ABSTRACT

The Effect of Brief Sex Offender Training on the Graduate Counseling Students' Scores on the Discrete Emotions Questionnaire and Working Alliance Inventory

By

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Clinicians who treat sex offenders commonly struggle with the tension between conceptualizing them as rehabilitative or instinctively predatory. On the one hand, there is the well-intended goal of forming an alliance with the offender and helping them develop into more functional human beings. On the other, counselors experience common emotional reactions such as anger, disgust, and even fear of sex offenders that negatively impact their perceptions and attitudes. Forensic clinicians are trained to treat sex offenders; however, with the continuing trend of treating more sex offenders in the community rather than in the prison system, some community clinicians will inevitably counsel sex offenders after they are released into the general public. Despite the presence of comorbid and treatable psychiatric symptoms, the disturbing crimes committed by sex offenders can make them morally intolerable to some counselors. In these circumstances, there is little guidance to help clinicians carry out their treatment duties competently and ethically. Participants in this study were graduate counseling students. The graduate counseling students were divided into two groups and asked to examine and evaluate a Tier I sex offense. Next, the participants completed the DEQ, which documents the participant's emotional reaction to the offense. Afterward, they completed the WAI-SRT as a

pretest that assessed their confidence in establishing a relationship with the offender. A 45-minute sex offender training intervention (independent variable) was given to one group and no training to the other. After the training, each group examined and evaluated a Tier III sex offense. The DEQ and WAI-SRT post-tests (dependent variables) were given to each group to compare the change over time between the training-treatment and the no training-control groups.

THE EFFECT OF BRIEF SEX OFFENDER TRAINING ON THE GRADUATE COUNSELING STUDENTS' SCORES ON THE DISCRETE EMOTIONS QUESTIONNAIRE AND WORKING ALLIANCE INVENTORY

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

Introduction to the Study

Over the past twenty years, the need for sex offender treatment has increased in the United States. In 2016, the National Center for Missing & Exploited Children (NCMEC, 2019) reported that there were 859,500 registered sex offenders in the United States, increasing from about 600,000 in 2006 when the count was initially taken. Each year over 31% of the offenders convicted of a sex crime are released from prison (Levenson & Tewksbury, 2009). A rise in sex crimes has increased public awareness and concern about sexual violence (Nelson, 2007). Despite improved sex offender policies and treatment, the general public lacks leniency toward sex offenders and often condemns them for life (Valliant, Furac, & Antonowicz, 1994). The American criminal justice system has increasingly mandated that sex offenders be treated in outpatient settings rather than by incarceration alone (Barnard, Fuller, Robbins, & Shaw, 1989).

Consequently, more sex offenders receive treatment in their communities from counselors who work in community agencies and other outpatient facilities. Novice counselors are not mentally or clinically prepared to treat the offenders released. Sex offender treatment challenges counselors to adopt attitudes and perceptions about sex offenders that are therapeutic and objective. Without informative sex offender training, counselors will perpetuate countertransferential attitudes that undermine the therapeutic process (Polson & McCullom, 1995). Counselors' attitudes and perceptions about sex offenders can influence whether they view sex offenders as criminals needing punishment versus clients needing counseling (Nelson, 2002). Nelson, Herlihy, and Oescher (2002) believed that counseling professionals require specific training and knowledge to ensure the delivery of services efficiently and successfully to sex offenders. Research has not adequately explored whether training would encourage more

counselors to consider sex offender counseling as a professional mainstay. This discussion demonstrates the need for curricula that widens graduate-level counseling students' scope as it pertains to treating sex offenders. Cognitive dissonance and the working alliance have not been explored in graduate counseling students. This study will examine the effect of a 45-minute sex offender training on graduate counseling students as measured by the Working Alliance Inventory and Discrete Emotional Questionnaire.

Background to the Study

Counseling and evaluating sex offenders is an imperative mandate intended to reduce recidivism, promote safer communities, and provide adequate resources upon offender transition back into society (Olver & Wong, 2013). Counselors who emphasize a nurturing and supportive attitude exhibit warmth and empathy, collaborate better with the client and will have better working alliances (Marshall, 2005). Craig (2005) believes that the attitudes of working professionals towards sex offenders can have a positive influence on the working alliance. Regardless of the purpose of treatment, a positive working alliance between the client and counselor contributes approximately 30% to patients' improvements in counseling (Lambert & Barley, 2001). Furthermore, when counseling professionals have negative attitudes towards sex offenders, the treatment or working alliance can be ineffectual (Leist & Dadds, 2009). As such, research that examines the sex offender counselor's attitude toward the working alliance is sparse. This study has the potential to demonstrate that when a counselor's attitude towards the sex offender becomes more impartial, the working alliance becomes more perceptible.

Sex offenders do not fit precisely into one category and may require an array of treatment options based on their specific needs (Levenson et al., 2017). The overall aim of sex offender counseling is to assist sex offenders with self-management skills while avoiding triggers that

increase their risk of re-offending (Schneider & Wright, 2004). Counselors need specialized training and knowledge to provide services effectively to the sex offender population (O'Connell, Leberg, & Donaldson, 1990). Nelson, Herlihy, and Oescher (2002) recommended that providers possess familiarity with sexual deviancy and victimization issues and knowledge of the criminal justice system. Essential skills and attributes also include confrontation skills; community safety; coping with stress, discussing sexual matters openly, maintaining objectivity, and remaining realistic about sex offenders and their potential for re-offense (Nelson, Herlihy, & Oescher, 2002). Specialized sex offender programs involve focused treatment, collaborative case management, supervision, and detailed monitoring of an antagonized target population (Barabas, 2007).

History of sex offender counseling

Counseling is a relatively new component of sex offender treatment. In the 1950s, treatment involved the use of phallometric devices that monitored sex offender arousal and paired it with unpleasant stimuli or electrical shock to counter-condition the responses (Manejwala, 2016; Marshalls & Laws, 2003). Surgical castration was a treatment method for thousands of years and was once a punishment for sex offenders. Eventually, surgical castration evolved into chemical castration in the 1960s using pharmacological drugs to reduce sex offender libido (Douglas et al., 2013; Marshall & Laws, 2003). Several theorists, including Thorndike, Pavlov, Watson, Tolman, and Kinsey, were influential in the current movement that combines cognitive and behavior therapy techniques used today to treat sex offenders (Manejwala, 2016). Current sex offender programs are based on various methods, with cognitive behavior therapy becoming increasingly popular over the last three decades (Dolan, 2009). The therapeutic relationship became the central focus of sex offender treatment in the 1960s, and the

1970s involved micro-processing with sex offenders (Ardito & Rabellino, 2011). More cognitive and behavioral therapies were developed and integrated into psychotherapeutic interventions with sex offenders over the years.

The acknowledgment of sexual violence as a significant social problem emerged during the 1960s and 1970s. That emergence was primarily due to the anti-rape and feminist movements (McMahon & Baker, 2011). The feminist movement of the 1970s focused on holding the perpetrator responsible. In the 1980s, media attention focused on 'acquaintance rape,' which was happening across many college campuses (McMahon & Baker, 2011). Research shows that victim-blaming still exists; however, perceptions that victims asked for it due to their actions are diminishing, and more towards men need to be held accountable for their actions and control their sexual impulses (Dumont et al., 2003).

While there is significant evidence that therapeutic modalities are effective with most criminal populations, sex offender treatment has mostly failed to reduce recidivism rates and marginally produced positive treatment outcomes. The counselor's attitudes and perceptions are essential factors to consider in providing effective therapy because those attitudes adversely influence the treatment outcome (Ackerman & Hilsenroth, 2003). Negative attitudes held by working professionals can drastically weaken treatment effectiveness. According to Grady and Strom-Gottfried (2011), providing services to stigmatized populations can produce difficult obstacles for working professionals when negative attitudes held by the worker, or the community, endanger effective practice. Furthermore, the lack of counselor knowledge and training regarding sex offenses weighs heavily on the attitudes of professionals when working with sexual offenders (Newman, 2020). Consequently, those attitudes influence a counselor's

ability to form the working alliance, hindering the positive outcome that often results from the alliance.

Sex offender counseling and the working alliance

Working with sex offenders is demanding and intensive work for both the client and counselor (Barabas, 2007). Training objectives that address the working alliance will help counselors navigate these types of situations while providing effective treatment to sex offenders (Dolan, 2009). Counselors must understand the dynamics of the therapeutic alliance regarding tasks, goals, and bonds, as described by Bordin in the process of treatment (1979). Counselors must also assess the client's way of thinking, feeling, and acting, while understanding stressors, frustrations, and dissatisfactions he or she may experience (Macewan, 2008). Counselors who emphasize a nurturing and supportive attitude, exhibit warmth and empathy, and collaborate better with clients will have better working alliances (Marshall, 2005).

