levels of exposure to variables that contribute to the formation of both positive and negative attitudes toward sex offenders. As a result, mental health professionals have an obligation to understand how these factors impact their clinical practice when working with sex offenders.

Murphy & Gilligan (1980) argue that moral reasoning can evolve well into adulthood and experiences with moral conflict and decisions reconfigure reasoning. Moral conflict is a fundamental aspect within the counselor-client relationship when working with the sex offender population. Sex offending behavior is universally considered repugnant and morally objectionable. However, higher levels of moral reasoning by counselors are on a developmental staircase that progresses from a simplistic view of right and wrong to more universal principles. One way mental health professionals can manage their attitudes and values surrounding sex offenders is within the professional-personal dialectic, which describes the simultaneous need to develop a working relationship with a sex offender and the personal desire not to (Lea, Auburn, & Kibblewhite, 1999).

Counseling professionals work with sex offenders across the spectrum of risk in a variety of community and residential settings. A growing body of research (Craig, 2005; Goldsmith, Lewis, Dunn & Bentall, 2015; Blagden, Winder & Hames, 2014) and current ethical codes (ACA, 2014) indicate that counselor attitudes have the potential to impact treatment outcomes. Although it appears likely that there is a relationship between attitudes and moral development, this author was unable to find research conducted

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specifically to understand the relationship between counselor attitudes toward sex offenders and level of moral development. Kohlberg's model of moral development would seem to have the potential to be a guiding theoretical framework for counselor educators and clinical supervisors to conceptualize educational and experiential interventions to improve attitudes toward sex offenders. A pedagogy informed by Kohlberg's model of moral development is strengthened by several decades of research, a framework that includes levels and stages, and interventions that support the development of greater moral complexity (Kohlberg & Hersh, 1977; Rest, 1984; Rest, Navaez, Thoma & Bebeau, 2000). This dissertation is focused on exploring the potential relationship between mental health professional's attitudes toward sex offenders and moral development. The number of registered sex offenders and prevalence of sexual abuse necessitate the recruiting, preparation and retention of additional motivated, well-prepared counseling professionals who can provide effective treatment to sex offenders.

Problem Statement

The prevalence of sexual abuse that occurs across the United States creates a climate of mistrust and confusion toward sex offenders in the general public as well as for mental health professionals. It is imperative that mental health professionals understand their attitudes toward sex offenders and how these attitudes have the potential to impact treatment outcomes. To date, limited research has been conducted on the relationship between attitudes of mental health professionals toward sex offenders and level of moral development.

In the American Counseling Association's code of ethics section A.4.b. (Personal Values) it is written, "counselors are aware of and avoid imposing their own values,

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attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values, are inconsistent with the client's goals or are discriminatory in nature" (ACA, 2014).

The development of educational and experiential interventions to support improved attitudes toward sex offenders could be significantly enhanced by a guiding framework. Kohlberg's model of moral development offers a framework to conceptualize the development of attitudes toward sex offenders and a mechanism for developing effective training interventions for mental health professionals. With this in mind, this dissertation was designed to explore (1) the relationship between mental health professionals attitudes toward sex offenders and level of moral development, (2) the relationship between the mental health professionals length of experience and attitudes toward sex offenders, (3) the relationship between length of professional experiences and level of moral development, and (4) the relationship between training and attitudes toward sex offenders. Insights into these relationships have the potential to better inform the development of educational and experiential interventions that have a productive impact on the attitudes of mental health professionals toward sex offenders.

Training of Mental Health Professionals

Sex offender treatment providers have distinct credentialing, professional associations and ethical codes on both the national and state levels. The National Association of Forensic Counselors (NAFC) and states throughout the U.S. offer certification for mental health professionals in the area of sex offender treatment. These organizations have specific credentialing requirements regarding educational level,

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experience and specialized training. For example, in Virginia, the Board of Psychology requires certified sex offender treatment providers (CSOTP) to have a master's degree within specified fields, complete a supervised residency and attend sex offender specific training courses. The training requirements include assessment, treatment interventions (cognitive behavioral therapy, relapse prevention and others), etiology, legal issues and program evaluation/recidivism. On a national level, the NAFC offers credentialing as a Sex Offender Treatment Specialist (CSOTS) or Certified Juvenile Sex Offender Treatment Specialist (CJSOTS).

Sex offender treatment professionals work within community agencies, intensive outpatient programs, residential settings and the correctional system. It is imperative to have qualified mental health professionals to provide treatment services across this continuum. Supervision, in combination with mental health treatment, has been shown to be effective at reducing sex offender recidivism (Jenuwine et al., 2003).

Jeglic, Hanson & Calkins (2016) argue that there is a shortage of qualified professionals in the field and that many sex offender mental health professionals are not adequately trained in cognitive behavioral therapy (CBT) interventions. Although there is no single approach for treating sex offenders, research indicates that treatment fidelity, whether in a CBT program or another model, has been poor (Jeglic et al., 2016; Moon & Shivy, 2008). As a result, there is a need within the field of sex offender treatment for highly trained professionals with specialized skill sets to meet the specific needs of the sex offender population. Moon & Shivy (2008) emphasized the need for additional training related to the understanding and implementation of research-based interventions.

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On a national level, NAFC reported a total of 1,450 credentialed sex offender professionals (K. Taylor, personal communication, August 29, 2017) and the Center for Missing and Explored Children reported a total of 861,837 registered sex offenders in 2016. The Virginia Board of Psychology reported that as of the third quarter of 2017 there were 422 state-level CSOTPs and The Center for Missing and Explored Children indicated that in 2016 there were 22,410 registered sex offenders in Virginia. With these numbers, the estimated ratio of registered sex offenders to CSOTP providers in Virginia is 53:1. This ratio does not include juveniles convicted of a sex offense, pre-disposition juveniles and adults, adults that have committed an offense but have made a plea bargain or individuals that are seeking treatment prior to ever committing a hands-on offense. Even if a significant percentage of the Virginia registered sex offenders were placed within a secure setting, Moster, Wnuck & Jeglic (2008) make the argument that almost all will return to the community at some time. As a result, the number of qualified sex offender treatment providers is potentially mismatched with the size of the sex offender population and its needs.

In a study exploring the effectiveness of sex offender treatment, Harkins & Beech (2007) argued that “characteristics of treatment groups and therapists” impact outcomes. In order to foster effective treatment outcomes, the sex offender treatment professional needs training, support and supervision (Jeglic et al., 2016). The current magnitude of the sex offender population and difficulties with fidelity in the application of evidence-based interventions support the need for additional, specifically trained and motivated sex offender treatment providers.

Justification for Study

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The study described in this dissertation investigated the intersection of three important areas of counselor education: counselor attitudes, moral development and training/education. An enhanced understanding of this intersection would significantly benefit mental health professionals who specialize in the treatment of sex offenders, counselor educators, and clinical supervisors to address the complexities within the professional-personal dialectic (Lea et al., 1999). The significant impact of a sex offender's behavior (sexual abuse) and risk of relapse create a uniquely challenging treatment framework that has inherent moral complexity. A simplistic punishment-and-obedience orientation (Kohlberg Stage 1) is frequently verbalized within the media and by individuals within the community as a whole where the focus is deterrence and punishment. Mental health professionals are ethically obligated to embody a more developed level of moral reasoning to effectively support sex offender rehabilitation. All mental health students, para-professionals and professionals have been and are inundated with negative messages associated with sex offenders. As a result, research is needed to better understand how training and supervision can be further developed to support mental health professionals to work effectively with the sex offender population.

Lawrence Kohlberg created a theory of moral development that suggests people are able to progress across a continuum moving toward recognition of more universal moral principles. Attitudes are created by variable experiences, exposure and social circumstances. As a result, both an individual's attitudes and level of moral development are malleable. The foundational concept behind this dissertation study is to explore if there is a relationship between moral development and attitudes toward sex offenders among mental health professionals. Because moral development and attitudes are

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malleable, education and experiences to enhance the moral development of mental health professionals working with sex offenders should improve attitudes and have a positive impact on treatment outcomes. The initial step in this line of research was to demonstrate that a relationship exists between a mental health professional's level of moral development and attitude toward sex offenders.

Overview of Study

Two widely accepted instruments were used in this study to explore the relationship between a mental health professionals moral development and attitude toward sex offenders. The Defining Issues Test-II (DIT-II) was used as an assessment of moral development and to study attitudes toward sex offenders, the Community Attitudes Toward Sex Offender Scale (CATSO) was utilized. In addition, information was obtained regarding sample demographics and the Marlowe-Crowne Social Desirability Scale – Short Form (SDS) was administered. The instruments were distributed to licensed and unlicensed mental health professionals across the United States. Participants included professionals in the counseling, social work and psychology fields. Data from the study were analyzed to explore potential relationships among the variables. In addition to the overall relationship, relationships between the subcategories of the CATSO, which include social isolation, capacity to change, severity/dangerousness and deviancy, were considered at the onset of the study. Additional information related to the study population, research methodology and statistical methodologies are provided in chapter three.

Summary of Research Questions

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The specific research questions addressed in this study are the following: (1) Is there a relationship between counselors' attitudes toward sex offenders and their level of moral development? (2) Is there a relationship between length of professional experiences in the counseling field and attitudes toward sex offenders? (3) Is there a relationship between length of professional experiences in the counseling field and level of moral development? (4) Are attitudes toward sex offenders related to sex offender-specific training?

Chapter Two: Literature Review

In the field of sex offender treatment, there is a significant body of research related to the prevalence of sexual offenses and there is a growing body of research related to sex offender treatment. Limited research, however, has been conducted related to the development of attitudes toward sex offenders and interventions to improve mental health professional's attitudes. At this time, there is a gap in the research related to a guiding framework for understanding the development and changes of mental health professional's attitudes toward sex offenders. This chapter provides an overview of the existing literature on sex offending, sex offender treatment, recidivism, attitudes toward sex offenders and moral development. The literature review provides a justification for an exploration of relationships among these variables. A better understanding of the relationship between moral development and the attitudes of mental health professionals toward sex offenders could lead to changes in pedagogy and contribute to the development of more effective counseling interventions specific to the sex offender population.

Sex Offending

Although difficult to accurately quantify, the impact of sexual abuse is pervasive. Those who have been victims of sexual abuse experience elevated levels of PTSD (Nickerson, Steenkamp, Aerka, Salters-Pedneault, Carper, Barnes, & Litz, 2013), difficulties in intimate relationships (Lassri, Luyten, Fonagy & Shahar, 2017), self-criticism (Pagura, Cox, Sareen & Enns, 2006) and an increased risk of suicide (Davidson, Hughes & George, 1996). Sex offenders themselves experience incarceration, difficulties

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with housing (Clark, 2007), challenges finding employment (Lussier & McCuish, 2016) and social stigma (Zilney & Zilney, 2009). Sexual abuse has a national impact, which encompasses all major social institutions.

Prevalence. One indicator of prevalence related to sexual aggression is the reported total of 861,837 registered sex offenders in 2016 (Center for Missing and Exploited Children, 2017). Another indicator of prevalence is research in the United States conducted by Kilpatrick et al. (2007) who estimated the lifetime prevalence of rape for females at around 18%. Of rapes in the United States, Black, Basile, Breiding, Smith, Walters, Merrick, Chen, & Stevens (2011) found that 42.2% of females and 29.9% of males report being assaulted prior to the age of 18. Using estimates from The National Intimate Partner and Sexual Violence Survey, Black et al. (2011) reported that in the United States almost 1 in 5 females and 1 in 71 males have been raped in their lifetime.

Although the numbers of sexual abuse cases appear to be high, the rate of under reporting suggests that the problem may be much larger than generally estimated. Common barriers to reporting rape include not wanting others to know, fear of retaliation, uncertainty about sufficient evidence or intended harm, and uncertainty about seriousness (Kilpatrick et al., 2007). In the context of this dissertation, these numbers indicate that outside of professional experiences, most mental health professionals have been impacted by sexual abuse personally, within the family system or in the community. Personal knowledge of sex offending has the potential to impact both attitudes toward offenders and the recruiting, training and retention of mental health professionals to work with the sex offender population.

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Demographics. The U.S. Department of Justice National Crime Victimization Survey data, which is constructed from a representative sample, reported that 90% of rape victims in America were female and among these 63% were Caucasian and 28% were African America (Truman & Langton, 2015). Of note, Native American and Alaska Native females were at the highest risk across the lifetime for sexual assault (Tjaden & Thoennes, 2000). In 1997, FBI statistics indicated that 99% of reported rape cases involving a single-victim were perpetrated by a male (Greenfield, 1997). The Bureau of Justice Statistics reported that for adults 11.5% of sexual assaults are perpetrated by a family member, 61.1% by an acquaintance and 27.3% by a stranger (Synder, 2000). For juvenile victims, these percentages are 34.2% (family member), 58.7% (acquaintance) and 7.0% (stranger).

A study by Lea et al. (1999) investigated the perceptions of experienced professionals and paraprofessionals and found that the majority recognized sex offenders as a diverse group. Although significant variations within the sex offender population exist, two major trends are evident. First, the vast majority of individuals that perpetrate sexual abuse are males and second, females and children are disproportionately the victims of sexual abuse. As a result, inexperienced mental health professionals and community members may develop attitudes that inaccurately represent the sex offender population and impact their decision making. For example a parent or mental health professional may overemphasize the concept of “stranger danger” and under emphasize threats within family or acquaintances.

Cost to society. The national prevalence of sexual abuse has a tremendous impact societally and on the individuals harmed. Post, Mezey, Maxwell, & Wilbery (2002)

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estimated that in 1996 the intangible cost of sexual abuse, which includes psychological pain, pain and suffering of survivors, generalized fear of victimization and other impacts, amounted to \$6 billion for the state of Michigan. The study also estimated an additional \$400 million in tangible costs that included medical care, mental health services, insurance administration, police investigation, criminal prosecutions, correctional system costs (Miller et al., 1996) and other expenses. The researchers acknowledged that one of the limitations in developing an accurate estimate of tangible and intangible cost in Michigan is the underreporting of sexual abuse to authorities. Bitton & Shavit (2015) add additional insight by emphasizing that not only are females disproportionately the physical victims of sexual abuse but their fear of crime (intangible cost) contributes to an increased financial burden (tangible cost).

These high costs contributed to social pressure to find lower cost approaches to address sex offender crime and recidivism. The costs to the sex offenses themselves, prosecution, incarceration, supervision and treatment are high and are likely to remain high. After a reduction in the number of sexual assaults and rapes in the 1990s, the rates have remained fairly consistent since the early 2000s at around 1.6 per 1000 (Department of Justice, 2015). Data indicate that individuals and society as a whole will continue to experience significant tangible and intangible costs associated with sex offenders. Mental health professionals are an integral part of the system to support both the victims and perpetrators of sexual abuse.

Mental health. Both qualitative (Elder, Domino, Rentz, & Mata-Galan, 2017; Kim, Draucker, Bradway, Grisso & Sommers, 2017) and quantitative (Gidycz, Orchawski, King, & Rich, 2008; Kirkpatrick et al., 2007; Zinzow, Resnick, McCauley,

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Amstadter, Ruggiero & Kilpatrick, 2011) research evidence support the significant impact of sexual abuse on mental health. Zinzow et al. (2011) studied over 3,000 women to better understand how rape increases risk of mental health symptoms and found that the lifetime prevalence of Post-Traumatic Stress Disorder (PTSD) was 13% among individuals that have not experienced rape and 52% for victims of rape. When compared to individuals who have not experienced rape, victims of rape were five times more likely to report major depressive episodes and three times more likely to report alcohol abuse. Gidycz et al. (2008) reported that survivors of sexual assault are more likely to engage in high-risk behaviors (tobacco or marijuana use, suicidal ideations, violence in dating relationships, unhealthy dieting practices, multiple sexual partners, and early sexual intercourse) than individuals who have not been sexually assaulted. Research by Kirkpatrick et al. (2007) and Nickerson et al. (2013) also demonstrated that college student survivors of sexual abuse are more likely to experience Major Depressive Disorder, anxiety and PTSD. Researchers have described in detail the numerous psychological outcomes experienced by rape and sexual assault survivors, including decreased self-esteem, decreased self-perceived mate value (Perilloux, Duntley & Buss, 2012), increased rates of PTSD (Kirkpatrick et al., 2007; Nickerson et al., 2013), substance abuse (Gidycz et al., 2008; Nickerson et al., 2013; Zinzow et al., 2011), and depression (Zinzow et al., 2011).

Many of the adverse impacts of sexual abuse last a lifetime. Lassri et al. (2017) found that even among well-functioning (GAF score) survivors there were negative outcomes related to self-criticism and romantic relationship satisfaction. Post et al. (2002) emphasized that the tangible and intangible costs of sexual abuse have a profound

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impact on both the individual and society as a whole. Mental health professionals have been charged with the task of both supporting a reduction of symptoms in the victim and addressing sexual recidivism in the offender.

Sex Offender Treatment

Within the mental health field, common theoretical (Cognitive Behavioral Counseling, Person Centered) and technical strategies (Motivational Interviewing, Dialectical Behavioral Therapy, Trauma Informed Care) exist to treat a variety of client populations. Marshall et al. (2008) emphasized that there are treatment approaches (Good Lives Model, Pathways) and risk assessment strategies (ABEL, penile plethysmograph, polygraph, STATIC-99, etc.) specific to addressing the risk, needs and responsivity of the sex offender population. Sex offender-specific cognitive behavioral interventions and relapse prevention strategies both utilize a risk-needs approach (Ward & Gannon, 2006). The risk-needs model is designed to support the reduction of sex offender dynamic risk factors (Ward & Brown, 2004) such as antisocial interpersonal orientation, social isolation, negative associations, interpersonal aggression, poor self-regulation and others (Worling & Curwen, 2001). Meloy, Boatwright & Curtis (2013) summarized current research by citing six studies, which demonstrated that sex offenders who complete cognitive behavioral and/or relapse prevention focused treatment programs recidivate less often and less quickly than those that have not. Additionally, Kim, Benekos, & Merlo (2016) conducted a meta-analysis of meta-analyses (n = 11) published between 1995 and 2002 to explore the effect size of sex offender treatment and concluded that sex offender treatment is “proven” or at least “promising” to reduce recidivism rates by up to 22%.

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Cognitive behavioral and relapse prevention frameworks are currently the “overarching paradigms” in the field of sex offender treatment (Friestand, 2012).

Cognitive behavioral therapy. Jeglic, Hanson & Calkins (2016) assert that Cognitive Behavioral Therapy (CBT) has been a foundational aspect of sex offender treatment in the United States and Canada for over thirty years. Within that time period, CBT interventions have become more sophisticated due to a better understanding of the relationship between sex offender recidivism rates and attitudes (cognitions) that support sexual offending (Helmus, Hanson, Babchishin & Mann, 2013). Pamela Yates (2016), in her book chapter titled *Models of Sex Offender Treatment*, described cognitive behavioral interventions for sex offenders as based on “changing attitudes; altering cognitive distortions and schema; developing effective problem-solving abilities; improving sexual, intimate, and social relationships; managing affective states, reducing deviant sexual arousal; and developing adaptive thinking process, affect, and behavior”. Research has found that cognitive behavioral approaches can be effective in both individual and group therapy settings. Friestand (2012) noted that the application of cognitive behavioral therapy extends to the majority of correctional facilities, residential settings and outpatient treatment programs but is potentially being implemented incorrectly as part of a primarily risk-focused paradigm. Recently, there has been a push within the field of sex offender treatment to adopt strength-based treatment models (Good Lives) and reduce the emphasis on purely cognitive behavioral strategies (Ward & Gannon, 2006). An additional critique provided by Friestand (2012) is that a prescriptive application of cognitive behavioral therapy has impeded the abilities of programs and practitioners to integrate additional or alternative approaches to sex offender treatment.

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Maletzky & Steinhauser (2002) conducted a retrospective chart review (n = 7, 275) in a 25-year follow-up study of adult sex offenders that received cognitive behavioral therapy. Methodological issues included lack of control groups, differences in definitions and limited standardization of assessment tools. With these identified limitations, Maletzky & Steinhauser (2002) found reductions in rates of recidivism for almost all subcategories of sex offenders who received CBT treatment with the exception of rapists and homosexual pedophiles. Cognitive behavioral treatment interventions reduced the rate of recidivism and programs showed improved effectiveness over time.

Although there is a growing body of research to support the existence of productive outcomes with the use of cognitive behavioral therapy to treat sex offenders, several notable limitations do exist. These include a limited number of studies with appropriate control groups, limitations within follow up procedures, variable definitions and limitations in empirical assessments (Jewell et al., 2015; Maletzky & Steinhauser, 2002).

Relapse prevention. Although research related to relapse prevention outcomes indicates varied rates of success, relapse prevention continues to be one of the most commonly used approaches within the field of sex offender treatment (Marques, Nelson, Alarcon & Day, 2000; Polaschek, 2003). Olver & Wong (2014) described relapse prevention as a “plan that enables offenders to manage high risk situations, utilizing existing or acquired coping strategies to prevent relapse”. In practice, this means that the mental health professional assists the sex offender with understanding the cycle of behaviors that led to the pattern of sexual abuse in an effort to develop a specific plan to abstain from the behavior in the future. In a systematic review of research studies (n =

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18) conducted between 1994 and 2014, Marotta (2017) found positive outcomes related to recidivism rates. After acknowledging study limitations, the author concluded that relapse prevention can be an effective strategy for intellectually disabled sex offenders to reduce rates of sexual recidivism.

Although relapse prevention is widely used across the United States, criticisms of the strategy have started to mount. Research conducted by Marques, Wiederanders, Day, Nelson & Ommeren (2005) contributed justifiable criticisms of relapse prevention. In their longitudinal investigation conducted in California, no difference was found in recidivism rates between prisoners that received relapse prevention treatment and the two control groups (volunteer control and non-volunteer control). In a discussion of their findings, Marques et al. (2005) point out that a difference was found between sex offenders that completed established relapse prevention treatment goals and the two control groups. Additionally, some subpopulations within the category of sex offender responded more favorably to the relapse prevention treatment. The strong research design and incorporation of a control group in the Marques et al. (2005) study make it a cornerstone of current perceptions related to relapse prevention.

D’Orazio (2013) described, “lessons learned from history and experience” and identified ways to improve relapse prevention treatment interventions. These included recognition that relapse prevention strategies are frequently non-individualized, have nonequivalent language (lapse), and fail to take variable levels of motivation into consideration. The field of sex offender treatment has responded to critics of relapse prevention by calling for more holistic interventions. These include the Self-Regulation

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Model (Ward & Hudson, 2000), Good Lives Model (Barnao, Ward & Robertson, 2016), and other integrated approaches.

Regardless of the treatment strategy utilized by the mental health professional, a risk-needs-responsivity model has started to guide treatment methods for sex offenders. The education, training and residency of a professional specializing in sex offender treatment are distinct from other tracts of mental health professional development. The significant nuances within the assessment and treatment of the sex offender population necessitate the development of educational and training strategies to support productive mental health professional attitudes. The attitudes of mental health professionals toward sex offenders should be informed by an accurate understanding of prevalence, treatment approaches and recidivism rates.

Recidivism

Conflict exists within the field of sex offender treatment between research that indicates low rates of recidivism (Greenfeld, 1997; Hanson & Bussiere, 1998; Quinsey, Rice & Harris, 1995) and critics that demand more rigorous study methodology to support such claims. As discussed by Meloy et al. (2013) in their qualitative study exploring the perceptions and attitudes of lawmakers (n = 61) and practitioners (n = 25), significant legislative and clinical decisions are made without an accurate understanding of sex offender recidivism rates. For example, laws related to the sex offender registry and community notification have not been found to significantly impact sex offender recidivism rates but continue to be enacted and widely supported.

Langan, Schmitt & Durose (2003) conducted research for the US Department of Justice and reported a sex offender recidivism rate of 2.2% three years after release from

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incarceration for a population of 9,691 adult males from 15 states. A ten year follow up conducted on juvenile sex offenders for the Virginia Department of Juvenile Justice between 1992 and 2001 found that recidivism rates for adolescents who received self-contained treatment (n = 144) was 4.9% and prescriptive treatment (n = 112) was 4.5% (Waite, Keller, McGavery, Wieckowski, Pinkerton & Brown, 2005). The authors noted that both groups (self-contained, general population) within this study had higher rates of recidivism related to non-sexual crimes and impulsive/antisocial behaviors were identified as a risk factor associated with increased rates of reoffending.

Adult and juvenile sex offender recidivism rates for non-sexual crimes such as drug offenses or simple assault are consistently higher than the re-arrests for sex offenses (Griffin & West, 2006; Langan et al., 2003). Langan et al. (2003) noted three limitations impacting the ability of researchers to fully gauge recidivism rates; lack of information on treatment completion, limitations in rearrests rates and differences in risk factors among groups, but also reported that more intensive treatment was not related to significantly improved outcomes. Malesky & Keim (2001) also noted a major limitation within the field of sex offender recidivism research is that rates are impacted by length of follow-up time and they recommended longer-term research studies. Losel & Schumucher (2005) conducted a meta-analysis with 80 comparisons from 69 studies, which included over 22,000 individuals. The authors noted concerns with the current research within the field of sex offender treatment due to the limited usage of control groups, small sample size and differences within treatment approaches. Although problem areas are evident, Losel & Schumucher (2005) report an overall positive treatment effect.

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Recent recidivism research demonstrated that in addition to treatment, factors such as employment, external support and discharge planning are linked to sex offender success in the community (Willis, Malinen & Johnson, 2013). The field of sex offender treatment is starting to incorporate more recent research findings by reducing reliance on a purely CBT/relapse prevention methodology and implementing more multifaceted approaches. Losel & Schmucker (2005) summarize recommendations for future research by explaining the need to better understand “what works for who under which circumstances?” Overall, the research discussed above suggests that ethical and effective mental health professionals need attitudes that support flexibility, a willingness to recognize individual differences within the sex offender population and avoidance of outgroup derogation to foster treatment efficacy.

Attitudes Toward Sex Offenders

Attitudes are defined within the literature as “a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor” (Eagly & Chaiken, 1993). Within the concept, there are implicit or unconscious and explicit or conscious attitudes. Levenson, Brannon, Fortney & Baker (2007) conducted research on public perceptions of sex offenders and found that sex offenders were more feared and misunderstood than other categories of criminal offenders. These perceptions are created and perpetuated by media coverage that highlights cases of outliers within the sex offender population such as sex offense-murder (Zilney & Zilney, 2009). As a result, the public develops implicit and explicit biases based on the media overemphasis on outlying occurrences. The terms “predator” or “monster” have been used in the media regularly to characterize sex offenders. If individuals do not have quality contact with a known sex

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offender to dispute these stereotypes, they will retain the stereotypical thinking (Kjelsberg & Loos, 2008; Payne, Tewksbury, & Mustaine, 2010). Media coverage of sex offenders is an almost daily occurrence that impacts the attitudes of everyone in America.

The public may lump incidents of sexual offenses together due to the manner in which the media portrays the information. Williams & Hudson (2013) researched public perceptions and found that media coverage of outlying incidents of sex offenses is harmful because it reduces the awareness of risk factors such as familial grooming which is a common precursor to sexual abuse. For example, a parent may be much more concerned about protecting a child from sexual abuse perpetrated by a stranger and not accurately identify problematic grooming behavior perpetrated by a family member or acquaintance. Meloy et al. (2013) argue that the media focus on high profile cases has a disproportional impact on the development of individual and community attitudes toward sex offenders and related legislation. For example, the sex offense homicide of University of Virginia student Hannah Graham (Shapiro, 2016), the abduction, imprisonment and rape of teenagers Amanda Berry, Gina DeJesus and Michelle Knight for ten years in a Cleveland home (Berman, 2013), the serial child molestation perpetrated by Penn State football coach Jerry Sandusky (Penn State scandal fast facts, 2017), habitual cases of sexual violence in the military (Millegan et al., 2015), sex abuse by priests within the Catholic Church (Mancini & Shields, 2013) and the mishandling of sexual violence on college campuses across the country (Bazelon, 2015; Mervosh, 2016; Miller, 2016; Syrluga, 2016) have dominated media coverage. Consistent focus on such outlying cases can lead to a confused concept of the sex offender population and contribute to restricted insights into the risks posed by family members and acquaintances. As a result, sex

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offenders are regularly dehumanized (Viki et al., 2012) and relegated to an out-group status (Rade, Desmarais & Mitchell, 2016).

Haslam (2006) split dehumanization into categories of mechanistic dehumanization and animalistic dehumanization. Viki et al. (2012) found that individuals who demonstrated a tendency to dehumanize (animalistic) sex offenders were less supportive of rehabilitation and favored longer sentences and societal isolation. However, these researchers also found that having quality contact (equal status, common goals, intergroup cooperation, authority support) with sex offenders led to a reduction in dehumanizing ideas and increased support for rehabilitation.