The challenge for counselors is to manage, process, and navigate through emotional reactions to clients while forming the working alliance (Kernberg, Selzer, Keonigsberg, Carr, & Appelbaum, 1989). In a supportive emotional climate, clients frequently experience both a sense of being deeply understood and a diminishment of psychological threat, producing improved treatment outcomes (Myers, 2000). The interactions between counselors and clients influence relational growth in a mutually beneficial way. Within the working alliance, as in all relationships, relational functioning mutually affects and is influenced by interpersonal transactions (Talley, Strupp, & Morey, 1990).

The working alliance is a complex system encompassing both client and counselor interpersonal styles. Counselor attitudes have important implications for service delivery, including influencing the quality of care, staff selection, choice of intervention, and quality of the

counseling relationship. Empathy, unconditional positive regard, and genuineness, all needed to establish the working alliance, have been determined to be the main contributors to positive treatment outcomes (Orlinsky, Grawe, & Parks, 1994). Counselors who perceive sex offenders negatively cannot establish empathy, unconditional positive regard, and genuineness, which mitigates the formation of a working alliance and leads to ineffective treatment. When effective, the working alliance facilitates safety, exploration of emotions, and a relationship in which clients' issues are defined and addressed effectively (Erdur et al., 2000).

Furthermore, this implies that training may change the counselor's negative perception allowing the active formation of the working alliance, thus positively impacting treatment outcomes (Hovarth & Greenberg, 1994). Due to negative counselor perceptions and a lack of sex offender-specific training for counselors, sex offenders experience far more significant difficulties seeking treatment (Nelson, Herlihy, & Oescher, 2002). Wodarski and Whitaker (1989) asserted that sex offenders are viewed from a completely different and more negative perspective than any other group of clients served in community mental health settings. Therefore, counselors need specialized training and knowledge to provide services effectively to overcome the perceptual and attitudinal biases that may contribute to the difficulty of treating sex offenders (O'Connell, Leberg, & Donaldson, 1990). This study explains the link between sex offender training and the perceptions of counseling graduate students.

Conceptual Underpinnings for the Study

The theoretical framework that guides this study is Festinger's (1957) cognitive dissonance theory (CDT). Cognitive dissonance theory is commonly used to explain attitude changes from a social psychology standpoint (Cacioppo, Petty, & Crites, 1994). Festinger (1957) explained that when new cognitions are congruent with existing cognitions, an individual

experiences cognitive consonance. Conversely, a cognitive discrepancy occurs when the new cognitions are incongruent with current cognitions (Tsang, 2017). This cognitive discrepancy leads to cognitive dissonance, which is the psychological discomfort resulting from newly acquired information that contradicts current beliefs and attitudes (Tsang, 2017). For example, cognitive dissonance could occur when students are presented with information that contradicts their current beliefs, attitudes, and behaviors (Harmon-Jones & Mills, 2019). When individuals experience cognitive dissonance, they are motivated to decrease the dissonance by changing their attitudes, beliefs, or behaviors to align with new cognitions (Harmon-Jones & Mills, 2019).

Cognitive dissonance theory recognizes that behaviors and attitudes stem from cognitions and that learning (new cognitions) can effectively change attitudes and behaviors. The cognitive dissonance theory helps explain how counselors' negative perceptions about sex offenders can cause conflict between their need to be objective and their attitude toward this population. Cognitive dissonance theory also describes how training about sex offenders' mental health needs could create the cognitive dissonance needed to help change counselors' attitudes toward this population, thereby increasing counselors' willingness to work with sex offenders.

Statement of the Problem

When released from prison, sex offenders return to the community in need of efficacious community-based treatment that reduces recidivism rates (Kersting, 2003), and provides comprehensive supervision that promotes seamless community reintegration for the offender (Schmucker & Lösel, 2008). Instead of incarceration, community-based intervention strategies for sex offending behaviors have become increasingly prevalent over the past twenty years (Lobanov-Rostovsky, 2010). To prevent overcrowding of prisons, the courts have frequently

chosen to suspend the imprisonment of convicted sex offenders in favor of community-based supervision and participation in counseling programs (McGrath et al., 2007).

For treatment, sex offenders are often referred to state-approved psychologists or clinical social workers. However, private therapists regularly exercise the discretion of refusing high-risk patients (Dockterman, 2018). In 2008, the Safer Society survey (McGrath et al., 2010), found that 53,811 sex offenders required community treatment upon their release from prison, yet only 1,307 sex offender-specific treatment programs were operating in the United States. Based on this study and 2008 statistics from the National Center for Missing & Exploited Children, more than 600,000 sex offenders lived in the community in 2008; roughly 91% of sex offenders living in the community did not receive treatment. Between 10,000 and 20,000 sex offenders have been released to the community each year (CSOM, 2016) for the past five years. With over 800,000 sexual offenders registered in local, state, and federal databases in the United States (NCMEC, 2018) and 2,350 counselors across the nation who provide court-mandated sex offender treatment (Dockterman, 2018), there are not nearly enough counselors or treatment programs to accommodate the needs of this population. Even with improvements in availability and accessibility to sex offender treatment, recidivism rates remain high, and counseling services continue to be underutilized (Levenson et al., 2017).

Counselors with negative perceptions about sex offenders will be less motivated to work with these clients (Bach & Demuth, 2018; Paul & Paul, 2016), limiting the treatment options for sex offenders. Giordano and Cashwell (2018) contended that mental health professionals' lack of training about deviant sexual behaviors might be a barrier to providing effective services. Furthermore, recent research findings revealed that counselors who were apprehensive about working with sex offenders felt that they did not have enough knowledge about the population to

treat them effectively (Bach & Demuth, 2018; Morgan, McClendon, McCarty, & Zinck, 2016; Paul & Paul, 2016). According to Rosselli and Jeglic (2017), training can be used as a vehicle for changing perceptions and attitudes and providing new perspectives through learning. However, while searching the literature, no research was found to address or explore specific training for counselors about sex offenders to reduce misconceptions and encourage positive perceptions.

The influence of specific training about sex offenders on emerging counselors' perceptions of sex offenders is currently unclear. Likewise, researchers have little information about a training program's effect on the motivation of emerging counselors to work with sex offenders. However, counselors who gain knowledge about sex offenders through formal training will be more likely to form perceptions and make decisions based on critical and logical thinking rather than viewpoints portrayed in society and the media (McCartan, Kemshall, & Tabachnick, 2015; Rosselli & Jeglic, 2017).

Purpose of the Study

The purpose of this split-plot ANOVA design study is to determine if a training program changes graduate counseling students' attitudes and perceptions about sex offenders as measured by the WAI-SRT and DEQ.

Research Questions

Based on the research problem and gap in the literature, this study examined the following research questions:

RQ1: How does a 45-minute sex offender training for counseling graduate students influence their scores on the Working Alliance Inventory – Short Revised Therapist (WAI-SRT)?

RQ2: How does a 45-minute sex offender training for counseling graduate students influence their scores on the Discrete Emotional Questionnaire (DEQ)?

Significance of the Study

Managing sex offenders effectively once they reenter society is among the top priorities of lawmakers and their constituents (Center for Sex Offender Management, 2010). When offenders are mistakenly categorized in the same group, society views the entire group as a danger to society when only a small number are violent offenders (Duncan, 2009). The stigmatization that comes with a sex offender label, no matter the level of severity of the crime, creates a barrier for these individuals in society (Schultz, 2014). Sex offenders often are ostracized from society, stigmatized, and labeled as deviants, immoral, and evil (Schultz, 2014).

Societal stigma and misconceptions about sex offenders are pervasive and apparent; however, because counselors are expected to be objective, they conceal their attitudes and perceptions about sex offenders (Barabas, 2007). Counselors' perceptions and attitudes toward sex offenders are related to their experience, training, and personal characteristics (Craig, 2007; Hatcher & Noakes, 2010; Lea, Auburn, & Kibblewhite, 1999). Sex offender training emphasizing the critical elements of the working alliance (empathy, unconditional positive regard, and genuineness) might change the counselor's perception of sex offenders enough to encourage objectivity (Nelson, Herlihy, & Oescher, 2002). If sex offender training improves the working alliance, training could become instrumental in developing objective professionals in graduate programs. The implication is that counselors could benefit from training that confronts stereotypes and myths about sex offenders. Training could also explore the counselors' discrete emotions that create obstacles to effective treatment (Schneider & Wright, 2004). Due to scarce research on how sex offender training impacts the discrete emotions and working alliance

objectivity of counseling students, the results of this study will provide insight into how sex offender training can influence graduate counseling students.

Definitions of Key Terms

Cognitive dissonance theory. This theory suggests that "individuals who encounter a counter-attitudinal cognition or cognition that goes against their previous decision will experience some sort of psychological discomfort," and thus, are motivated to change their attitudes and behaviors to align with their cognitions (Tsang, 2017, p. 3).

Recidivism. Recidivism refers to the tendency for individuals convicted of a crime to re-offend after incarceration or treatment (Rosselli & Jeglic, 2017).

Sex offender. A sex offender is an individual who has committed a sex crime that is sexual or violated a sexually categorized law (Patterson & Graham, 2018).

Therapeutic alliance. The therapeutic alliance is defined as "a reality-based collaboration between patient and therapist," where the relationship consists of three core elements: congruence, empathy, and unconditional positive regard (Ardito & Rebellino, 2011, p. 2).

Summary

Counselor attitudes have important implications for service delivery, including impact on the quality of care, staff selection, choice of intervention, and quality of the counseling relationship. Empathy, unconditional positive regard, and genuineness, all needed to establish the working alliance, have been determined to be the main contributors to positive treatment outcomes (Orlinsky et al., 1994). Counselors who perceive sex offenders negatively are unable to establish empathy, unconditional positive regard, and genuineness, which mitigates the formation of a working alliance and leads to ineffective treatment. When effective, the working

alliance facilitates safety, exploration of emotions, and a relationship in which clients' issues are defined and addressed effectively (Erdur & Rude, 2000).

Although a counselor may have negative attitudes and beliefs about sex offenders, their profession requires empathy, unconditional positive regard, and genuineness when treating this population. Cognitive dissonance theory implies that counselors must regulate unpleasant emotions and display unbiased behavior despite their negative attitudes or perceptions about sex offenders. The implication is that sex offender training designed to decrease the cognitive dissonance of counselors can change their discrete emotions toward this target population and improve the working alliance (Hovarth & Greenberg, 1994). The inadequate number of sex offender counselors in the community limits sex offender treatment options (Nelson et al., 2002). Wodarski and Whitaker (1989) asserted that sex offenders are viewed from a completely different and more negative perspective than any other group of clients served in community mental health settings. Therefore, it is plausible that counselors need specialized training and knowledge to provide services effectively to overcome the perceptual and attitudinal biases that may contribute to the difficulty of treating sex offenders (O'Connell et al., 1990). As such, the purpose of this study is to determine if a 45-minute sex offender training for counseling graduate students will create cognitive dissonance that impacts their scores on the Working Alliance Inventory – Therapist, and Discrete Emotions Questionnaire.

CHAPTER 2: LITERATURE REVIEW

Introduction to Literature Review

The current study introduces a 45-minute training designed to reduce cognitive dissonance in counseling students as measured by changing scores on the Working Alliance Inventory - Therapist and Discrete Emotions Questionnaire. There are focused sections on contributions to counselor dissonance, including (a) the historical perception of sex offenders, (b) current societal perception of sex offenders, and (c) sex offense categorization. This chapter discusses the psychological impact of sex offender treatment on counselors and the current state of sex offender treatment. Cognitive dissonance theory is explained and proposed as a theoretical foundation for sex offender training. Finally, this chapter concludes with a summary.

Historical Perception of Sex Offenders

To fully understand the evolution of sex offender treatment, one must consider the historical influences that shape societal perceptions and legislative trends. The material contained in the historical books, *Moral Panic: Changing Concepts of the Child Molester in Modern America* by Philip Jenkins (1998), and *Sex Fiends, Perverts, and Pedophiles: Understanding Sex Crime Policy in America* by Chrysanthi S. Leon (2011) help align historical events that shape current sex offender legislation and perceptions (Logue, 2012). Many factors contributing to sex offender legislation are not discussed; however, the authors' comprehensive approaches offer fundamentally historical information. Their timeline is divided into four main eras: (1) the Construction/ Progressive Era (1880-1935); (2) the Sexual Psychopath Era (1930-1955); (3) the Rehabilitative/ Liberal Era (1950-1980); and (4) the Containment Era (1980-Present). Each area will be discussed in this section. As noted by Logue (2012), sex offenders were stereotyped as monsters during each era, which is a viewpoint that helped shape public policy.

Pre-modern influences (Pre-1880). Pre-modern sex offender policy is not well documented, making the book *Moral Panic: Changing Concepts of the Child Molester in Modern America* by Philip Jenkins (1998) one of the more informative literary works on sex crimes. Jenkins (1998) explains that sex during biblical times was almost always associated with sin or evil. Sexually immoral people were often depicted as ungodly and criminal. To impose morality, sex crime laws were enacted and enforced with penalties ranging from monetary fines to death, depending on how deviant the act was perceived. The following sex acts were considered deviant and criminal during this era: exhibitionism, voyeurism, abortion, bestiality, masturbation, contraception, consensual sadomasochistic activity, interracial relationships, homosexuality, heterosexual relationships between those not legally married to each other, certain sexual positions or techniques, such as oral or anal sex (sodomy). Sexual deviance was a construct motivated by religious practices; it was also driven by the burden of illegitimate births created on the public welfare system. The psychological and physical trauma against rape victims was secondary to the economic impact made on society (Jenkins, 1998).

The Progressive Era (1880-1930). By the late 19th century, rational thought about sex crimes became more dependent on science than religion. Social scientists started to treat offenders like mental health patients rather than criminals, which prompted deviation from paradigms founded by strict religious convictions. The influx of science also resulted in more open-minded legislation regarding sex offenders. Despite an influx of scientific ideals, scientists still sought to preserve sexual morality. Sexual impropriety was still a contentious topic, and sex offender scrutinization persisted (Jenkins, 2012).

In the late 1800s, the media became the primary propagandist against sex offenders, reporting that increased STDs, child prostitution, and pederasty were primarily associated with

sex offenders. Despite scientific assertions that sex offenders may suffer from a diseased mind, the media used perception shaping terms such as moral leper, wild beast, human gorillas, and sex killers to describe and label sex offenders (Jenkins, 2012). According to Jenkins, between 1905 and 1915, the criminal justice system launched initiatives to track and more harshly punish habitual offenders due to their portrayal by the media. Legislators used propaganda against sex offenders and exploited it to further their political careers (Jenkins, 2012). Society responded with unease, fear, and prejudice against sex offenders that still dominate public perception. During this era, sex offenders were castrated and denied the right to procreate because they were perceived as perverted.

The Sexual Psychopath Era (1930-1950). As noted earlier, the term sexual psychopath originated in the Progressive Era; however, the 1930s started a new era marred by economic instability and sensationalized crime called the Sexual Psychopath Era. The Lindbergh baby kidnapping, the Cleveland Torso Killings, and Albert Fish solidified societal fears of sexually deviant killers. As noted in previous sections, the national media amplified sex crimes, making them a widespread concern. Consequently, laws justifying civil commitment, laws for keeping lists of known sex offenders, and castration laws were introduced (Jenkins, 2012; Leon, 2011). The Leopold and Loeb child killer trial helped establish the psychiatric profession's role in sex offender management. Paul De River is credited with developing the nation's first *Sex Offender Bureau* (Jenkins, 2012). Through his series of training casebooks, sex offenders were further vilified and personified as public menaces. Concurrently, FBI Director J. Edgar Hoover propagated the *Stranger Danger* mantra and focused FBI resources on containing the supposed threat sex offenders presented. The actions of Hoover and De River negatively shaped public

perception and public policy despite growing optimism about sex offender rehabilitation in the academic community (Jenkins, 2012; Leon, 2011).

Sexual psychopath laws combined treatment, punishment, and reproductive control strategies influenced by positivism and eugenics (Leon, 2011). According to experts in the psychiatric community, the term sexual psychopath was considered general, overbroad, vague, and subject to abuse. As a result of this generalization, the public made no distinctions between the tier of the offenses, lumping all offenders into one category. Without criteria differentiating sex offenses; the laws, policies, and treatment for offenders were undeviating and did not meet their individual needs. Over time the psychiatric profession lost its ability to influence public policy, leaving few experts to continue work in the field (Leon, 2012). Treatment for sex offenders was not efficacious or a priority during the Sexual Psychopath Era, making necessary an era more conducive to changing public perception and creating effective treatment strategies, the Rehabilitative/Liberal Era (Jenkins, 2012).