General population attitudes. Payne et al. (2010) conducted research in Virginia surveying 746 residents in the Norfolk and Virginia Beach communities about their attitudes toward the rehabilitation of sex offenders. The results indicated that there are variations in attitudes toward sex offender rehabilitation depending on personal experience, demographics and community level factors (social disorganization). In the sample, 52% responded that they strongly agreed with the statement “It is impossible to rehabilitate or reform a sex offender”. The authors point out that these negative attitudes toward sex offender rehabilitation could reflect a generally negative attitude toward rehabilitation as a whole but also indicate a need to increase accurate understanding of rehabilitation to the public.

In a study exploring demographic differences (sex, age, education, occupation, parental status, victim acquaintance), Willis et al. (2013) noted that all groups hold some form of negative attitude toward sex offenders. The researchers utilized an online questionnaire to measure affective, cognitive and behavioral aspects of attitudes toward

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sex offenders. The authors acknowledged significant limitations including small sample size ($n = 401$) and overrepresentation of females ($n = 305$) and well-educated respondents. Despite the study limitations, Willis et al. (2013) concluded that negative attitudes toward sex offenders are prevalent and recommended further research related to community level interventions to reform the multifaceted nature of these attitudes. The Center for Sex Offender Management surveyed a representative sample ($n = 1002$) and found that 72% of participants endorsed misperceptions about sex offender recidivism rates (CSOM, 2010). Each of these studies (CSOM, 2010; Payne et al., 2010; Willis et al., 2013) demonstrated that the general public holds inaccurate and negative perceptions toward sex offenders.

One subcategory that emerges from the research is positive differences in attitude toward sex offenders related to educational level (Shackely, Weiner, Day & Willis, 2014). Church, Wakeman, Miller, Clements, & Sun (2008) worked with a sample of 347 undergraduate students enrolled in an introduction to psychology course to develop an attitude instrument. This work led to the development of an eighteen-item inventory (CATSO) that included four factors (social isolation, capacity to change, severity/dangerousness, and deviancy). Church et al. (2008) advocated for further validation of the CATSO and acknowledged that it was developed using a non-representative sample. It is notable that Church et al. (2008) recommended that follow up research include a social desirability scale. Hoing, Petrina, Duke, Vollm & Vogelbang (2016) conducted research on community support of sex offender rehabilitation in Europe, which included nine countries ($n = 1874$). The researchers used the Community Attitudes Toward Sex Offender (CATSO), Attitudes Toward the Treatment of Sex

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Offenders (ATTSO) and Public Attitudes Toward Sex Offender Rehabilitation (PATSOR) scales and found that individuals in the sample who were less educated and/or older exhibited more negative attitudes toward sex offenders on cognitive and behavioral measures. Hoing et al. (2016) acknowledged several limitations to their study (a non-representative sample and the limited validity of the CATSO) and concluded that additional research is needed to better understand the formation of attitudes toward sex offenders and how these attitudes impact policy.

In an additional study exploring attitudes toward sex offenders by Olver & Barlow (2010), respondents ($n = 78$) endorsed a desire for sex offenders to receive longer sentences, favored treatment and risk management strategies but had negative feelings toward “severe punishments” such as surgical castration. Olver and Barlow reported results that were congruent with other researchers in which higher educational level was related to more positive attitudes toward sex offenders. In a study designed to identify demographic groups with more negative attitudes toward sex offenders, Willis et al. (2013) conducted an international online survey with 401 community participants. For both cognitive and behavioral measures, educational level was again indicated as a predictor of less negative attitudes toward sex offenders, but feelings scales showed no statistically significant differences among groups. One of the important findings from the Willis et al. (2013) study is the limited relationship between psycho-educational interventions, contact with a sex offender and improvements related to feelings measures. The authors indicated several limitations to the study that included a non-representative sample, limiting participation to those who have access to the Internet, and a notable number of participants knowing a sex offender. Overall, significant limitations have been

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noted within research related to attitudes toward sex offenders and educational level. As a result, additional research is needed to better understand the formation of attitudes toward sex offenders and identify a guiding framework to conceptualize educational and experiential interventions.

Attitudes regarding sex offenders have real-world consequences and impact everything from community housing for sex offenders to legislative policies regarding their sentencing and treatment. Clark (2007) conducted a study exploring the attitudes of landlords toward renting to offenders. Both sexual and non-sexual offenders faced significant barriers to housing but sex offenders experienced an additional level of stigma. Clark (2007) recommended that additional research should be conducted on the intersection between racial discrimination, offenders and housing with an emphasis on factors that promote landlord trust in the potential tenant. Petrunik & Deutschmann (2008) go on to say that even if a sex offender is able to find housing, they could be “driven out of town through community-organized pickets, vigils and evictions”. Housing difficulties are pervasive and Brown (1999) found that they also exist in the United Kingdom. In their study contrasting Anglo-American and European community responses to sex offenders, these authors acknowledged the “social constructions of sex offenders as highly dangerous, mentally abnormal, and morally contaminated”. Petrunik & Deutschmann highlighted important differences between the United States approach to sex offenders, which primarily includes community protection (registration, notification, commitment), in contrast to more restorative justice approaches (accountability and Circles of Support) in Canada and Europe. Although there are significant differences

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among countries regarding the political response to sex offenders, international research on attitudes toward sex offenders has been limited (Shackley et al., 2014).

On a state and national level, the majority of legislators (65%) link the need for sex offender laws to specific (Meloy et al., 2013) and often highly publicized crimes. In their study exploring the perceptions and attitudes of policy makers, the authors identified two problems that emerge from this pattern of legislative action. The first problem is a disproportionate focus on victims that are white, female children and the second issue involves an over emphasis on rare occurrences of sex offenses (rape-homicide) rather than those that are statistically more likely (familiar molestation). In their conclusion, Meloy et al. recommended that both policy makers and clinicians ground their decision making in research rather than anecdotal evidence.

Male and female attitudes. Research related to attitudes toward sex offenders and gender has been inconclusive (Brown, 1999; Hoing et al., 2016). Hoing et al. (2016) found no difference between men and women related to their broad attitudes toward sex offenders and argued that further research is needed. In a study of students ($n = 49$) and forensic staff ($n = 90$), Ferguson & Ireland (2006) found that for perpetrators of all categories of sex offenses, women had more positive attitudes than their male counterparts. Specifically, males viewed categories of sex offenders involving children more negatively than other offenses. In a study of perceptions toward sex offender community protection policies, Levenson et al. (2007) found that females were significantly more likely to experience a greater degree of fear and agreement with community notification laws. Levenson et al. (2007) acknowledged a significant study limitation because the participants ($n = 193$) were individuals waiting at the DMV from

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only one locality in Florida. With these limitations in mind, Levenson et al. (2007) recommended additional research be conducted on interventions to educate the public with more accurate information about sex offenders. However, Kernsmith, Craun & Foster (2009) also found that females report experiencing greater fear than males regarding living near a sex offender. In a study conducted by Willis et al. (2013) on demographic differences in attitudes toward sex offenders, males expressed less negative attitudes on affective and behavioral measures. Kernsmith et al. (2009) designed a phone survey to measure participant (n = 733) fear of sex offenders and support of registration. The researchers identified study limitations to include the phone survey method and the sample being limited to only one state. Kernsmith et al. (2009) found that as the level of fear toward sex offenders increases so does support for registration and the authors also recommended further research designed to explore the link between offender type, registration, fear and actual behavior.

In a study by Craig (2005) to better understand the impact of training professionals to work with sex offenders, female employees expressed more safety concerns and negative attitudes than males. In conjunction with the study, Craig conducted a two-day workshop for professionals and para-professionals (n = 85) designed to enhance knowledge and improve attitudes toward sex offenders. The results indicated improvements related to confidence and awareness but no statistically significant change in attitudes.

The complex web of findings related to gender and attitudes toward sex offenders indicates the need for additional research and clarification. Taken together, these studies indicate that differences in attitudes toward sex offenders exist and that context is an

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important consideration. Across all of the studies discussed, authors recommended additional research to better understand how gender interacts with attitudes toward sex offenders. A more complete understanding of the impact of gender would empower counselor educators and supervisors to better develop educational and experiential strategies.

Professional attitudes. It is important to understand how widespread attitudes toward sex offenders translate into the mental health professionals working with them. Individuals entering a career working with sex offenders have already been exposed to media and other factors that dehumanize sex offenders and potentially put them in an out-group status. Lea et al. (1999) coined the term “professional-personal dialectic” to describe the professional’s need to develop a relationship with a sex offender and conflict or desire not to do so. While conducting one to two-hour interviews with 23 men and women, Lea et al. (1999) found “that professionals simultaneously held both positive (e.g., empathy) and negative (e.g., hatred) attitudes toward sex offenders with whom they worked”.

One professional group with a particularly challenging role in the spectrum of sex offender treatment is police officers. Flynt (2017) conducted a research study that included 63 officers in Florida using the Community Attitudes Toward Sex Offender Scale (CATSO). Overall, the findings indicated that police officers in the sample held negative attitudes toward sex offenders but females and more experienced officers endorsed less negative attitudes. One of the important findings from the Flynt (2017) study is that the police officers sampled supported the Sex Offender Registration and Notification Act (SORNA) although no current research or statistics indicate that it is

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effective at reducing recidivism or increasing community safety. Previous research by Hogue (1993) and Weekes, Pelletier, & Beaudette (1995) also found that police officers have more negative attitudes toward sex offenders than other professionals. This was particularly true for sex offenders that had abused children.

In contrast, Fortney, Baker & Levenson (2009) surveyed a nonrandom sample ($n = 264$) of professionals working with sex offenders and found that sex offender treatment professionals endorsed fewer myths and had a more accurate understanding of the population than the general public, other professionals or sex offenders themselves. Fortney et al. (2009) also noted that sex offender treatment professionals overestimated the frequency at which adult offenders experienced sexual abuse during childhood. A study limitation outlined by the authors was that the sample consisted of professionals attending a sex offender treatment conference, which may have contributed to an overrepresentation of individuals keeping track of current research findings. Although research by Nelson et al. (2002) found that counselors have more positive attitudes toward sex offenders than other professional groups and the general public, the researchers argued that the term “less negative” is a better description of the attitudes.

Farrenkopf (1992) conducted a study to explore how working with sex offenders impacts mental health professionals. The results of surveying 24 experienced therapists highlighted the self-reported detrimental impacts (vicarious traumatization) of working with sex offenders to include “emotional hardening, rising anger, confrontation, frustration with the correctional system or society, increased suspiciousness and vulnerability, repressed emotions, and a sense of disenchantment”. Clarke (2011) described the impact of treating sex offenders on the professional by saying that the work

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is “likely to have cognitive, behaviorally and emotionally negative consequences, and that anywhere between a fifth and quarter of therapists will be affected”. A study conducted in Canada by Kadambi & Truscott (2003) to explore vicarious traumatization on counselors found that 24% of the sample (n = 91) scored in the range of moderate or severe and 33% scored high in areas of emotional exhaustion and depersonalization. The researchers identified the small sample size, make up of participants (only currently practicing) and a lack of a control group as limitations and recommended that future research focus on the positive benefits (work satisfaction) and negative impacts (vicarious traumatization) experienced by sex offender treatment professionals.

One finding within the exploration of attitudes toward sex offenders that Nelson et al. (2002) found particularly surprising was related to the impact of a history of victimization. The authors collected responses of 264 mental health professionals through the Association of Mental Health Counselors (AMHCA), International Association of Addictions and Offender Counselors (IAAOC) and American Counseling Association (ACA) to explore their attitudes toward sex offenders. Counselors who had been sexually assaulted or had a close relationship with a victim of sexual abuse endorsed less negative attitudes toward sex offenders than others. Clark et al. (2002) attempted to explain these results by writing “most individuals are victimized by people they know” and as a result “are more aware of the full range of personality characteristics of the sex offender”. Sandhu & Rose (2012) reported that no follow up study could be identified regarding the findings of Clark et al. (2002) but highlighted findings from a much earlier study by Hilton, Jennings, Drugge & Stephens (1995) that clinicians reporting a history of sexual

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abuse rated the long-term impact as low. To date, the complex relationships among the interacting factors surrounding attitudes toward sex offenders are not fully understood.

As discussed above, the media is one of the primary factors influencing the attitudes of mental health professionals entering the field and the common vicarious traumatization experienced by sex offender treatment providers once in practice reshapes these attitudes. The Association for the Treatment of Sex Offenders (ATSA) outlines in their code of ethics that “members shall not allow personal feelings related to a client’s crimes or behaviors to interfere with professional judgments and objectivity”. Currently, there is no identified guiding framework to inform the development of and changes in attitudes toward sex offenders among treatment providers despite recognition that clinician attitudes have the potential to impact both service delivery and treatment outcomes.

Attitudes impact counseling outcomes. Patterns of sensationalized media coverage contribute to the dehumanization, out-group derogation and negative attitudes toward sex offenders which mental health providers experience within the professional-personal dialectic. Lea et al. (1999) conducted a qualitative study with 23 professionals and paraprofessionals that worked with sex offenders. In this study, the researchers explained that attitude “undoubtedly” impacts behavior and the findings supported the idea that professionals can hold both positive and negative attitudes about sex offenders simultaneously. Management or compartmentalization of negative attitudes requires awareness and vigilance on the part of the treatment provider. Nelson (2002) found that the therapeutic relationship is compromised if the counselor endorses negative attitudes toward sex offenders. In a study that included 12 treatment groups of male sex offenders

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(n = 100) receiving CBT treatment within prisons throughout the United Kingdom, Beech & Hamilton-Giachritsis (2005) explored the relationship between treatment outcomes and therapeutic climate. Each study participant completed pre-and-post assessments that included The Group Environment Scale (GES), Victim Empathy Distortions Scale, Cognitive Distortions Scale and Emotional Identification with Children measure. A statistically significant effect was found related to variations among groups on the GES to include subcategories of anger and aggression, cohesion, expressiveness, innovation, leader control, leader support, self-disclosure and task orientation. The researchers concluded that factors related to the therapist, which Harper et al. (2017) equate to expressions of attitude, had an impact on treatment outcomes.