The Rehabilitative/ Liberal Era (1950-1980). The Rehabilitative/Liberal Era ushered in a more liberal society, which resulted in changing public views about the "monstrous" sex offenders in the past. Many considered Alfred Kinsey, who performed a comprehensive series of studies on male and female sexuality, to be the most influential person in this era regarding sex offender research. Kinsey's famous reports opened a dialogue over sexuality in America, forcing society to reassess the sexual psychopath stereotype that sex offenders are monsters (Leon, 2011). The term child molester rose to prominence to describe *minor interference* instead of force or violence. It soon became a catch-all term for most non-violent acts between adults and children. Kinsey's reports stated that not every child molester is a *pedophile*. The psychiatric profession raised a call to standardize the definition of a *pedophile*, which had no set criteria at

the time. The result was that most sex offenders were seen as people to be pitied as *sick* people. Those who committed non-violent sex crimes were considered mentally immature rather than the calculating, manipulating monster depicted in the sexual psychopath era. During this era, law enforcement and government officials' distrust of sex offenders contributed to sex offender labeling practices, which undermined their positive human qualities (Jenkins, 2012).

During the Rehabilitative era, judges involuntarily committed sex offenders to psychiatric facilities under the guise of treatment. Castration, sex offender registration, the death penalty, and pornography bans were utilized to deter sex crimes (Leon, 2012). Because the question arose of whether indefinite confinement can be justified if no remedy for sex offenders exists (Jenkins, 2011; Leon, 2012), this era was termed the "rehabilitation" era, despite a lack of documented research or rehabilitative treatment implementation. By 1980, rehabilitation efforts were nearly abandoned and the monster image of the sex offender reemerged as the Containment Era began in the early 1980s.

The Containment Era (1980-Present). The current era began the same as the Sexual Psychopath Era in the mid-1930s—through a series of high-profile cases leading to harsh legislation against sex offenders. During the 1980s, victim advocate groups dominated the discussion and influenced government policy without opposition. Any opposition to the dominating Feminist / Victim Advocate view was seen as pro-offender and implied anti-victim. Like Kinsey, experts of the past were derided as apologists for sex offenders. Even other victim groups were ignored if they did not adopt the dominant perspective on sex offenders. Any perspective that did not emphasize victim status devalued the victim and mitigated the offender's predatory nature. This bias effectively silenced any criticisms of these movements (Leon, 2011).

The Containment Era refreshed the belief that sex offenders were equally deviant and indistinguishably dangerous to society despite the severity of their crime. Definitions of abuse were broadened to include anything that made a person feel' uncomfortable,' such as hearing sex talk (Jenkins, 2012). *Strange Men* were cast as potential predators, and the *patriarchal family* was viewed as possible rape ruses. The term molester was expanded from repeat offenders to include single acts; even a brief sexual act with a willing participant was deemed to cause irreparable lifelong harm (Jenkins, 2012). Unlike previous eras, the image of the *monster* was unanimous, and sex offenders were "*monsters*" incapable of rehabilitation (Leon, 2011).

Studies conducted during the late 1980s focused on serial offenders, which led to the belief that sex offenders perpetuated crimes far more than most offender types. The term pedophile became a word used to denote anyone who has ever had sexual contact with a minor, suggesting that sex offenders were compulsive, obsessive, violent, and resistant to change (Jenkins, 2012). The term predator was applied to sex offenders in the early 1990s and portrayed sex offenders as hunters looking for prey. Further reinforcing public fear, the media popularized the term *Stranger-Danger* during this era, depicting the sex offender as a stranger waiting to abduct children (Jenkins, 2012). By viewing sex offenders as uncontrollable monsters that could not be cured, the government could justify an anything-goes approach to dealing with sex offenders. Classifying sex offenders in this manner was not unique to this era. The impact on societal perceptions remained widespread, and sex offenders were further ostracized (Leon, 2011).

Theoretical Framework

The theoretical framework that guides this study is Festinger's (1957) cognitive dissonance theory (CDT). Cognitive dissonance theory is commonly used to explain attitude and

behavioral changes from a social psychology standpoint (Cacioppo et al., 1994; Draycott & Dabbs, 1998). According to CDT, when new cognitions are congruent with existing cognitions, an individual experiences cognitive consonance. Conversely, a cognitive discrepancy occurs when new cognitions are incongruent with current cognitions (Tsang, 2017). Cognitive discrepancies generate cognitive dissonance, which is psychological discomfort resulting from new information that contradicts current beliefs and attitudes (Tsang, 2017). When an individual observes a serious problem but has trouble believing it is their problem, they must overcome denial to act (Aronson et al., 1991). In previous studies, researchers have created dissonance in participants by identifying the hypocrisy (i.e., the inconsistency between attitudes and behavior) in identifying a serious problem while failing to be a part of the solution. The dissonance created motivated participants to challenge the discrepancies in their paradigm, leading to reduced denial and accepting responsibility for correcting the problem (Fried & Aronson, 1995). Festinger (1957) asserts people reduce their cognitive dissonance in four ways:

1. Change the behavior or the cognition ("I'll eat no more of this doughnut")
2. Justify the behavior or the cognition, by changing the conflicting cognition ("I'm allowed to cheat on my diet every once in a while.")
3. Justify the behavior or the cognition by adding new behaviors or cognitions ("I'll spend thirty extra minutes at the gymnasium to work off the doughnut.")
4. Ignore or deny information that conflicts with existing beliefs ("This doughnut is not a high-sugar food.")

Cognitive dissonance theory has been widely researched and can be broken down into three theoretical paradigms important in attitude change. These paradigms include (a) forced compliance from an outside authority, (b) ambiguity in decision making, and (c) when the

expended effort to achieve a goal does not match the desired result (Festinger and Carlsmith, 1959; Brehm, 1956; Aronson and Mills, 1959).

Forced or Induced Compliance Behavior. Cognitive dissonance theory purports that dissonance is created when forcing someone to perform a task they would rather not perform (Festinger & Carlsmith, 1959). Forced compliance occurs when an individual is instructed to perform an action that is inconsistent with his or her beliefs. When one's beliefs do not align with their behavior, voluntary or forced, the dissonance is created and can only be reduced when there are changes in the previously helpful attitude. Festinger and Carlsmith (1959) found that when the incentive is sufficient, the participant did not experience dissonance when performing a task about which they previously held negative attitudes. Meanwhile, when the incentive or reward was not sufficient, participant dissonance was higher, prompting them to change their views to reduce the dissonance.

Counselors frequently possess attitudes, beliefs, or behaviors that conflict with those of the clients they serve (Harmon-Jones & Mills, 2019). When counselors encounter clients with opposing attitudes and behaviors that trigger negative emotions, they remain obligated to demonstrate objectivity. Given the social and professional expectations that counselors build alliances with clients while managing their emotions, forced compliance can be assumed in the counseling profession.

Decision Making or Free Choice. People are often faced with difficult choices between equally reasonable alternatives. Once a reasonable alternative is decided upon, the other alternative is no longer considered similarly desirable (Brehm, 1956; Harmon-Jones and Harmon-Jones, 2002). In other words, people adjust their attitudes to support their decision. Doing so increases the attractiveness of the chosen alternative and decreases the attractiveness of

the rejected alternative. This rationalization is thought to be motivated by the need to reduce cognitive dissonance (Festinger, 1957; Zanna and Cooper, 1974; Elliot and Devine, 1994).

More recent studies suggest that as an unintentional consequence of decision making, psychological distress associated with cognitive dissonance can be resolved quickly (Shultz and Lepper, 1996; Lieberman et al., 2001; Simon et al., 2004; Egan et al., 2007). Magnetic resonance imaging (fMRI) studies that evaluated activity in the right inferior frontal gyrus (IFG) displayed motor and cognitive conflict, as well as affective distress when subjects were presented with decisions (Goel and Dolan, 2003; Aron et al., 2004; Ochsner and Gross, 2005). Given that deciding between equally attractive options provokes conflict, and attitude change resolves that conflict, decision-related attitude change might involve reappraisal processes, which are often associated with rapid increases in right IFG, and decreases in limbic activity (Ochsner et al., 2004; Kalisch et al., 2005; Lieberman, 2007a; Tabibnia et al., 2008). As such, activity in brain regions associated with conflict resolution during decision making, such as right IFG, may be associated with decision-related attitude change and reductions in cognitive dissonance.

Effort Justification. Effort justification is a person's tendency to create a value-based outcome compared to the effort required to achieve that outcome (Festinger, 1957). When justifying effort, there is a dissonance between the amount of effort exerted into achieving a goal or completing a task (high effort equaling high "cost") and the reward for that effort (lower than was expected for such an effort). Essentially, when effort does not match reward, cognitive dissonance is created. In essence, we value most highly those goals which have required considerable effort to achieve. By adjusting and increasing one's attitude or the subjective value of the goal, this dissonance is resolved (Aronson & Mills, 1957). To avoid the dissonance created during disparate cost/reward activities, the effort put into the activity is often minimized through

rationalizing the time expended, and making the effort enjoyable or beneficial. By adopting the mentality that the goal was worthwhile, cognitive dissonance is reduced. This method of reducing dissonance is known as effort justification (Cacioppo et al., 1994; Draycott & Dabbs, 1998).