Fernandez (2006) advocated for a significant shift in the field of sex offender treatment that involves taking a more positive approach. Suggestions included changing patterns of language (relapse prevention vs. self-management) that cultivate negative attitudes within treatment providers, reduced sex offender self-efficacy and potentially led to the development of the out-group status for sex offenders. Research into the concept of in-group (mental health professionals, community members) and out-group statuses (sex offenders) found that quality contact had a positive impact on attitudes (Pettigrew & Tropp, 2006) and reduced dehumanization (Brown et al., 2007). Although the general public holds negative attitudes related to sex offender rehabilitation (Sample & Bray, 2006), mental health professionals cannot share these attitudes if interventions are to be most effective. A literature review by Harkins & Beech (2007) led to the conclusion that “although therapist attitudes and experience are not traditionally discussed as therapist characteristics, it is likely that they will also play a role in

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influencing treatment effectiveness”. Furthermore, in a meta-analytic review, Dowden & Andrews (2004) found that the quality of professional and client relationships impacted recidivism outcomes. Of the five Core Correctional Practices (CCP: effective use of authority, appropriate modeling, teaching problem-solving, advocacy/brokerage, and relationship factors), relationship factors had the most significant impact on outcomes. Unfortunately, Dowden & Andrews noted that one of the major study limitations was the inconsistent use of the CCPs within the studies included in the meta-analysis.

Zebel, Zimmerman, Viki, & Doosje (2008) conducted a study on dehumanization and guilt as predictors of support for reparation policies. In a discussion of their findings, Zebel et al. (2008) link out-group (long-term prisoners) and in-group (normative people) behaviors with morality. They found that the greater the out-group was dehumanized the lower levels of guilt felt by in-group members, which reduced support for reparation. In a review of the literature related to moral judgments of patients, Hill (2010) explained that moral judgments of clinicians are impacted by patient characteristics, clinician characteristics, task, and other organizational factors within a variety of professional domains (physicians, nurses, clinicians). The research findings from the above studies support the relationship between the attitude of mental health professionals and treatment outcomes but also recommend additional research to better understand possible interventions that enhance mental health professional’s attitudes. As discussed below, moral development may provide a valuable framework to better understand, in whole or in part, the development of attitudes toward sex offenders.

Moral Development

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Viki et al. (2012) discuss the importance of moral development in mental health professionals and state, “that dehumanization may inhibit the experiences of moral emotions and manifestation of moral behavior toward out-groups”. Placement of sex offenders into an out-group status is easy to image because they are commonly described in the media and viewed in the community as “hated and feared criminals” (Meloy et al., 2013). It is inconsistent with professional ethical standards (ACA, 2014; ATSA, 2017) and research recommendations for mental health professionals to endorse attitudes that create counterproductive moral judgements when working with sex offenders.

Morality is often conceptualized as a static characteristic and ethics are written into prescriptive standards. As a result, mental health professionals, counselor educators and clinical supervisors may overlook the potential for improvements in these areas. Currently, mental health professionals lack a guiding theoretical framework to inform training and experiential interventions to foster the productive navigation of the professional-personal dialectic experienced by sex offender treatment providers.

In his 1958 dissertation, Kohlberg started the construction of a moral development model that was grounded on ideas within Jean Piaget’s theory of cognitive development (Krebs & Denton, 2005). Kohlberg’s model of moral development is comprised of three levels (preconventional, conventional and postconventional) and six stages (Stage 1: The punishment-and-obedience orientation, Stage 2: The instrumental-relativist orientation, Stage 3: The interpersonal concordance orientation, Stage 4: The “law and order” orientation, Stage 5: The social-contract, legalistic orientation, Stage 6: The universal-ethical-principle) across a developmental continuum (Kohlberg & Hersh, 1977). Krebs & Denton (2005) explained that the foundations of Kohlberg’s moral development model

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include the following concepts: “(a) the primary criterion of moral development is maturity of moral judgements (Colby & Kohlberg, 1987, pp. 1-2), (b) moral judgement is organized in “structure of the whole” (p.8), and (c) the new structures that people acquire as they develop transform and displace their older structures (p.7)”. The treatment of sex offenders by mental health professionals creates a uniquely challenging experience which taxes moral structures and attitude development within the previously described professional-personal dialectic. Kohlberg’s model of moral development potentially provides a unifying framework for counselor educators and supervisors to develop educational and experiential interventions to improve the attitudes of mental health professionals toward sex offenders.

Dimensions of moral development. In a review by Kohlberg & Hersh (1977), Kohlberg’s model of moral development was described as being universal across cultures and occurring in an invariant sequence. Although debate exists related to the universality of Kohlberg’s model across cultures, Gibbs, Basinger, Grime & Snarey (2007) reviewed several decades of research and concluded that there is “universality of basic moral judgement development, moral values, and related social perspective-taking processes across culture”. The authors argue that the conclusion of universality is appropriate despite recognition that the translation of assessment tools (DIT-II) across cultures has been identified as problematic. In relation to the invariant sequence of moral development, several modifications have been made to Kohlberg’s original theory. Neo-Kohlbergian theorists discarded the concept of stages and replaced it with overlapping schemas (Rest, Narvaez, Thoma & Bebeau, 2000). Although the Kohlbergian Model continues to be evaluated, Snarey (1985) provided an effective summary of this debate by

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stating “the significant shortcomings of Kohlberg’s work should not overshadow its remarkable achievements”. One piece of evidence that supports the continued utility of Kohlberg’s model of moral development is its application as a research framework within the field of counselor education (Tsai, 2013; Markve, 2013).

Passini (2014) conducted a study titled *Effect of personal orientations toward intergroup relations on moral reasoning*. This study described important relationships between moral development, attitudes and potential decision-making. Passini’s study included 200 “ordinary Italians” (in-group) that completed the Bogardus Social Distance Scale, self-categorization measure and Defining Issues Test. The primary limitations identified by Passini were that the study results indicate a correlation that cannot necessarily be linked to causality and that there were limitations related to the instrument used to explore attitudes around moral inclusion/exclusion. Study results indicated that respondents in the post-conventional levels of moral development were less likely to exclude the perceived out-group (Romanian). If the results were to be applied to the mental health professional/sex offender relationship, it is possible that providers in the post-conventional stage of moral development would be less likely to derogate sex offenders to an out-group status, which should enhance moral decision-making toward the population.

Neo-Kohlbergian theory. Rest et al. (2000) outline four similarities in Kohlberg’s cognitive-developmental model and Neo-Kohlbergian approaches. These include (1) an emphasis on cognitions, (2) “the personal construction of basic epistemological categories”, (3) “change over time in terms of development” and (4) the change into adulthood from conventional to postconventional stages. The Neo-

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Kohlbergian perspective elaborates on Kohlberg's cognitive-developmental approach with a four-component model. Rest (1986) worked toward identifying an integrative approach to moral decision by asking the question "what processes or functions must have occurred in order for an individual to perform a moral act?". The result is Rest's Neo-Kohlbergian four-component model which includes component 1: to interpret (sensitivity), component 2: to formulate (judgement), component 3: to select among (motivation) and component 4: to execute (commitment) (Rest, 1986). Rest conceptualized the four components as a dynamic system and Morton, Worthley, Testerman & Mahoney (2006) suggest that they could be deconstructed further and utilized within training programs. Mental health professionals working with sex offenders encounter moral intersections that necessitate a framework that supports postconventional levels of reasoning and an application of the four-component model.

Chapter Three: Methodology

As outlined above, the goal of the study was to examine the relationship between the attitudes of mental health professionals toward sex offenders and their level of moral development. The overarching research question explored whether there is a relationship between the positive attitudes of mental health professionals toward sex offenders and higher levels of moral development. Identified research questions in the study are (1) is there a relationship between counselor's attitudes toward sex offenders and their level of moral development, (2) is there a relationship between the length of professional experiences in the counseling field and attitudes toward sex offenders, (3) is there a relationship between length of professional experiences in the counseling field and level of moral development, and (4) are attitudes toward sex offenders related to sex offender-specific training?

Chapter 3 provides the quantitative methodology employed in the dissertation research. Study instruments included the Defining Issues Test Version II (DIT-II), Community Attitudes Toward Sex Offender Scale (CATSO) and Marlowe-Crowne Social Desirability Scale Short-Form (SDS). In addition, a demographic questionnaire was included within the battery of assessments.

Research Questions

Research question one. Is there a relationship between counselors' attitudes toward sex offenders and their level of moral development? This research question was explored using the sample results from the Community Attitudes Toward Sex Offender Scale (dependent variable) and the Defining Issues Test-II (independent variable). In

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addition, the Marlowe-Crowne Social Desirability Scale (SDS) was utilized as a check for the potential influence of respondents providing socially desirable response patterns. A linear regression with a predetermined alpha level of 0.05 was used to analyze the data for research question one. The original research design planned to explore the relationships between the subscales of the CASTO and the relevant N2 score provided by the DIT-II as outlined by the University of Alabama Center for the Study of Ethical Development. For reason discussed later in chapter 4, the CATSO subscales were removed from the final analysis.

Higher scores on the CATSO indicate increasingly negative attitudes toward sex offenders. The CATSO has sub-scales that include social isolation, capacity to change, severity/dangerousness and deviancy. The Defining Issues Test provides the participant's level of moral development across six different stages that include the Punishment-and-obedience, Instrumental-relativist orientation, Interpersonal concordance, Law and Order, Social-contract, Legalistic orientation and Universal-ethical-principle (Kolhberg & Hersh, 1977; Thoma, Bebeau & Narvaez, 2016). A negative relationship between the CATSO and DIT-II would suggest that as a mental health professional's level of moral development increases their attitudes toward sex offenders become more positive.

Research question two. Is there a relationship between length of professional experiences in the counseling field and attitudes toward sex offenders? To explore research question two, three separate data analyses were conducted to explore the relationship between the total score from the CATSO (dependent variable) and information related to length of professional experiences. Details related to the mental health professional's experience were divided into licensed experience, sex offender

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credentialed experience and percentage of sex offender (SO) caseload (independent variables). Lengths of professional experiences in each category were included as continuous variables.

The first analysis for research question two conducted was a linear regression utilizing all participants, CATSO total score and the professional experience results from the demographic questionnaire. Next, a two-sample t-test was conducted between individuals with professional experiences in a category in comparison to those that reported no experience. The final analysis was a linear regression with individuals removed from the data set that had no reported experiences in a particular category.

No relationship is expected between the length of a mental health professional's licensed experience in the field and more positive attitudes toward sex offenders. In contrast, a positive relationship is expected between length of the mental health professional's experience specific to working with the sex offender population and more positive attitudes. In addition, it is hypothesized that professionals that have decided to work with sex offenders (higher percentage of caseload) will have more positive attitudes.

Research question three. Is there a relationship between length of professional experiences in the counseling field and level of moral development? In order to explore research question three, the DIT-II (dependent variable) and data obtained from the demographic questionnaire (independent variable) were analyzed using linear regression and a two-sample t-test. The analysis utilized the DIT-II N2 scores provided by the DIT-II as the dependent variable. The independent variables included in the regression

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analysis were the length of licensed experience, SO credentialed experience and percentage of SO caseload.

The first analysis for research question three conducted was a linear regression utilizing all participants, the DIT-II N2 score and professional experiences collected from the demographic questionnaire. Next, a two-sample t-test was conducted between individuals with professional experiences in a category verse those that did not report experience in a specific category. The final analysis was a linear regression with individuals removed from the data set that had no reported experiences in a particular category.

The linear regression analysis for research question three is expected to indicate that there is a relationship between length of licensed experience in the counseling field and level of moral development. In addition, it is expected that professionals with more experience as a credentialed sex offender treatment provider will have higher DIT-II N2 scores and relationship is expected between the percentage of SO caseload and DIT-N2 scores.

Research question four. Are attitudes toward sex offenders related to sex offender-specific training? To test research question four, the CASTO (dependent variable) and demographic questionnaire (independent variable) were utilized. The primary linear regression was conducted on the mental health professional's amount of training specific to sex offenders and total score on the CATSO. The amount of training received by the research participants was collected related to hours of conference attendance, work site training, self-directed training, continuing education, other and total training. It is expected that mental health professionals with greater training specific to

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the sex offender population will exhibit more positive attitudes toward sex offenders as evidenced by their lower overall CASTO scores.

Participants and Data Collection

Due to the specific focus of this study, the research sample consisted of licensed and unlicensed mental health professionals in the fields of counseling, social work or psychology. The sample included current residents in counseling, supervisees in social work and psychologists in training working toward licensure or individuals that have already achieved licensure. Efforts were made to obtain a wide range of lengths of experiences in the mental health field and variation within the other demographic variables. Based on the nature of the study, efforts were made to ensure that a portion of the sample included mental health professionals that have credentialing specific to working with the sex offender population.

For the purposes of this study, a convenience sample was recruited of master's level mental health professionals and licensed professionals in the United States (counselors, social workers and psychologists). Recruitment and sampling were contracted through Qualtrics research panel services. Participants were also identified using a professional listserv (cesnet), organizational requests and other methods. The final sample of 135 participants met adequate statistical power for the study. The final sample size was congruent with the recommendations provided by Green (1991).

Instruments

In order to explore the potential relationship between mental health professional's attitudes toward sex offenders and level of moral development, a battery of instruments was identified. These include a demographic questionnaire, the Marlowe-Crowne Social

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Desirability Scale (SDS), Defining Issues Test (DIT-II) and Community Attitudes Toward Sex Offender Scale (CATSO). The instruments were distributed online using Qualtrics statistical services.

Demographic questionnaire. The research survey requested that participants provide demographic information including age, gender, race/ethnicity, details related to experience (general and sex offender specific), professional identification and details related to training specific to working with the sex offender population (Appendix A).

Defining Issues Test (DIT-II). The DIT-II is the guiding instruments utilized to measure moral development within Kolberg's model (Appendix C). More than thirty-five years of research have been conducted on the reliability, validity and application of the DIT-II. Rest et al. (2000) summarized the research conducted on the DIT-II and highlighted six conclusions which included "differentiation of various age/education groups, longitudinal gains, significance related to cognitive capacity measures, sensitive to moral education interventions, link to pro-social behaviors and to desired professional decision making, link to political attitudes and choices and reliability". It is particularly important to note that Rest and Narvaez (1994) concluded that higher levels of moral develop empower professionals by helping them understand that "1. some ways of deciding what is right (making ethical decisions) are more justifiable than others 2. there must be some agreement among "experts" on what the more justifiable ethical positions are" and ethics training can influence moral development in a positive manner. In a review of multiple research studies, the Crombach's alpha for the test-retest for the DIT-II is in the "upper 0.70s/low 0.80s and the reliability is adequate" (Rest et al., 2000).

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The DIT-II is estimated to take about 40 to 45 minutes to complete and is constructed of five dilemmas. Respondents complete the DIT-II by reading the five dilemmas provided and then rating/ranking twelve items for each dilemma that represent different aspects of moral reasoning. Although a shortened version of the DIT-II is available, it has not been selected for this study due to reductions in reliability and validity. The DIT-II is an objective measure, which provides both a P-score and an N2 score for the respondent. The data analysis for this study was conducted using the N2 score which is constructed of both post-conventional and pre-conventional selections on the DIT-II. As explained by Roche & Thoma (2017) “the N2 represents the extent to which post-conventional items are prioritized and the degree to which personal interest items receive lower ratings than the ratings given to post-conventional items”.

Community Attitudes Toward Sex Offenders Scale (CATSO). The Community Attitudes Toward Sex Offenders Scale (CATSO) was utilized as a measure to gauge participant attitudes toward sex offenders (Appendix D). Church et al. (2008; 2010) developed the CATSO to measure community perceptions and stereotypes toward sex offenders. At the start of the CATSO development, it included 332 items that were later reduced to 97 items for factor analysis. Church et al. report that the final 18 items in the CATSO make a distinctive contribution and factor loadings are statistically significant (over 0.40). The reported Cronbach’s alpha for the CATSO is 0.74. Alpha values for each factor, social isolation (0.80), capacity to change (0.80), severity/dangerousness (0.70) and deviancy (0.43), are acceptable with reported adequate internal consistency. For this study, internal consistency was determined as adequate at a level of 0.7 or above.

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Each of the eighteen statements in the CATSO is rated using a six point Likert scale ranging from strongly disagree to strongly agree. Items one, four, nine, thirteen, fifteen and seventeen are reverse scored. The total CATSO score is calculated by adding all question responses together and a higher score indicates more negative attitudes toward sex offenders. Within the CATSO three (deviancy) or five (social isolation, capacity to change, severity/dangerousness) questions contribute to each of the subscale scores. The subscale scores are totaled in the same manner as the CATSO overall score.

The CATSO has been utilized recently and consistently to research attitudes of general populations and specific professional groups toward sex offenders. Flynt (2017) utilized the CATSO to explore the relationship between law enforcement officer's attitudes toward sex offenders and stance toward Sex Offender Registration and Notification Action (SORNA) policies. With a sample of 63 officers from three agencies, the researchers were able to utilize the CATSO as an effective measure of attitudes toward sex offenders. In addition, the instrument had a level of sensitivity that allowed the researchers to distinguish that female officers endorsed less negative attitudes toward both sex offenders and SORNA policies. Similar research conducted by Deluca, Vaccaro, Graham, Giannicchi & Yanos (2018) utilized the CATSO to explore sociodemographic predictors related to sex offender stigma. The researchers found that the CATSO assisted them to demonstrate that an individual's political identification had a relationship with their attitudes toward sex offenders. The ability of the CATSO to assist researchers in better understanding the perspectives of demographic and professional groups toward sex offenders (Harper, 2018) and its statistical reliability contributed to the decision to utilize it within this study.

Marlowe-Crowne Social Desirability Scale – Short Form (SDS). When conducting research related to attitudes toward out-group populations, it is important to evaluate participant responses for potentially socially desirable patterns (Haghighat, 2007). This is particularly important because values, morals and beliefs may impact response patterns. The Marlowe-Crowne Social Desirability Scale-Short Form has similar reliability and validity to the original long-form (Appendix B). The shortened scale is recommended for self-report surveys in which length or time is a consideration. Due to the time required for participants to complete the DIT-II, CATSO and demographic survey, the short form of the Marlowe-Crowne SDS was utilized for this study.

Research conducted by Church et al. (2008) recommended the incorporation of a social desirability scale when evaluating attitudes toward sex offenders. The Marlowe-Crowne Social Desirability Scale (Short-form) is constructed of 13 questions designed to evaluate “a propensity of individuals to report favorable responses” (Vu, Tran, Pham & Ahmed, 2011). For example, question one states, “It is sometimes hard for me to go on with my work if I am not encouraged” (Marlowe-Crowne). The assessment prompts require respondents to provide a true or false response with true scored as one and false scored as two. For items five, seven, nine, ten and thirteen the responses are reverse scored. The scoring range for the scale is between thirteen and twenty-six. A respondent with a higher score demonstrates a propensity to provide socially desirable answers.

In a study conducted by van de Mortel (2008), the importance of incorporating a social desirability scale into self-report research is evident in her finding that around half of the studies that utilized a social desirability scale found that it had an influence on the

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interpretation of results. If the SDS scores were found to significantly impact response patterns, finding will be further analyzed to identify specific relationships.

Ethical Considerations

Approval from the Institutional Review Board at the College of William & Mary was obtained prior to starting the study. Participation in the research study was voluntary and consent was obtained from all participants. Informed consent provided participants with information related to confidentiality, purpose of the study, and details related to the use of non-identifying ID numbers. In addition, informed consent outlined that there are no known risks from the study and participants have the option to withdraw from the study at any time for any reason. All data obtained specific to the identifying information of research participants was stored in a separate and secure database from the primary survey results. At the conclusion, when all results had been provided, the secure database of identifying information was destroyed.

Chapter Four: Analysis of Results

The fourth chapter provides an overview of the final data set and statistical procedures used to explore the potential relationship between mental health professional's level of moral development and attitudes toward sex offenders. Prior to statistical analysis, a detailed description of the sample is provided.

Description of Data Set

Data collection was conducted between January 3, 2019 and February 21, 2019 using Qualtrics survey tools. Responses were reviewed periodically throughout data collection and aberrant responses were discarded. The preliminary data set identified at the close of data collection consisted of responses from 164 participants which included 100 obtained from the Qualtrics data collection panel and 64 from other participant recruitment methods (email requests, listserv requests, conference attendance, etc.). This initial data set was evaluated using graphical and statistical methods. These procedures led to the removal of 29 participant's responses. The initial eight participant's responses were removed due to missing data, incomplete responses or unrealistically short completion times (less than 8 minutes). Four participant's responses were removed due to incongruent age ($n = 1$) and/or education ($n = 3$). An additional two participant's responses were removed from the sample due to participants reporting zero months/years of post-master's degree experience. Nine participant's responses were removed for reports of training (Conference Attendance, Work Site Training, Self-directed Training, Continuing Education and other) beyond reasonable estimates. For example, one respondent indicated 54,300 hours of self-directed training and a total of 9 years and 11

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months of post-master's degree experiences. Three were removed from the final sample due to invalid responses related to percentage of caseload working with sex offenders (years/months instead of percentage provided). One respondent was removed for invalid reporting related to post-master's and licensed experience. An additional three participant's responses were removed due to repetitive response patterns. Of the 29 removed participant responses, 19 were from the Qualtrics research panel and eight from other recruitment methods.

Demographics. The data set used for final analysis (n = 135) consisted of 103 females, 34 males and 1 non-binary/third gender. The age range for the mental health professionals sampled was 24 to 80 years old with a mean of 41.2 (median = 38). Data were also collected related to the participant's profession as a counselor (n = 83), social worker (n = 32) or psychologist (n = 22). A summary of the demographic variables of participants in the final data set is provided in Table 4.1.

Table 4.1

Demographics Related to Gender, Age and Ethnicity/Race for Participants

	n	%
Demographic Variable		
Gender		
Female	100	74.8
Male	34	25.2
Non-binary/Third gender	1	0.7

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Age Range

24 to 30	36	26.6
31 to 35	20	14.8
36 to 40	18	13.3
41 to 45	16	11.8
46 to 50	14	10.3
51 to 55	9	6.6
56 to 60	7	5.1
61 to 65	7	5.1
66 to 80	8	5.9

Ethnicity and Race

Hispanic, Latino or Spanish Origin	0	0.0
American Indian or Alaska Native	1	0.7
Asian	7	5.2
Black or African American	9	6.7
Native Hawaiian or Other Pacific Islander	0	0.0
White	108	80.0
Multiracial	10	7.4

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Note. n = sample size

Experience and training. Information related to participant’s experiences as a mental health professional post-master’s degree and licensed experiences are summarized in Table 4.2.

Table 4.2

Distributions of Experience and Training in Months

	Range	Median	Mean	sd
Experience and Training in Months				
Post Masters Experience	1 to 528	78.0	112.7	106.8
Licensed Experience	0 to 488	38.0	74.9	97.5
Sex Offender Specific Credential	0 to 204	0.0	6.0	28.4
Percentage of Caseload	0 to 89%	0	10.9%	0.21

Note. n = 135. A median of zero indicates that greater than 50% of participants indicated a response of zero in the category.

Further data were collected regarding participant training specific to working with the sex offender population. All collected data associated with experience and education are summarized in Table 4.3.

Table 4.3

Description of Sex Offender Specific Training

	Range	Median	Mean	sd
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Training Type

Conference Attendance	0 to 180	0.0	16.1	44.4
Worksite Training	0 to 750	0.0	35.8	103.6
Self-Directed Training	0 to 500	0.0	19.34	56.1
Continuing Education	0 to 350	0.0	19.5	54.3
Other Training	0 to 200	0.0	5.6	23.3
Total Training	0 to 1600	6.0	96.6	231.8

Note. All data provided in hours. A median of zero indicates that greater than 50% of participants indicated a response of zero in the category.

Comparison Qualtrics Panel and Non-Qualtrics Panel Portions of Sample

Due to multiple data collection methods for obtaining the final sample, an analysis of frequencies was conducted using Chi-square statistics. These analyses were completed to determine if differences were evident between the two sources (Qualtrics Panel, Non-Qualtrics Panel) that could impact the interpretation of results. Table 4.4 summarizes recoded categorical variables that were utilized in the statistical analysis.

Table 4.4

Chi-square Analysis Comparing Qualtrics and Non-Qualtrics Panel Demographics

	Qualtrics		Non-Qualtrics		Total Sample	
Demographic Variable	n	%	n	%	n	%
Gender						

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Male	23	29.1	11	20	34	25
Female	56	70.9	44	80	100	75
Ethnicity/Race						
White	66	83.5	41	73.2	107	79.3
Black	4	5.06	7	12.5	11	8.1
Combined	9	11.4	8	14.3	17	12.6

Note. Total gender sample is 134; a participant identified as non-binary/third gender was not included in the table summary

Chi-square tests were completed for a comparison between the Qualtrics panel and other recruitment of participant methods related to gender and ethnicity/race (Table 4.5). For the Chi-square test related to gender, the participant that identified as non-binary/third gender was removed prior to analysis due to small representation within the sample. The resulting Chi-square value indicated no difference in the distribution of gender between the Qualtrics Panel and other recruitment methods ($p = 0.233$). Table 4.5 is a summary of comparisons between the participants recruited from the Qualtrics panel ($n = 79$) and other recruitment methods ($n = 56$) related to demographic variables. Chi-square analysis was also conducted related to ethnicity/race between the Qualtrics panel and other recruitment method. Due to small number of participants in several demographic categories, data were condensed into white, black and combined ethnicity/racial groups.

Table 4.5

Chi-square Analyses for Categorical Variables Between Qualtrics Panel and Other

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Recruitment Methods

	df	χ^2	p Value
Demographic Variables			
Gender	1	1.422	.233
Ethnicity/Race	2	2.883	.237

Note. Qualtrics (n = 79) and other recruitment methods (n = 56)

The results for the Chi-square statistic indicate no statistically significant differences between the Qualtrics and non-Qualtrics recruitment methods related to gender or ethnicity/race. This finding supports, in part, the use of the entire sample (n = 135) for statistical analysis addressing research questions. Table 4.6 provides results from t-tests used to compare the Qualtrics and non-Qualtrics recruitment methods for all continuous variables collected.

Table 4.6

Summary of t-tests for Continuous Variables Comparing Qualtrics Panel and Non-Qualtrics Recruitment Methods

Variable	t	p	M (Qualtrics)	M (Non-Qualtrics)
Age (years)	-0.95	.343	42.3	40.1
Post-master's (months)	-1.889	.061	127	92

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Licensed Experience (months)	-1.806	.073	87.6	57.1
Sex Offender Specific (months)	-.752	.454	7.6	3.9
Percentage of Caseload (%)	-2.754	.007	14.9	5.3
Conference Attendance (hours)	-2.793	.006	24.9	3.8
Worksite Training (hours)	-1.759	.081	49	17
Self-directed Training (hours)	-3.264	.001	32.2	1.3
Continuing Education (hours)	-2.906	.004	30.6	3.8
Other Training (hours)	-1.924	.057	8.8	1.1
Total Training (hours)	-3.004	.003	145.4	27.2
CATSO	-4.767	.000	62.85	55.48
Marlowe-Crowne SDS	-3.446	.001	7.32	5.41
DIT-II (N2 Score)	3.767	.000	35.61	46.18

Note. M = mean

The t-test results related to demographic and experiential variables indicate a statically significant difference in percentage of caseload, conference attendance, worksite training, self-directed training, continuing education, other training and total training. The mean for the Qualtrics panel for percent of caseload with sex offenders was 14.9% compared to 5.3% for the non-Qualtrics recruitment methods. Overall, the Qualtrics panel has reported a higher percentage of caseload working with sex offenders and more hours in each training category.

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Outcome variables between groups have also been found to have statistically significant differences. The Qualtrics panel had a higher mean score on the CATSO and Marlowe-Crowne SDS. This would indicate that the Qualtrics panel has more negative attitudes toward sex offenders and a greater tendency to provide socially desirable response patterns. In addition, the non-Qualtrics recruitment method had higher average N2 scores on the DIT-II. This indicates that participants from the non-Qualtrics recruitment methods on average have less negative attitudes toward sex offenders, are less likely to provide a socially desirable response pattern and have a score that would indicate greater average moral development.

Although statistically significant differences were found between the Qualtrics and non-Qualtrics recruitment portions of the sample, data analysis were conducted using the entire sample ($n = 135$). A review of the sampling procedures indicated no systematic bias likely to impact data interpretation. The differences between the Qualtrics and non-Qualtrics data collection methods support potentially productive variations within the sample variables.

CATSO Confirmatory Factor Analysis

The community attitudes toward sex offender scale (CATSO) was developed by Church et al. in 2008 with the goal of creating an instrument to measure public attitudes toward sex offenders. The CATSO instrument includes 18 items that provide outcomes related to four subcategories (social isolation, capacity to change, severity/dangerousness, deviancy) and a total score. Since the CATSO was developed in 2008, it has been used within community, correctional and mental health settings to measure attitudes toward sex offenders.

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A confirmatory factor analysis (CFA) was conducted on the CATSO subcategory scores. The assumed hypothesis in the CFA was that the subcategories identified by Church et al. (2008) would be confirmed within the current data set. Figure 4.1 provides a summary of the CFA input for the CATSO items and subcategories.