Several counseling principles have been derived from cognitive dissonance theory that could increase the probability of a self-directed change occurring within the counselor (Mayer et al., 1968). Cognitive dissonance opinion-change research, examined within a cognitive dissonance framework, demonstrates that opinion change is controlled by (a) communication discrepancy, (b) perception of communicator expertness, (c) perception of communicator trustworthiness, (d) perception of communicator attractiveness, and (e) involvement (Strong, 1968). When skillfully manipulated or developed through training, one can assume these perceptual and involvement factors can change counselor perceptions regarding sex offenders.

Societal Perceptions That Influence the Counselor

Early studies of social perceptions of sexual violence suggested that societal views of crime are limited and depict rape crimes where a stranger violently attacked the victim at night (McMahon & Baker, 2011). Since the early 1800s, sex offenders have been perceived as monsters worthy of public judgment and ridicule. Individuals committing sex crimes "were typically viewed as strangers who were psychologically disturbed, pathological men who preyed on women and children" (Donat & D'Emilio, 1992, p. 10). The myth of *stranger danger* may have created false security for parents, who believed their children are at most significant risk of being abused by a stranger when the real danger is usually from *everyday people* they know and trust (Berliner et al., 1995; O'Neil & Morgan, 2010).

The social paradigm that predators are created by poor upbringing has been difficult to dispel (O'Neil & Morgan, 2010). Often parents are seen as the only source to teach children how to protect themselves from harm or danger (O'Neil & Morgan, 2010). Respondents consistently conveyed the impression that sexual predators are made, not born. Researchers found that respondents did not believe genetic influence was a predictor of sexual deviance, and respondents believed sex offenders acquired their behaviors from the environment (O'Neil & Morgan, 2010). In the same study, respondents argued that sexual violence occurs because individuals do not learn right from wrong from their parents as young children, often neglecting to acknowledge the cultural and social contexts impacting sexual abuse in contemporary American society (O'Neil & Morgan, 2010).

The acknowledgment of sexual violence as a significant social problem occurred relatively late in our country's history. The modern era of classification emerged during the 1960s and 1970s. Due primarily to the anti-rape and feminist movements (McMahon & Baker, 2011), sex offenders' labels deemed them incapable of rehabilitation. Consequently, through the lens of labeling theory developed during the 1960s, people often viewed sex offender deviance as the byproduct of social reaction (Schultz, 2014). The labeling theory suggests that individuals with criminal records and placed on sex offender registry lists received adverse responses from society (Schultz, 2014), contributing to their seclusion and recidivism.

The public frequently views sex offenders as sick or psychologically disturbed, fundamentally immoral, and violent strangers who use force or aggression during the commission of sex crimes (O'Neil & Morgan, 2010). Some of these views may be caused by exaggerating violent and heinous sex crimes by the media (Duncan, 2012; King & Roberts, 2017). The media attention given to sex offenses, especially rape, incites public fear and panic,

causing the entire sex offender population to be viewed as a danger to communities (Duncan, 2012). Throughout history, the media has controlled the narrative about sex offenders, including the over-sexualization of women and normalizing violence toward women.

Over-sexualization of women and the normalization of violence towards women in the media has created a 'culture of confusion' (O'Neil & Morgan, 2010) wherein sex is sensationalized and criticized concurrently. From the 1800s through the present, news outlets have sporadically become propagandists against sex offenders (Jenkins, 2014). For decades, the media characterized perpetrators as sick and fundamentally immoral. Sex offenders were considered immoral, with behaviors exclusive to sexually deviant criminals (King & Roberts, 2017; O'Neil & Morgan, 2010). Fuselier et al. (2002) also found that the general public believed child molesters are social misfits, strangers, or "dirty old men." Sex offenders were described as predators who stalked and attacked vulnerable women and children. The media indirectly contended that those who commit acts of sexual violence were predators, preying on victims (O'Neil & Morgan, 2010). Because the media dictates the national discussion and shapes public opinion, the assumption can be made that media influence regarding sex offenders has been monumental throughout recent history.

Media influences. Sex offenders and sex crimes depicted as heinous and unforgivable in the media negatively shape public perceptions. Media portrayals of sex crimes and the individuals who commit these offenses are not always grounded in current statistics, research, and accurate information (Center for Sex Offender Management, 2010), leading to public misconceptions. As a result of media influence, society often views sex offenders as a homogenous group rather than individuals, even though there are many sexual offenses such as child molestation, rape, and violent and non-violent sex offenses (Duncan, 2012). Some

misperceptions about sex offenders include that reoffending is likely because these individuals are unlikely to benefit from treatment (Duncan, 2012). The unrealistic fear of sexual victimization in our society creates anxiety-driven individuals who distrust authentic interactions (Duncan, 2012; King & Roberts, 2017).

Several respondents shared a deep-seated, powerful, and pervasive assumption that sexual predators are unreceptive to any help or intervention in a Frameworks survey (O'Neil & Morgan, 2010). Between twelve to twenty-four percent of sex offenders re-offend, and usually, their new offense is not a sex crime (Center for Sex Offender Management, 2008). A poll conducted by the Center for Sex Offender Management (2010) found that the public believes at least seventy-five percent or more of convicted sex offenders would commit future sex crimes. The same poll indicated that female respondents over sixty-five years of age were more likely than men to believe that higher proportions of sex offenders would recidivate. Respondents recognized that sex crimes against children generally involve perpetrators known or related to the victim, and stranger-related sex offenses are relatively uncommon (Center for Sex Offender Management, 2010). These perceptions do not comport with research which has shown that sex offenders are more apt to be rearrested for non-sexual and non-violent crimes than additional sex offenses (2010). Sex offenders are often viewed by society as a continuing threat and should be condemned because of their past actions, whether they seek treatment (Duncan, 2012).

The media has an influential role in shaping public perceptions, knowledge, attitudes, and opinions (Center for Sex Offender Management, 2010). While often focused on the most heinous sex crimes, the media is mostly responsible for how the public understands and receives information about sex crimes and the stigmatized population of sex offenders (Duncan, 2012). The media attention given to sex offenses, especially rape, incites public fear and panic, shaping

the social perception that the entire sex offender population is a danger to communities (Duncan, 2012). The social acceptability of violence is further reinforced by women's sexualization in the public sphere through the media (King & Roberts, 2017; O'Neil & Morgan, 2010). The media normalizes violence towards women, creating a "culture of confusion," especially for young people, so that many are unclear about what constitutes sexual violence (O'Neil & Morgan, 2010).

The Center for Sex Offender Management (2010) conducted a poll and found that 74% of respondents reported that the news media was the predominant source from which they received information and knowledge about sex offenders. The other twenty-six percent of the respondents said their knowledge of sex offenders was obtained by a combination of internet searches, sex offender registries, professionals in the field, community members, or family members (Center for Sex Offender Management, 2010). Because the public and lawmakers used the media as their primary means to obtain information about sex crimes, counselor perceptions may also be highly influenced by media coverage.

People believe that the government's job is to inform citizens of sex offenders who could endanger others (Levenson et al., 2017). New community notification strategies commonly included press releases, flyers, and door-to-door warnings about the presence of sex offenders (Levenson et al., 2017). This offender group is ostracized from society, stigmatized, and often labeled as deviants, immoral, and evil (Schultz, 2014). However, a public opinion survey conducted in Washington state reported that despite community notification of surrounding sex offenders, more than half of the parents described no change in their behaviors regarding the supervision of their children (Phillips, 1998).

Public concern also continues to influence local, state, and federal creation of policies and laws, including the formation of the United States Department of Justice National Sex Offender Registry List (Duncan, 2012). Managing sex offenders effectively once they reenter society is among the critical public policy interests and priorities among lawmakers and constituents (Center for Sex Offender Management, 2010). Beliefs influence the public perception and demand for action in the form of "stringent sanctions, long prison terms, intensive monitoring, and other community protection measures about the potential for sex offenders to re-offend" (Center for Sex Offender Management, 2010, para 9). All fifty states require sex offenders to be on a registry that is readily accessible to everyone. The ease with which the public can access this information creates problems for the sex offenders, who are often harassed, threatened, and even attacked (Duncan, 2012).

When offenders are mistakenly categorized in the same group, society views the entire group as a danger to society when only a small number are violent offenders (Duncan, 2009). While this represents a formidable enough battlefront on its own, sex offender counselors are faced with another, perhaps even more challenging front that our society, including our lawmakers, has set in motion. Risk mitigation associated with sex offender recidivism is a primary concern for society and a primary directive for all sex offender psychotherapies.

Many barriers that prevent sex offenders from maximizing their treatment efforts are the byproduct of societal fear. Punitive barriers such as limited jobs, housing restrictions, and sex offender registration raise significant recidivism risk factors. Despite many of the ‘one-size-fits-all’ restrictive policies not based on empirical research (Duncan, 2009), sex offenders continue to be labeled and considered untreatable. The stigmatization that comes with a sex offender label, no matter the level of severity of the crime, creates a barrier for these individuals in society

(Schultz, 2014). “Stigma and misconceptions about sex offenders are pervasive and apparent in our society, but these are typically inconspicuous in clinical staff, primarily because of professionally appropriate behavior” (Barabas, 2007, p. 10). These barriers often negate the efforts of sex offender counselors and those clients who possess legitimate desires to recover and return as productive members of society. In reality, our society may be contributing to future victimization, which is the opposite of our primary goal. As a result, the successful reintegration of sex offenders has proven to be remarkably unsuccessful due to the impending social consequences of these laws and the misconceptions held by society (Duncan, 2009).

Social and legal barriers specific to this offender type make transitions from prisons to the community extremely challenging (Duncan, 2012), both with and without counseling. Experts described detrimental behaviors related to the sex offender’s isolation and alienation. As with any crime, sexual offenses create employment hardships for sexual offenders because some employers will refuse to hire them or fire them for minor offenses (Duncan, 2012). For others, it can create housing issues because of restrictions on distance from schools or parks (Duncan, 2012). These collateral consequences also have ramifications for the offender's family, as negative public perception and resentment can be projected onto the immediate family (Duncan, 2012).

Sex Offense Categorization

According to the North Carolina General Statutes, “'sex offender' is a generic term for all persons convicted of crimes involving sex, including statutory sexual assault, rape, molestation, sexual harassment, and certain forms of pornography production or distribution” (North Carolina General Assembly, 2011, para 1). Similarly, the Federal Bureau of Investigation Criminal Justice Information Division considers indecent exposure, incest, statutory rapes, and rape attempts as

sex offenses (U.S. Department of Justice, 2010). Adults make up about eighty percent of arrests for sexual crimes. In comparison, juveniles account for the other twenty percent, with males accounting for approximately ninety-five percent of these arrests (Center for Sex Offender Management [CSOM], 2007). These percentages do not make a distinction between violent (sexual assault and abuse) from non-violent (streaking, solicitation, public urination, consensual sex with a minor) offenders, nor consider offenders who may not have been convicted (CSOM, 2007). The terms *sex offense* and *sex crime* encompass various sexual acts (Schultz, 2014) that do not impartially relate to an offender's propensity to re-offend. On July 27, 2007, President George W. Bush signed the Adam Walsh Protection Act (AWA), which classifies sexual offenses in tiers based on the crime committed versus their risk for re-offense (McGrath et al., 007). With tiered classification in place, violent offenders and non-violent offenders are no longer indiscriminately classified (Schultz, 2014).

A tier is a level in which a sex offender is categorized based on his or her offense, and there are three tiers (see Table 1). Tier I offenders commit crimes punishable by up to a year in prison. Tier II and Tier III offenders are convicted of an offense punishable by more than one year in prison, with Tier III being the most severe classification (Reinhart, 2006). Tiers II and III also have additional criteria to further distinguish the severity of the crime.

Table 1

Sex Offender Typology

Type	**Definition**
Tier I	Commit crimes punishable by up to a year in prison
Tier II	Convicted of an offense punishable by more than one year in prison that: 1. is committed against a minor and is comparable or more severe than one of the following federal crimes or attempt or conspiracy to commit one of them: sex trafficking, coercion, and enticement, transportation with intent to engage in criminal sexual activity, or abusive sexual contact;

	2. involves using a minor in a sexual performance, soliciting a minor for prostitution, or producing or distributing child pornography; or 3. occurs after the offender became a Tier I sex offender.
Tier III	Convicted of an offense punishable by more than one year and: 1. is comparable or more severe than one of the following federal crimes or conspiracy or attempt to commit one of them: aggravated sexual abuse, sexual abuse, or abusive sexual contact against a minor under the age of 13; 2. involves kidnapping a minor unless the actor is a parent or guardian; 3. occurs after the offender became a Tier II sex offender

Information in this table was taken from Reinhart's (2006) work on sex offender typology.

Tier Classification Impacts Registration and Treatment Requirements

Tier I offenders must update their registration once a year for fifteen years, Tier II every six months for twenty-five years, and Tier III every three months for life (Reinhart, 2006). Because state laws and statutes differ, these requirements may vary from state to state, depending on their definition of a sex crime. The tier system provides classification and enables treatment programs to link the dosage of treatment to the level of risk the offender poses to society. The risk principle suggests that practitioners should differentiate services by offender risk, with higher-risk offenders receiving more intense services than lower-risk offenders (Andrews, Bonta, & Hoge, 1990; Sperber, Latessa, & Makarios, 2013). Higher tiered offenders have a higher propensity to re-offend, classifying them as higher risk. Higher-risk offenders require an increased number of individual and group counseling sessions, closer supervision, and stricter registration requirements. Researchers found that treatment programs that did not consider the offender's risk level failed to reduce offender recidivism (Lowenkamp et al., 2006). Furthermore, programs were more likely to reduce recidivism if they (a) targeted higher risk cases, (b) provided increased treatment to highest risk cases, and (c) increased treatment length for the highest risk cases.

Impact of Sex Offender Treatment on Counselors

Research suggests that providing sex offender treatment triggers discrete emotions and can lead to vicarious traumatization in counselors (Elias & Haj-Yahia, 2019; Rosselli & Jeglic, 2017). Studies have examined the effects of treatment delivery through various methods such as focus groups, surveys, and anecdotal accounts of counselor experiences (McCulloch & Kelly, 2007). The specific effects identified across previous research studies are diverse due to the array of practitioners working in different roles, contexts, and delivery of treatment in different settings (Lea, Auburn, & Kibblewhite, 1999). Counselors who provided treatment to sex offenders reported intrusive thoughts that triggered depression, problems in romantic relationships, changes in sexual activity or arousal, and self-defeating predispositions (Dean & Barnett, 2011; Evans & Ward, 2019). Cartwright, Stark, and Mountain (2018) report that counselors working with sex offenders are prone to feeling uncomfortable, worried, and anxious during counseling sessions. In addition to emotional distress, female sex offender counselors reported safety concerns, often avoiding angering the patient because they were fearful of physical confrontation or becoming a victim (Cartwright et al., 2018). Regardless of socioeconomic background, race, or gender, counselors consistently report emotional discomfort when exposed to sexually deviant material (Elias & Haj-Yahia, 2019). Because the emotions experienced are universally similar, research suggests that counselors feel discrete emotions when counseling sex offenders (Harmon-Jones, 2010).

Discrete Emotions. Discrete emotion theory states that regardless of ethnic and cultural differences, every person experiences specific core emotions whose expression and recognition are fundamentally similar (Boyle, 1984; Boyle et al., 2015). A series of cross-cultural studies found that six to twelve emotions are experienced similarly worldwide (Ekman, 2007). Research

on facial expressions, behavioral expressions, and brain stimulations found legitimacy in the concept of Discrete Emotions (Harmon-Jones, 2016). The Discrete Emotions Questionnaire is a measure of discrete emotions that can be used to assess multiple state emotions (Harmon-Jones, 2016). Measuring emotional reactions allows a greater understanding of the emotional processes that underlie much of our cognitive, social, and behavioral responses (Boyle, 1984; Harmon-Jones, 2010).

Vicarious traumatization. The psychological and emotional phenomenon of vicarious traumatization (McCann & Pearlman, 1990), has been investigated and explains how counselors may collectively respond to working with sexual offenders (Rich, 1997). Vicarious traumatization is described as a process by which counselors experience emotional and physical discomfort resulting from a client's traumatic disclosure (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1996a). McCann and Pearlman (1990) applied vicarious traumatization to the emotional and physical effects of working with sexual violence. They believed that counselors often relive the graphic details of human cruelty and participate in "traumatic re-enactments" in counseling with these clients. This process can result in changes in the counselor's worldview, self-identity, and cognitive schemata associated with safety and trust (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). This process can also change the counselor's attitude and perception about the treatment needs of sex offenders.