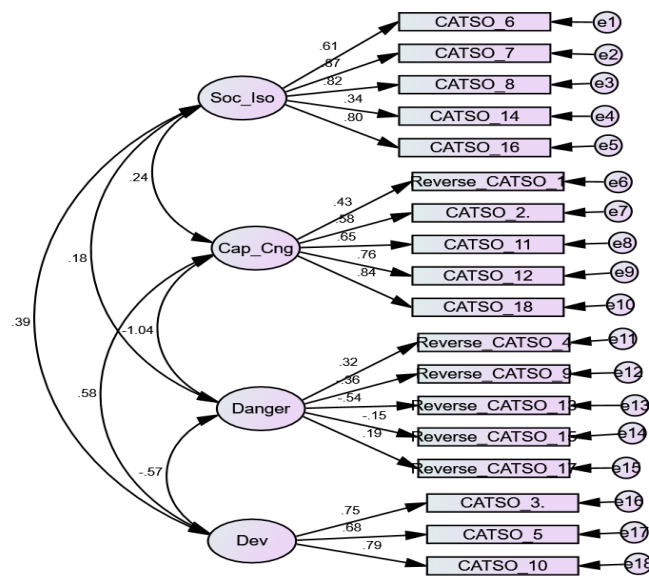


Figure 4.1. CASTO CFA Input

The CFA results produced a Chi-square value of 247.707 with 129 degrees of freedom and a probability level of 0.000. As a result, the sample obtained for this study does not fit the subcategory model found by Church et al. (2008). Additionally, the Comparative Fit Index (CFI) value falls short of the recommended parameters of 0.90 with a value of 0.853. The Root Mean Square Error of Approximation (RMSEA) is related to the residual in the model and values range between zero and one with lower values indicating a better model fit. The observed RMSEA value of 0.083 exceeds the

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acceptable value of 0.06 or less suggested by Hu & Bentler (1999). Results of the CFA guided the decision to exclude the subcategories from final analysis. Given the statistical output, the subcategories within the CATSO were not utilized and only the CATSO total score was incorporated into final analyses.

Marlowe-Crowne Social Desirability Scale

Due to the potential for providing socially desirable responses on self-report survey research, the Marlowe-Crowne Social Desirability Scale has been utilized (Barger, 2002). When researching emotionally or psychologically taxing subject matter, there is the potential for participants to respond in a manner that is less congruent with what they actually believe and instead respond in a manner congruent with what they feel is socially desirable. The Marlowe-Crowne Social Desirability Scale short form has a total of thirteen true/false questions and is designed to evaluate a participant's tendency to respond in a socially desirable manner. Social desirability scores were not used to identify and remove individual participants. The Marlowe-Crowne SDS scores were utilized as one method of describing the sample and also to develop residualized scores for the DIT-II and CATSO. Figure 4.2 provides the distribution of all scores within the study sample (n = 135).

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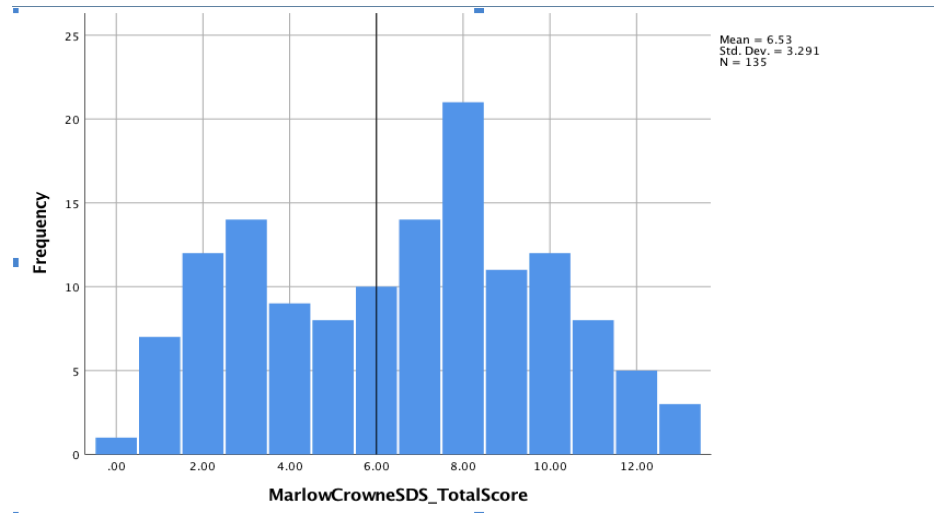


Figure 4.2. Distribution of Marlowe-Crowne Social Desirability Scores

Figure 4.2 provides a graphical representation of the samples SDS scores with a mean of 6.53 and standard deviation of 3.29. The results show a wide distribution of responses with some participants demonstrating a moderate to significant pattern of socially desirable responses.

Linear regression analysis was utilized to explore the potential relationship between the Marlow-Crowne SDS, DIT-II and CATSO. It was found that there is a statistically significant relationship between the assessments. Results are summarized below.

Table 4.7

Marlowe-Crowne SDS Linear Regression with Dependent Variables

Variables	p	R-square
SDS and CATSO	0.004	0.062
SDS and DIT-II	0.001	0.121

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Both linear regression results support a statistically significant relationship between the Marlowe-Crowne SDS, CATSO and DIT-II. The R-square output support low explanatory power at 6.2% for the CATSO and 12.1% for the DIT-II which indicate low levels of variability that are explained by the Marlow-Crowne SDS. Further analyses were conducted to explore correlations between the CATSO scoring items and Marlow-Crowne SDS.

Table 4.8

Correlations Between CATSO Items and Marlowe-Crowne SDS

	p	R-square
CATSO Scale Item		
1. With support and therapy, someone who committed a sexual offense can learn to change their behavior.	0.455	0.004
2. People who commit sex offenses should lose their civil rights (e.g. voting and privacy).	0.250	0.01
3. People who commit sex offenses want to have sex more often than the average person.	0.046	0.029
4. Male sex offenders should be punished more severely than female sex offenders.	0.748	0.001
5. A lot of sex offenders use their victims to create pornography.	0.002	0.070
6. Sex offenders prefer to stay at home alone rather than be around lots of people.	0.056	0.027

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7. Most sex offenders do not have close friends.	0.080	0.023
8. Sex offenders have difficulties making friends even if they try real hard.	0.367	0.006
9. The prison sentences sex offenders receive are much too long when compared to the sentence lengths of other crimes.	0.776	0.001
10. Sex offenders have high rates of sexual activity.	0.043	0.030
11. Trying to really rehabilitate a sex offender is a waste of time.	0.482	0.004
12. Sex offenders should wear tracking devices so their locations can be pinpointed at any time.	0.012	0.046
13. Only a few sex offenders are dangerous.	0.257	0.010
14. Most sex offenders are unmarried men.	0.170	0.014
15. Someone who uses emotional control when committing a sex offense is not as bad as someone who uses physical control when committing a sex offense.	0.113	0.019
16. Most sex offenders keep to themselves.	0.005	0.057
17. A sex offense committed against someone the perpetrator knows is less serious than a sex offense committed against a stranger.	0.338	0.007

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18. Convicted sex offenders should never be release from prison. 0.009 0.050

Table 4.8 indicates that item numbers 5, 12, 16 and 18 have a statistically significant relationship with the Marlowe-Crowne SDS. The R-square values for each item indicate relativity low explanatory power of the Marlowe-Crowne SDS with the CATSO items. The result of the final analysis led to the decision to residualize both the DIT-II and CATSO scores in order to remove the social desirability response bias indicated by the Marlowe-Crowne SDS.

Research Question One

The first research question proposed a negative relationship between counselors' attitudes toward sex offenders (CATSO) and their level of moral development (DIT-II N2 Score). Kohlberg's model of moral development was predicted to assist counselors, supervisors and counselor educators to understand and navigate the professional-personal dialectic as described by Lea et al. (1999). Prehn, Korczykowski, Rao, Fang, Detre and Robertson (2015) found that individuals with higher levels of moral development "showed increased gray matter in areas of the brain implicated in complex social behavior, decision making, and conflict processing as compared to subjects at a lower level of moral reasoning". These complex and flexible facets of moral reasoning would empower a mental health professional to navigate the professional-personal dialectic more successfully. Therefore, it was expected that there would be a relationship between more positive attitudes toward sex offenders as measured by low CATSO scores and higher levels of moral development as measured by the DIT-II.

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A linear regression analysis was utilized to explore research and the output graph is included in Figure 4.3.

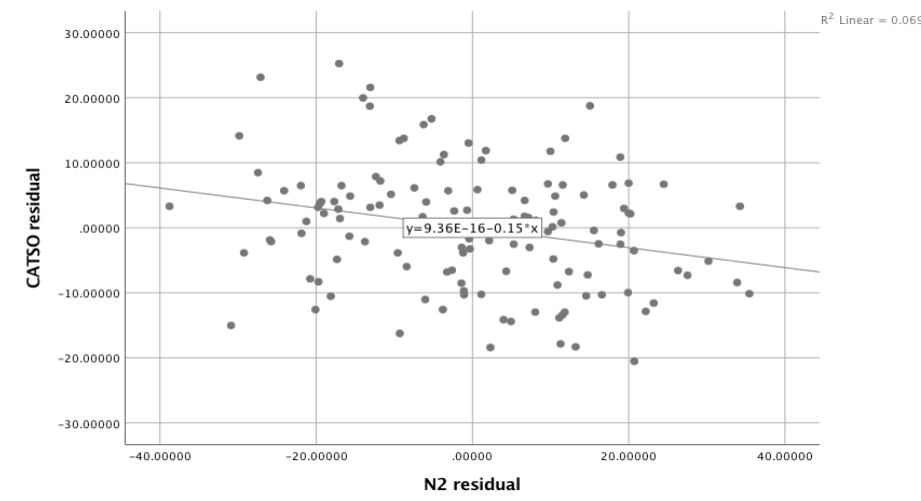


Figure 4.3. Linear Regression Analysis for CATSO Residuals and DIT-II N2 Residuals

The linear regression analysis supports the research hypothesis that as a mental health professional's level of moral development increases their negative attitudes toward sex offenders decrease. Although there is a statistically significant relationship (Table 4.10), the R-square value of 0.069 indicates that only 6.9% of the variance in CATSO scores is explained by the DIT-II N2 score. Table 4.9 outlines that there is a statistically significant relationship between mental health professionals' scores on the DIT-II and CATSO total score.

Table 4.9

Linear Regression Output for CATSO and DIT-II

	p	Beta Weight	R-square
Regression Variables			

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DIT-II and CATSO	0.002	-0.262	0.069
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Notes. Both scores residualized with Marlowe-Crowne SDS

The Beta weight was -0.262 and indicates a moderate decrease in CATSO scores as mental health professional's level of moral development increases as evidenced by higher DIT-II N2 scores. The R-square value indicates that 6.9% of the variation in CATSO scores is accounted for by the participant's DIT-II score. On average, individuals with higher levels of moral development endorsed less negative attitudes toward sex offenders. An R-square of 0.069 indicates low explanatory value.

Research Question Two

Research question two proposed that as the length of professional experiences increases negative attitudes toward sex offenders as measured by the CATSO would decrease. Research related to experiences with sex offenders (personal and professional) and its impact on attitudes toward the population has been mixed. Studies by Hogue (1993) and Nelson et al. (2002) found that increased contact with a sex offender reduces negative attitudes. Higgins & Ireland (2009) and Johnson, Hughes & Ireland (2007) found that a variety of professional experiences with sex offenders contribute to more positive attitudes. In contrast, Wilson, Picheca & Prinzo (2007) found in their research on volunteers working with sex offenders that increased experience was correlated with more negative attitudes.

Statistical analysis for research question two was conducted in three parts. The first analysis utilized linear regression with licensed experience, SO credentialed experience and percentage of SO caseload as independent variables and the overall CATSO score as the dependent variable. Table 4.10 provides an overview of the results.

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Table 4.10

Linear Regression Analysis for Professional Experiences and Residualized CATSO Score

	M	Median	p	R-square
Professional Experience Type				
Licensed Experience	74.9	38.0	0.758	0.001
SO Credentialed Experience	6.0	0.0	0.713	0.001
Percentage of SO Caseload	10.9%	0.0	0.174	0.014

Notes. SO = Sex offender. A median of zero indicates that greater than 50% of participants indicated a response of zero in the category.

No statistically significant relationships were found related to the length of experience (licensed experience, SO credentialed experience, percentage of SO caseload) and attitudes toward sex offenders. Next, because a notable number of participants indicated zero experience in some of the categories, t-tests were conducted to compare non-licensed and licensed mental health professionals, with and without SO credentialed experience and mental health professionals with and without some percentage of their caseload being sex offenders. The t-test results are summarized in Table 4.11.

Table 4.11

Professional Experience and CATSO Residuals Two Tailed t-tests

	t	p	M (No)	M (Yes)
Variable				
Licensed Experience	-0.376	0.708	59.3 (n = 28)	59.9 (n = 107)

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SO Credential Experience	-0.615	0.554	59.5 (n = 126)	63.9 (n = 9)
Percentage of Caseload SO	-0.350	0.727	-0.3 (n = 75)	0.3 (n = 60)

Notes. Means provided for raw CATSO score

The t-test results continue to indicate no statistically significant relationship between a mental health professional's length experience and attitude toward sex offenders. The final statistical analysis for research question two was done after removing all individuals from the sample that reported no experience in a specific category. The linear regression results are summarized in table 4.12.

Table 4.12

Professional Experiences with 0's Removed and CATSO Residuals Linear Regression

	p	R-square
Professional Experience Type		
Licensed Experience (n = 107)	0.855	0.000
SO Specific Credential (n = 9)	0.233	0.196
Percentage of SO Caseload (n = 60)	0.196	0.029

Notes. All participants with zero experience in a category removed

The results of the final three linear regression analyses for research question two indicate no statistically significant relationship between length of professional experiences and attitudes toward sex offenders. In summary, the current data do not

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support the idea that experience as measured in this study is associated with more positive attitudes toward sex offenders.

Research Question Three

Research question three proposed that there is a positive relationship between length of professional experiences in the counseling field and level of moral development as measured by the DIT-II N2 score. One of the foundational assumptions of Kohlberg's model of moral development is that an individual's moral reasoning can be impacted by experiential and educational interventions. As previously discussed by Viki et al. (2012), the placement of an individual into an out-group (sex offenders) creates a reduction in higher-level moral judgments by the in-group (non-sex offenders or mental health professionals). In addition, Fortney et al. (2009) found that professionals that work specifically with sex offender endorse fewer myths and have a more accurate understanding of the population. It is predicted that more experienced counselors would have achieved higher levels of moral reasoning and as a result would be less likely to derogate a sex offender to an out-group status.