Vicariously traumatized counselors report increased levels of anxiety, including avoidance of disturbing material in the session; hypervigilance regarding their own and others' behavior, particularly toward children; and intrusive images and thoughts about case material (Kassam-Adams, 1995; Pearlman & Mac Ian, 1995; Steed & Bicknell, 2001). Some counselors have also described changes in their mood, characterized by depression, cynicism, mistrust,

hopelessness, irritability, anger, and frustration (Edmunds, 1997; Pearlman & Mac Ian, 1995; Farrenkopf, 1992). When working with sex offenders with strong anti-social traits, counselors commonly struggle with the tension between conceptualizing these either men clients as to be respected or beasts to be dealt with in a harsher manner (Farrenkopf, 1992). On the one hand, there is the well-intended goal of helping the offender develop into a more functional human being. On the other, there are the common emotional reactions of anger, disgust, and even fear of predation.

While general mental health clinicians are often taught to avoid treating anti-social patients, forensic clinicians frequently find themselves in circumstances that compel them to treat such patients. Sixty-two percent of counselors working with perpetrators or victims of sexually violent crime identified themselves as suffering from vicarious trauma (Rich, 1997). The participants were more likely to report experiencing difficulties in coping with stress associated with their work, doubts about their ability to manage the stress of their jobs, distressing images of traumatic material, discouragement, anxiety, and feeling at odds with the world (Rich, 1997). Counselors have also described changes in their mood, characterized by feelings of depression, cynicism, mistrust, and hopelessness (Edmunds, 1997; Pearlman & Mac Ian, 1995) and increased irritability, anger, and frustration (Farrenkopf, 1992). Counselors who treat sex offenders with strong anti-social traits, commonly struggle with the tension between conceptualizing them as either person to be treated or an animal to be dealt with harshly (Farrenkopf, 1992). Treating the offender becomes more complicated when the counselor is psychologically and emotionally disturbed by the treatment they provide, which leads to further gaps in the continuity of care for sex offenders.

Poor Working Alliance. Merriam-Webster defines an alliance as a union or association formed for mutual benefit. The working alliance is between the client seeking change and the counselor acting as a change agent (Hovarth & Greenberg, 1994). When healthy, the working alliance is a bond of mutual trust created between the counselor and client, fostering progression towards a goal and establishing a resilient partnership (Marshall, 2005). Bordin (1979) describes the working alliance as being composed of an emotional bond and the agreement of tasks and goals between counselor and client. The process of forming and maintaining a working alliance is especially challenging in that the counselor must be able to respond to the client's emotions and hostilities adequately, as well as difficulties communicating their setbacks (Nissen-Lie et al., 2010). A counselor must be attentive to the client's state of mind and the client's needs and minimize frustration with the process (Hovarth & Greenberg, 1994). When counselors treat the client and each session individually by responding with empathy and non-defensively, clients report better outcomes (Nissen-Lie et al., 2010). Effective counselors reassess the working alliance by identifying obstacles that hinder the positive working relationship and using techniques to repair the alliance when necessary (Nissen-Lie et al., 2010).

Working alliances with empathy, genuineness, and honesty have better treatment outcomes (Nissen-Lie et al., 2010). The counselor's characteristics that predict positive alliance relationships are relational skills such as being warm, accepting, engaged, empathic, and responsive (Nissen-Lie et al., 2010), which align with those discussed in previous studies. Ackerman and Hilsenroth (2001, 2003) report that being open, flexible, and respectful also positively influences the working alliance. Displays of empathy and warmth by the counselor, "the provision of rewards for progress, and some degree of directiveness maximize the benefits" derived from procedures employed in treating sexual offenders (Marshall, 2005). These specific

behaviors can also positively influence the perspective-taking, coping skills, and relationship difficulties that sex offender clients face (Marshall et al., 2003). Empathy, congruence, and unconditional positive regard were the ideal conditions offered by the counselors and were later shown to be specifically essential for client-centered therapy (Ardito & Rebellino, 2011).

The working alliance concept originated in psychoanalytic theory and is now an integral part of most cognitive behavior therapies (Blasko & Jeglic, 2014). The working alliance focuses on building cooperation and collaboration between the counselor and client "against the familiar foe of the client's debilitating pain, providing the client with a safe environment to explore the self (Hovarth & Greenberg, 1994) and allowing both past and present issues to be addressed. The working alliance is an agreement between the client and counselor that is built on trust and unified terms for treatment (Ardito & Rabellino, 2011). The 12-item Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and the 10-item Working Alliance Inventory Short Revised - Therapist (WAI-SRT; Tracey & Kokotovic, 1989) are measures created to assess the alliance between counselor and client in psychotherapy. The working alliance inventory (WAI-SRT) consists of ten items and is one of the most frequently used methods to assess the working alliance (Nissen-Lie et al., 2010). It measures the bond between the counselor and client, agreement on what needs to be done in treatment, and how it should be achieved in the therapy process (Nissen-Lie et al., 2010). The working alliance inventory also measures the strength and quality of the relationship through client and counselor self-assessment (Hovarth & Bedi, 2002). One study's results obtained from evaluating alliance using the working alliance inventory suggests that the quality of the alliance affected the nature of the treatment (Ardito & Rabellino, 2011).

Research conducted on working alliances with sexual offenders has been focused on identifying counselor factors related to the quality of the working alliance (Marshall et al., 2003) and the essential role they play in the working alliance. According to Marshall (2005), in a study identifying twenty-eight counselor features present during therapy sessions, among the highest identified as being present were warm, respectful, reasonable time on issues, appropriate body language, time speaking and tone of voice, non-confrontational, excellent communication and employment of open-ended questions. Some of the twenty-eight features did not appear very often; for example, counselors rarely offered self-disclosure and humor, although the general literature records their importance (Marshall, 2005). Some studies show that the therapeutic process's outcome is influenced by the personal characteristics of the counselor and the positive feelings experienced by the patient (Ardito & Rebellino, 2011).

There are several overlapping counselor features supported by research that are both influential and positively related to client behavior changes. Marshall (2005) concluded that these features included empathy, warmth, directiveness, and a non-confrontational approach defined as firm but supportive of challenges. Kindness and compassion have long been viewed as essential features of competent counselors regardless of therapeutic orientation (Rogers, 1951). According to both counselor and client, counselors who emphasize a nurturing and supportive attitude, focusing on developing mutual trust, produced a better alliance rating (Ardito & Rebellino, 2011). These characteristics build the trust and confidence needed for positive collaboration in the alliance and set the foundation for working through difficulties during sessions (Marshall, 2005).

Research has shown that positive working alliances often lead to the completion of therapy tasks, skill and knowledge development (Tatman & Love, 2010), and a stronger sense of

mastery over unwanted impulses (Ardito & Rabellino, 2011). The working alliance positively correlates with increased motivation for task completion, reflecting a heightened sense of optimism for a positive outcome and the client's desire to please the counselor (Nissen-Lie et al., 2010). A strong working alliance in cognitive-based therapy is also reported to facilitate positive cognitive change and reinforce functional interpersonal behavior (Marshall, 2005) that decreases the propensity to re-offend.

Studies have found that when counseling sex offenders, it is crucial to establish a strong working alliance within the first five sessions. A strong alliance allows the counselor to challenge the offender's dysfunctional sexual behaviors and thoughts in non-offensive ways (Nissen-Lie et al., 2010). During these studies, when the working alliance was established early in treatment, outcomes were more positive. Researchers consider the existence of two critical phases of the working alliance (Ardito & Rabellino, 2011). The first phase, occurring during the first five sessions, consists of developing a sense of collaboration and confidence, establishing agreed-upon goals between client and counselor, and developing client confidence in the procedures of the therapy sessions (Ardito & Rabellino, 2011). In the second phase, the counselor begins to challenge the patient's dysfunctional thoughts and behavior patterns to change them (Ardito & Rabellino, 2011). Although trust over time can be established, trust and intimacy from the beginning have produced better treatment outcomes (Hersoug, Hoglend, Monsen, Havik, 2001).

The client's perception of the alliance is a better predictor of outcome than the counselor's (Horvath & Bedi, 2002; Hersoug et al., 2001). Clients evaluate the alliance by their knowledge and beliefs about what proved helpful to them in treatment (Zilcha-Mano et al., 2015). Soliciting client perceptions of the client-counselor relationship is integral to

understanding how the relationship develops through the client's lens (Blasko & Jeglic, 2014). The counselor's experience, professional training, and counseling skills did not significantly impact how the client rated the working alliance (Hersoug et al., 2001). Client ratings were directly linked to their perception of the counselor's attributes. Such findings suggest that one should focus more on the counselor's contribution to the alliance (Nissen-Lie et al., 2010).