For research question three, statistical analysis was conducted in three parts. The first analysis utilized linear regression with licensed experience, SO credentialed experience and percentage of SO caseload as the independent variables. The DIT-II N2 moral reasoning score was the dependent variable in research question three. Table 4.13 summarizes the results of the first set of linear regressions.

Table 4.13

Linear Regression of Professional Experiences and DIT-II N2 Residual Score

	M	Median	p	R-square
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Professional Experience Type				
Licensed Experience	74.9	38.0	0.411	0.005
SO Credentialed Experience	6.0	0	0.614	0.002
Percentage of SO Caseload	10.9%	0	0.693	0.001

Notes. Mean and median related to raw DIT-II N2 scores. A median of zero indicates that greater than 50% of participants indicated a response of zero in the category.

Results from the first set of linear regressions for research question three indicate no statistically significant relationship between length of professional experiences and level of moral development (N2 score). Next, t-tests were conducted to compare mental health professionals with and without experience in the three categories (Licensed Experiences, SO credentialed experience, percentage of SO caseload). The t-test results for research question three are summarized in table 4.14.

Table 4.14

Professional Experiences and DIT-II N2 Residuals t-tests

	t	p	M (No)	M (Yes)
Variable				
Licensed Experience	-0.764	0.104	37.8 (n = 28)	40.6 (n = 107)
Sex Offender Specific Credential	0.053	0.959	40.3 (n = 126)	35.8 (n = 9)
Sex Offender Percentage of Caseload	0.885	0.378	41.9 (n = 75)	37.6 (n = 60)

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Notes. DIT-II N2 raw scores shown in means

The t-tests for research question three continue to indicate no statistically significant relationship between mental health professionals length of professional experience and level of moral develop as measured by the DIT-II N2 score. The third statistical analysis for research question three involved removing all individuals that reported no experience in a specific category from the analysis. Results of the linear regression analysis are presented in table 4.15.

Table 4.15

Linear Regression for Professional Experience with 0's Removed and DIT-II N2

Residuals

	p	R-square
Professional Experience Type		
Licensed Experience (n = 107)	0.206	0.006
SO Credentialed Experience (n = 9)	0.060	0.418
Percentage of SO Caseload (n = 60)	0.871	0.000

The results of the final regression analysis for research question three indicate no findings of statistical significance between the length of reported professional experience and level of moral development. In summary, the collected data do not support the predictions of research question three. Results from all analyses (linear regression, t-test) indicate no relationship between mental health professional's length of professional experience and level of moral development.

Research Question Four

Research question four proposed that attitudes toward sex offenders have a positive relationship to sex offender specific training. Professionals with greater amounts of sex offender specific training are predicted to endorse more positive attitudes toward sex offenders as evidenced by lower CATSO scores. As previously discussed, age (Olver & Barlow, 2010) and educational level (Shackely et al., 2014) are positively related to more attitudes toward sex offenders. These research results support the hypothesis that greater amounts of sex offender specific training will have a positive impact on the attitudes of mental health professionals. Statistical analysis for research question four was conducted in three parts in a similar manner as described previously for research questions two and three. The first set of linear regressions utilized sex offender specific training (conference attendance, worksite training, self-directed training, continuing education, other training and total training) as the independent variable and CATSO total score as the dependent variable. Table 4.16 provides an overview of the results.

Table 4.16

Linear Regression for Sex Offender Specific Training and CATSO Residualized Score

	M	Median	p	R-square
Sex Offender Specific Training Type				
Conference Attendance	16.1	0.0	0.828	0.000
Work Site Training	35.8	0.0	0.753	0.001
Self-Directed Training	19.3	0.0	0.036	0.033

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Continuing Education	19.5	0.0	0.680	0.001
Other	5.6	0.0	0.951	0.000
Total Training	96.4	6.0	0.613	0.002

Notes. Mean and median are based on raw scores. A median of zero indicates that greater than 50% of participants indicated a response of zero in the category.

For conference attendance, work site training, continuing education, other training and total training no statistically significant relationship was found using the first set of linear regressions. A statistically significant relationship was found between self-directed training and CATSO total scores. The p-value was 0.036 and the R-square value was 0.033. This means that 3.3% of the variation in the CATSO score can be explained by self-directed training. Although this is a statistically significant relationship, the effect size is minimal. Next, t-tests were conducted to compare the CATSO scores of mental health professionals that reported training in the specific area against those that did not. The t-test results are summarized in Table 4.17.

Table 4.17

Training and CATSO Residual t-tests

	t	p	M (Yes)	M (No)
Variable				
Conference Attendance	-0.408	0.684	58.92 (n = 80)	61.1 (n = 55)
Work Site Training	-1.225	0.223	58.4 (n = 77)	61.6 (n = 58)
Self-Directed Training	0.127	0.899	59.2 (n = 77)	60.6 (n = 58)

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Continuing Education	0.155	0.877	59.7 (n = 76)	60.0 (n = 59)
Other	-0.470	0.641	59.6 (n = 112)	60.9 (n = 23)
Total Training	1.422	0.158	59.3 (n = 88)	60.7 (n = 47)

Notes. Raw scores are used for means.

The t-tests for research question four indicate no statistically significant relationship between the independent (sex offender specific training) and dependent variable (CATSO Score). The final statistical analysis for research question four was completed after removing all mental health professionals from the sample that reported no experience in the specific categories. The final linear regression results are summarized in Table 4.18.

Table 4.18

Training with 0's Removed and CATSO Residuals Linear Regression

	p	R-square
Professional Experience Type		
Conference Attendance	0.975	0.000
Work Site Training	0.423	0.012
Self-Directed Training	0.030	0.082
Continuing Education	0.677	0.008
Other Training	0.642	0.004

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Total Training	0.829	0.002
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The results from the final linear regression analysis indicate no statistically significant relationship between conference attendance, work site training, continuing education, other training and total training and the total CATSO score. Again, a statistically significant relationship was observed between self-directed training and CATSO scores. The p-value was 0.030 and the R-square value was 0.082. This means that 8.2% of the variation in the CATSO score can be explained by self-directed training.

Chapter Five: Discussion and Conclusions

Study Overview

With over 861,837 registered sex offenders reported by the Center for Missing and Exploited Children in 2016, the need for qualified mental health professionals to treat the population is high. The unique challenges of working with sex offenders are experienced by mental health professionals within the professional-personal dialectic (Lea et al., 1999; Viki et al., 2012). The media and other societal influences create negative attitudes toward sex offenders (Malinen, 2012), which foster conflicts related to attitudes and moral decision making by the mental health professional. Research indicates that educational and experiential interventions have the potential to impact the attitudes of community members and mental health professionals toward sex offenders. At this time, no unifying model exists to understand the development and maturation of mental health professionals' attitudes toward sex offenders. Kohlberg's model of moral development potentially offers a framework to understand factors that contribute to attitudes surrounding sex offenders.

In order to explore the potential relationship between mental health professionals' attitudes toward sex offenders and level of moral development, the current study examined the following research questions: (1) Is there a relationship between counselors' attitudes toward sex offenders and their level of moral development? (2) Is there a relationship between length of professional experiences in the counseling field and attitudes toward sex offenders? (3) Is there a relationship between length of

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professional experiences in the counseling field and level of moral development? (4) Are attitudes toward sex offenders related to sex offender-specific training?

Discussion of Research Findings

CATSO CFA Interpretation. The Community Attitudes Toward Sex Offender Scale has been widely used across the United States and is accepted as a valid measure of public attitudes toward sex offenders. The data collected in this study did not align with the four subscales identified by Church et al. (2008). In a review of the literature, many studies did not include a confirmatory factor analysis for the CATSO prior to utilizing the subcategories as part of outcome measures. As the current study indicates, in the absence of a CFA, interpretation of the CATSO subscales could be statistically invalid. It is recommended that future studies are conducted with an emphasis on the CATSO subscales and that when using the CATSO as an outcome measure CFA analysis is conducted prior to interpretation.

Research question one. Currently, there is limited research into the factors that contribute to and impact the attitudes of mental health professionals toward sex offenders. This dissertation was designed to explore the potential relationship between level of moral development and the attitudes of mental health professionals toward sex offenders. The total sample included 135 research participants comprised of counselors (n = 83), social workers (n = 32) and psychologists (n = 22). The mean DIT-2 N2 score for the study sample was 39.9 with a standard deviation of 16.8. This is comparable to the means reported by the DIT-II test developer's for professionals with a MS degree (n = 853) with a mean N2 score of 40.56 and standard deviation of 15.06 (Bebeau & Thoma, 2003). There is no statistically significant difference ($p = 0.649$) between the mean N2

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score obtained for participants in this study and reported means in the DIT-II manual for MS degree professionals.

This study employed a linear regression analysis and identified a statistically significant relationship between mental health professional's attitudes toward sex offenders as measured by the CATSO and their level of moral development measured by the DIT-II N2 score. Although a statistically significant relationship ($p = 0.002$) was found, the Pearson's R-squared value is 0.069. This low value means that only 6.9% of the variation in the scores of mental health professionals on the CATSO (attitudes to sex offenders) was explained by their level of moral development as measured by the DIT-II.

At the start of the study, it was anticipated that a stronger relationship would be found between the attitudes of mental health professionals and their level of moral development. Failure to find a strong explanatory relationship between the moral development of mental health professionals and their attitudes toward sex offenders suggests that moral development may be one of many factors in a larger system that informs the development of attitudes toward sex offenders by mental health professionals. Due to the low explanatory power found in this study, justification cannot be provided at this time for utilizing Kohlberg's model of moral development as a unifying framework to guide educational and experiential training interventions for mental health professionals. Instead, this study suggests that a mental health professional's level of moral development is one factor that contributes to their attitudes toward sex offenders.

Research question two. Research question two was designed to explore the potential relationship between mental health professionals' attitudes toward sex offenders

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and their length of professional experiences. As discussed in chapter one, both education and age are associated with less negative attitudes toward sex offenders (Olver & Barlow, 2010). In addition, Willis et al. (2013) found that exposure to or a relationship with a sex offender had a positive impact on attitudes toward the sex offender population. The combination of these research studies contributed to the prediction that master's level mental health professionals (higher education), with increasing amounts of experience (higher age) and greater levels of exposure to sex offenders (professional relationship) would endorse less negative attitudes toward sex offenders.

This relationship between length of professional experiences and attitudes toward sex offenders was measured by the CATSO (attitudes) and demographic questionnaire in the categories of (1) post master's degree experience, (2) licensed experience, (3) sex offender credentialed experience and (4) percent of caseload with sex offenders. The first statistical analysis for research question two was a linear regression using licensed experience, sex offender-credentialed experience and percent of caseload sex offender as the independent variables. No statistically significant relationships were observed. Next, a two-sample t-test was conducted for the same independent variables between those participants who reported experience in the category and those that did not. No statistically significant difference was found in the mean CATSO scores between the two groups. The final statistical analysis for research question two was a linear regression with those participants that reported no experience in the categories removed. This analysis again revealed no statistically significant relationship between the attitudes of mental health professionals toward sex offenders and length of experiences.

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Despite an initial expectation that there would be a relationship between length of professional experiences and attitude toward sex offenders none was found. Results indicated that as the length of license experience, sex offender credentialed experience and percentage of caseload with sex offenders increase, there were no statistically significant changes in observed attitudes toward sex offenders within the study population. This research study does not support previous findings that individuals with more education, older individuals and individuals with more exposure to sex offenders would exhibit more positive attitudes toward sex offenders. The result observed in this study could potentially be explained by the finding of Nelson et al. (2002) which indicated that counselors endorse less negative attitudes toward sex offenders than the general public and other professionals. Although previous research has found differences when comparing among populations, the current research study included only mental health professionals and no significant relationship could be found related to length of professional experiences and attitudes toward sex offenders. Since counselors endorse less negative attitudes toward sex offenders these attitudes may not be readily changed by greater lengths of professionals' experience in the mental health field.

Research question three. Research question three and the accompanying statistical methods were designed to explore the potential relationship between the length of mental health professional's experiences and level of moral development as measured by the DIT-II N2 score. As previously discussed by Viki et al. (2012), there are moral components to the out-group derogation of sex offenders. These authors go on to say that this type of moral decision-making contributes to the dehumanization and a reduction in moral emotions toward the out-group (sex offenders). Passini (2014) found that this

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pattern of moral decision making towards an out-group was evident in his sample and contributed to both negative attitudes and harsh treatment. Kohlberg's model of moral development argues that moral stages are not fixed. As people develop new moral structures, they transform and replace the old structures (Krebs & Denton, 2005). Both the American Counseling Association and Association for the Treatment of Sexual Abusers place an emphasis on appropriate professional ethical decision making toward clients (sex offenders). Detert, Trevino & Sweitzer (2008) found that "moral disengagement is positively related to unethical decision making". This dissertation research study hypothesized that there would be a positive relationship between the length of professional experiences and a mental health professional's level of moral development.

For research question three, moral development was measured by the DIT-II N2 score and statistical processes that parallel those used for hypothesis two. The results for research question three indicate no significant relationship between length of professional experiences and level of moral development. Study outcomes do not support the initial hypothesis that as mental health professional gain additional experiences their level of moral development would increase. This result could potentially be explained because there is inadequate (1) mental health professionals are evaluated as having higher levels of moral development which are potentially less likely to change over time or (1) there simply is no relationship between the length of professional experiences and a mental health professional's level of moral development.

Research question four. Research question four utilizes the CATSO and information collected from the study's demographic questionnaire to explore the potential

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relationship between mental health professionals' attitudes toward sex offenders and sex offender specific training. As previously discussed, Lea et al. (1999) describe the complicated relationship between the mental health provider and sex offenders within the professional-personal dialectic. In the Lea et al., study it is recommended that professionals working with sex offenders receive "adequate training and ongoing support". In addition, ongoing research links the positive attitudes of mental health professionals with more productive treatment outcomes (Harkins & Beech, 2007; Andrews, 2004), which, in turn, should inform training interventions. Furthermore, a general shift within the field of sex offender treatment has been a movement to more positive treatment approaches, language and perspectives (Fernandez, 2006). The results of these research studies and changes within the field support the prediction that as mental health professionals receive more sex offender specific training their attitudes toward the sex offender population should improve.

The research methodology for research question four parallels research questions two and three. This includes conducting a linear regression followed by a two-sample t-test to explore differences in means and then a final linear regression with the participants reporting no training in a category removed. For the first set of linear regressions, no significant relationship was found between amounts of conference attendance, work site training, continuing education, other training and total training. However, a significant relationship was found between self-directed training (training undertaken outside of the work place or other professional obligations) and the attitudes of mental health professionals toward sex offenders. A p-value of 0.036 and Pearson R-square value of 0.033 were found. These indicate a statistically significant relationship with low

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explanatory power. Approximately 3.6% of the variation in attitudes towards sex offenders as measured by the CATSO can be explained by the reported amount of self-directed training. This could suggest that mental health professionals that independently seek additional knowledge (self-directed training) about the sex offender population have more positive attitudes than their peers that do less or no self-directed training on the population.

Critique and Limitations

This dissertation research was designed to explore the potential relationship between level of moral development and the attitudes of mental health professionals toward sex offenders. If a stronger relationship had been observed, Kohlberg's model of moral development could have offered a potential guiding framework for developing effective educational and experiential interventions to support more positive attitudes toward sex offenders by mental health professionals. Identified research limitations for this study fall within the categories of data collection, instruments, participants and general research limitations.

Data collection. The original method of data collection that was identified for this study utilized both the Qualtrics survey platform (survey) and Qualtrics data collection services (sampling). As data collection progressed, it became evident that the necessary sample size would not be achieved solely by utilizing Qualtrics data collection services. The researcher identified several other methods of recruiting participants such as soliciting on listservs (cesnet), at professional conferences (North Carolina Counseling Association Conference 2019) and within local agencies. The combination of these efforts led to a final sample of 135 participants which included 79 from the Qualtrics data

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collection panel and 56 from other recruitment methods. All participants completed identical Qualtrics online surveys regardless of recruitment method.

No obvious procedural differences could be identified between the Qualtrics and non-Qualtrics portions of the sample that would justify separate analysis. However, statistically significant differences were evident. These differences are outlined in Table 4.6 and include percentage of caseload with sex offenders, conference attendance, worksite training, self-directed training, continuing education, total training, CATSO, Marlowe-Crowne SDS and DIT-II N2 score. In addition, the researcher noted that a higher proportion of participants from the Qualtrics data collection panel were excluded from the final sample due to aberrant response patterns. The statically significant differences between the two groups and increased frequency of aberrant responses validate the inclusion of sampling as one of the study limitations.

The length of the final research survey has also been identified as a study limitation. At the onset of the study, the goal was to obtain the entire sample from the Qualtrics research panel (paid incentive). As a result, reduced emphasis was placed on limiting the overall length of the survey to minimize participant fatigue. The final survey included a demographic questionnaire (estimated time 5 minutes), Community Attitudes Toward Sex Offender Scale (5 or more minutes), Defining Issues Test-II (45 minutes) and Marlowe-Crowne Short-Form (5 or more minutes) which when combined required approximately 60 to complete. On average the 135 participates took approximately 44 minutes to complete the survey in its entirety. This time may have resulted in a potential loss of subjects and reduction in representation by some groups.

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Instruments. Several critiques have been identified within the instruments used for this research project. The first critique can be found within the demographic questionnaire which asked research participants to identify their post-master's degree experiences. When evaluating survey results, it was evident that the questions related to post-master's degree experience and licensed experiences promoted responses that could not be generalized between states and professional groups. The variations in response patterns were likely due to differences in mental health licensure standards among states. For example, several states provide preliminary licensure to master's level professionals immediately after graduation while other states require a residency prior to licensure. In addition, differences in licensure standards exist between professional counselors, social workers and psychologists. Overall, the question did not adequately specify the request for years and months of experiences pre- and post-licensure in a manner that could be consistently interpreted. To address this limitation all participants that reported no experience as a licensed mental health professional were included in the final analysis as having zero experience. As a result, the final sample was not able to include accurate variations within the subset of mental health professionals that had not yet received licensure. This potential source of error variance could have reduced the likelihood of finding significant results.

The second limitation within the demographic survey was found in the interpretation of participants related to training-specific questions. Each participant was asked about the amount of training they received within the categories of conference attendance, work site training, self-directed training, continuing education and other training. Although these categories were thought to be distinct and self-explanatory; the

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results indicate potential differences in interpretation. Also, it is unclear whether participants thought of the categories as distinct and mutually exclusive as intended by the researcher.

The final limitation within the survey instruments was the finding with the CFA that the CATSO subscales do not validated. Confirmatory factor analysis was conducted on the CATSO using this research sample. The results indicate that the subcategories of social isolation (factor 1), capacity to change (factor 2), severity/dangerousness (factor 3) and deviancy (factor 4) did not fit the model outlined by Church et al. (2008). As a result, the CATSO subcategories were not utilized within the final analysis and the CATSO total score was used as the measure of mental health professional's attitudes toward sex offenders.

Participants. Within the participants for this study, limitations related to racial/ethnic diversity, number of certified sex offender treatment providers and training questions were identified. The sample consisted for 135 participants and included 108 that self-identified as white and 27 that identified as non-white ethnic/racial groups. The final sample was collapsed into white and non-white categories for statistical analysis. Overall, the sample is not representative of all racial/ethnic groups and sexual minorities.

The final sample included a total of nine mental health professionals with credentialed experience specific to work with sex offenders. Research question two investigated the potential relationship between the experience of mental health professionals and their attitudes toward sex offenders. The limited number of mental health professionals with sex offender specific credentialing clearly impacted the power of the statistical analysis and is identified as a study limitation.

Implications of Findings

The overall goal of the study was to explore the potential relationship between a mental health professional's level of moral development (DIT-II N2) and attitude toward sex offenders (CATSO). This study does provide statistically significant evidence that mental health professionals with higher levels of moral development endorse less negative attitudes toward sex offenders as measured by the CATSO. Although there is a relationship between these two variables, the results of the linear regression analysis indicate that only 6.9% of the variation in CATSO scores can be explained by the DIT-II N2 scores. Given the statistically significant result but low explanatory power observed in the study, future research should be conducted which takes steps to address the limitations of the current study. It is recommended that future researchers obtain a larger sample that includes a greater representation of mental health professionals with sex offender-specific credentialing. In addition, future research should consider incorporating additional or alternative assessments of attitudes toward sex offenders.

This study does not establish a statistically significant relationship between the lengths of the mental health professional's experiences and their attitudes toward sex offenders. Additionally, there is no established relationship between a mental health professional's level of moral development and experiences in the field. These findings do not appear to be congruent with previous research that support an increase in both less negative attitudes toward sex offenders and increased moral development related to age and educational level. Previous research has also found that quality contact with a sex offender reduces myths and negative attitudes toward the population. It is recommended that future research be designed to further explore and explain these findings. These

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dissertation results indicate that experience and exposure alone do not have a positive impact on the attitudes of mental health professionals toward sex offenders as measured by the CATSO. One application of these findings is that mental health and agency supervisors may want to consider that the impact of experience and training alone does not translate into less negative attitudes toward sex offenders and does not increase moral development.

The amount of training reported by a mental health professional was also hypothesized to have a positive relationship with attitudes toward sex offenders. No significant relationship was found between amount of conference attendance, work site training, continuing education, other training and total training. In contrast, a significant relationship was established between self-directed training and attitudes toward sex offenders. This result, in combination with the low number of professionals with sex offender specific credentialing, indicates a need for future research. Additional studies should be conducted that explore further the potential relationship between mental health professionals that demonstrate self-directed interest in learning about sex offenders in contrast to their peers that do not. For example, there may be a difference between mental health professionals who attend a sex offender conference to complete mandatory continuing education requirements and those who independently participate in self-directed training or study of sex offenders. One of the differences between conference or worksite training and self-directed training is the required vs. optional formats.

Conclusion

The professional values outlined in the preamble of the American Counseling Association's code of ethics emphasize the importance of "safeguarding the integrity of

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the counselor-client relationship” (ACA, 2014). The professional-personal dialectic identified by Lea et al., (1999) highlights the complex experiences of mental health professionals that are required to work with sex offenders but may have a personal desire not to do so. While there is an ongoing effort in the field to research improved strategies for treating sex offenders limited study has been conducted on how the attitudes of mental health professionals impact outcomes and even less research has been designed to understand the development of treatment provider attitudes toward sex offenders. This dissertation research study does establish a relationship between a counselor’s level of moral development, participation in self-directed training and their attitudes toward sex offenders, but the explanatory value is low. It is clear that the attitudes of mental health professionals towards their clients do impact treatment outcomes, but limited research has been conducted on identifying a guiding theoretical framework to inform educational or experiential training for mental health professionals that work with the sex offender population. Enhancing the attitudes of mental health professionals toward sex offenders is not only important because it has the potential to improve treatment outcomes but also it may reduce the societal impact by reducing the prevalence of future sex abuse.

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Appendix A:

Informed Consent

Consent Form for Online Research Survey

You are invited to participate in a web-based online survey on exploring mental health professionals attitudes toward sex offenders. This is a research project being conducted by Ben Newman, LPC, a doctoral candidate at the College of William & Mary. The survey should take approximately 30 minutes to complete.

PARTICIPATION: Your participation in this survey is voluntary. You may refuse to take part in the research or exit the survey at any time without penalty.

BENEFITS: You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about mental health professionals attitudes toward sex offenders.

RISKS: There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life.

CONFIDENTIALITY: Your survey answers will be collected within Qualtrics where data will be stored in a password protected electronic format. Qualtrics does not collect identifying information such as your name, email address, or IP address. Therefore, your responses will remain anonymous. No one will be able to identify you or your answers, and no one will know whether or not you participated in the study.

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CONTACT INFORMATION:

If you have questions at any time about the study or the procedures, you may contact my research supervisor, Dr. Rick Gressard via phone at (757) 221 - 2352 or via email at cfgres@wm.edu.

If you feel you have not been treated according to the descriptions in this form, or that your rights as a participant in research have not been honored during the course of this project, or you have any questions, concerns, or complaints that you wish to address to someone other than the investigator, you may contact the College of William & Mary Institutional Review Board at 301 Monticello Ave, Williamsburg, VA 23185 or email tjward@wm.edu.

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Appendix B:

Demographic Questionnaire

1. Gender:

- a. Female
- b. Male
- c. Non-binary/Third Gender
- d. Prefer to self-describe:
- e. Prefer not to say

2. Age:

3. Race or Ethnicity (Please select multiple options as appropriate) (only to describe): National Census (Double check)

- a. African-American/Black – not of Hispanic Origin (A person having origins in any of the black racial groups of Africa. Does not include persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish cultures or origins – see Hispanic)
- b. American Indian or Alaska Native (A person having origins in any of the original people of North American, and who maintains cultural identification through community recognition or tribal affiliation)
- c. Asian (A person having origins in any of the original peoples of the Far East, South Asia, the Indian Subcontinent, or the pacific islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands and Samoa.)
- d. Hispanic, Latino, or Spanish (A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish cultures or origins.)
- e. Middle Eastern

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- f. Native Hawaiian or Other Pacific Islander
- g. White, not of Hispanic origin (A person having origins in any of the original peoples of Europe, North Africa, or the Middle East. Does not include persons from Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish cultures or origins)
- h. Other Race or Ethnicity: _____
- 4. Years of general experience post-master's?
- 5. Years of experience as a licensed mental health professional:
 - a. Free Response question (less than 1 year and up to 100)
- 6. Do you have credentialing specific to working with the sex offender population?
- 7. What percentage of your caseload in the five years has been specifically with sex offenders?
- 8. Please provide a summary of the training experience you have received specific to working with the sex offender population (Units of Hours):
 - a. Conference Attendance
 - b. Worksite Training
 - c. Self-Directed Training (reading, etc.)
 - d. Continuing Education

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Appendix C:

Community Attitudes Toward Sex Offenders-R (CATSO-R)

Items and Scoring

Directions: Below are 18 statements about sex offenders and sex offenses. Please select the corresponding number from the rating scale given below for the answer that best describes the way you feel or what you believe. Most of the statements below are difficult to prove or verify in an absolute sense, and many are specifically about your opinion based on what you may have heard, read, or learned; thus, we are less interested in the “right” or “wrong” answers, and more interested in your beliefs and opinions regarding sex offenders. Even if you have no general knowledge about the issue, please provide an answer to each question.

Strongly Disagree	Disagree	Probably Disagree	Probably Agree	Agree	Strongly Agree
1	2	3	4	5	6

1. With support and therapy, someone who committed a sexual offense can learn to change their behavior.
2. People who commit sex offenses should lose their civil rights (e.g. voting and privacy).
3. People who commit sex offenses want to have sex more often than the average person.
4. Male sex offenders should be punished more severely than female sex offenders.
5. A lot of sex offenders use their victims to create pornography.
6. Sex offenders prefer to stay home alone rather than be around lots of people.

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7. Most sex offenders do not have close friends.
8. Sex offenders have difficulty making friends even if they try real hard.
9. The prison sentences sex offenders receive are much too long when compared to the sentence lengths for other crimes.
10. Sex offenders have high rates of sexual activity.
11. Trying to rehabilitate a sex offender is a waste of time.
12. Sex offenders should wear tracking devices so their location can be pinpointed at any time.
13. Only a few sex offenders are dangerous.
14. Most sex offenders are unmarried men.
15. Someone who uses emotional control when committing a sex offense is not as bad as someone who uses physical control when committing a sex offense.
16. Most sex offenders keep to themselves.
17. A sex offense committed against someone the perpetrator knows is less serious than a sex offense committed against a stranger.
18. Convicted sex offenders should never be released from prison.

Factor 1 (Social Isolation): 6, 7, 8, 14, 16

Factor 2 (Capacity to Change): 1*, 2, 11, 12, 18

Factor 3 (Severity/Dangerousness): 4*, 9*, 13*, 15*, 17*

Factor 4 (Deviancy): 3, 5, 10

* these items must be reverse scored when computing factor scores

Add all 4 factors together to get a total score; higher scores represent more negative attitudes.

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Appendix D:

Marlowe-Crowne Social Desirability Scale

1. It is sometimes hard for me to go on with my work if I am not encouraged. True
False
2. I sometimes feel resentful when I don't get my own way. True False
3. On a few occasions, I have given up doing something because I thought too little of my ability. True False
4. There have been times when I felt like rebelling against people in authority even though I knew they were right. True False
5. No matter who I'm talking to, I'm always a good listener. True False
6. There have been occasions when I took advantage of someone. True False
7. I'm always willing to admit it when I make a mistake. True False
8. I sometimes try to get even, rather than forgive and forget. True False
9. I am always courteous, even to people who are disagreeable. True False
10. I have never been irked when people expressed ideas very different from my own. True False
11. There have been times when I was quite jealous of the good fortunes of others.
True False
12. I am sometimes irritated by people who ask favors of me. True False
13. I have never deliberately said something that hurt someone's feelings.
True False

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Professional Experience

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