Current Sex Offender Training Objectives

Sex offenders have various levels of risk, and various levels of need, making them one of the more diverse offender groups. Many treatment approaches must be designed to reduce recidivism risk (McGrath et al., 2010). Sex offender treatment teaches offenders strategies for stopping abusive behavior and taking responsibility for their sex-related indecencies (Evans & Ward, 2019). The structure, delivery, and philosophies of sex offender treatment have been inconsistent throughout history, with varying treatment methods ranging from psychodynamic principles to strict behaviorism (Laws & Marshall, 2003). Current best practice involves cognitive-behavioral interventions (Andrews & Bonta, 2010; Hanson, Bourgon, Helmus, & Hodgson, 2009).

Historically, treatment options have included psychotherapy, neurosurgery, physical and chemical castration, and relapse prevention; nevertheless, treatment options that include cognitive-behavioral therapy are the most widely used and accepted due to their evidence of reduced recidivism rates (Hansen et al., 2002). Despite the vast number of treatment models, the main objective of sex offender treatment is to keep the community safe by reducing sex offender recidivism risk (Evans & Ward, 2019). Although counselors may be available to provide them with mental health treatment, released offenders often find themselves without resources or support for sex offender-specific treatment because of a deficit of programs in their community.

Without treatment, the prospect of re-offending increases. The following sections provide a synthesis of research regarding the various treatment options for sex offenders.

Criminogenic factors. Criminogenic factors are characteristics, traits, problems, or issues of an individual that directly relate to the individual's likelihood of re-offending and committing another crime. These factors can be divided into two categories: static and dynamic. Static characteristics cannot be changed or addressed by any program or therapy to prevent future crimes. Examples of static factors include age at the time of first arrest, criminal history, or residing in a single-parent home. Generally, these are structural elements of a person's life that led them to commit a crime. In contrast, dynamic factors could be a lack of respect for authority, anti-social behavior, lack of literacy or job skills, or other expressed nonconformist behaviors, values, and attitudes correlated with criminal activity. These factors can be addressed by therapy, training, education, and targeted programming and subsequently altered to result in more law-abiding behavior (Mann, Hanson, & Thornton, 2010; Sperber, Latessa, & Makarios, 2013).

Researchers began focusing on how these needs relate to risk factors with a better understanding of criminogenic needs. Risk factors are precursors to the dynamic factors mentioned earlier in this chapter. For instance, if an individual lacks literacy and cannot complete a standard job application, they may struggle to obtain employment. As a result of no employment, the same individual may resort to criminal activity to obtain money. When illiteracy is the reason an offender cannot obtain employment, it is considered a risk factor. Because illiteracy may be a factor that influences more criminal activity by the offender, it is a criminogenic need that, if addressed, may keep the offender from re-offending (Mann et al., 2010; Sperber et al., 2013). Alternatively, if an individual has an anger management issue as a risk factor, providing therapy to help the individual learn to control that anger is a criminogenic

need (Sperber et al., 2013). The need is what must be provided by some correctional programming to reduce the risk of recidivism. The risk factor is generally determined as part of the initial assessment process because an offender is entering treatment or a correctional facility (Mann et al., 2010; Sperber et al., 2013).

Risk-need-responsivity. One useful model for sex offender treatment is the risk-need-responsivity model that evolved through 30 years of research on interventions for criminal offenders (Yates, 2013). The risk principle states that intervention intensity should be matched to the offender's level of risk and used to determine the duration and type of treatment (Yates, 2013). Intensive treatment, categorized by more sessions with a longer duration, should be required for high-risk offenders. Low-risk offenders may benefit from fewer sessions and routine supervision (Yates, 2013). Research indicates treatment outcomes are positive, and recidivism is lowered when treatment intensity is correctly matched to risk; however, when incorrectly matched, the recidivism rate can increase (Lovins, Lowenkamp, & Latessa, 2009). Therefore, effective sex offender treatment programs should target the criminogenic needs of high-risk offenders or factors that could cause them to re-offend. Substance abuse and anti-social lifestyle issues are commonly addressed with sex offender risk factors (Yates, 2013). The last part of the model, responsivity, incorporates therapy techniques that respond to the motivation, cognitive abilities, learning styles, and capabilities of the offender (Yates, 2013). Programs using the risk-need-responsivity model are incredibly effective at reducing recidivism (Andrews & Bonta, 2006). Additionally, a study by Lovins et al. (2009) determined that intensive treatment with more weekly counseling sessions and pronounced interventions was more effective for high-risk sex offenders than for low-risk sex offenders to reduce recidivism. This study (2009) further

concluded that high-risk offenders completing intensive treatment were more than two times less likely to recidivate than those who did not receive intensive treatment.

Recidivism. Reducing sex offender recidivism remains a priority for the local and federal governments. Although incidents of reported sexual improprieties have increased over the past 20 years, sex offenders are unlikely to voluntarily seek or receive treatment (Levenson, Willis, & Vicencia 2017) before they offend or re-offend (Piche, Mathesius, Lussier, & Scweighofer, 2016). Identifying and decreasing the deficits in sex offender treatment access and availability can improve the quality of life for sex offenders (Levenson et al., 2017); it also can reduce sex offender recidivism, thus enhancing safety for the community. New research, published by the American Public Health Association, suggests that focusing on consequences rather than positive goals can increase the chance of recidivism (Dockterman, 2018). Unfortunately, social and government paradigms support consequences over rehabilitation, contributing to ineffective treatment applications, and increased recidivism.

Langan, Schmitt, and Durose (2003) found that the probability of sex offenders' recidivism (the re-offense of sexual assault) rate is around five percent (Office for Victims of Crime, 2011). Sample and Bray (2003) found that, at a three-year follow-up, there was a 5.3% sexual recidivism rate among the sample. However, violent and overall arrests were much higher, with 38.6% of sex offenders in the study returning to prison within three years due to a commission of a new crime that was not sex-related. The study also showed that sex-crime rearrests rates for violent offenders were four times higher for sex offenders than the sex crime rearrest rates for non-sex offenders (five versus one percent) (Sample & Bray, 2006). For rapists precisely, at a three-year follow-up, there was an 18.7% recidivism rate for violent crime, and a 46% recidivism rate for the commission of any crime (Harris & Hanson, 2004). These results

imply that violent sex offenders are more likely to commit crimes that are not sex offenses after three years; however, they continue to pose a significant sexual threat to others. Similar studies illustrate that sexual recidivism for violent offenders was 14% during a five-year follow-up and increased to 21% during the 10-year follow-up. During the 15-year follow-up, recidivism rates increased to 24% for violent offenders (Harris & Hanson, 2004). One study shows recidivism rates rising to as much as 39% at a 25-year follow-up (Prentky, Lee, Knight, & Cerce, 1997). These statistics indicate that the category of offenders who engaged in "rape" may have higher sexual recidivism rates than sexual offenders in general while also suggesting that sexual recidivism rates increase over time. Although recidivism is less likely with lower-tier offenders, matching treatment and legal consequences for the offense and offender are paramount. Effective treatment includes evidence-based counseling provided by professionals whose bias does not negatively influence treatment.

Cognitive-behavioral therapy. According to research findings, cognitive-behavioral therapy is the most promising approach to sex offender treatment based on recidivism rate reduction compared to criminal punishment and other treatments (Mancini, 2013; Nwokeoma et al., 2019; Yates, 2013). Along with the development of actuarial risk assessment instruments and criminogenic factors (Craig et al., 2008; Mann et al., 2010), these studies advanced the empirical basis of assessing and treating sex offenders. Lipsey, Landenberger, and Wilson (2007) conducted a meta-analysis of over 40 cognitive-behavioral programs and found that programs that targeted moderate and high-risk offenders were more successful. Furthermore, they found that increases in sessions per week or total programming hours resulted in increased effect sizes. In summation, programs that targeted higher-risk offenders were most effective when using CBT and a higher frequency of treatment sessions per week.

Sex offender treatment approaches have ranged from strict behavioral, wherein the offender is conditioned to unlearn deviant behaviors, psychodynamics, discussions of childhood trauma, and understanding the effects of the past on present behaviors (DeSorcy, Olver, & Wormith, 2016). According to the CSOM (2016), effective intervention is based on several factors, which include:

(1) availability, capacity, and accessibility of programs along a continuum of care;

(2) goals and frameworks of treatment;

(3) modes, methods, and targets of intervention;

(4) treatment planning, including progress reports and complete documentation;

(5) specialized training of providers; and

(6) support from stakeholders

In the early 1980s, social scientists combined cognitive-behavioral and relapse prevention principles to target risk and adhered to the standards of effective correctional intervention (Andrews & Bonta, 2010; Hanson, Bourgon, Helmus, & Hodgson, 2009). Combining cognitive behavioral therapy and relapse prevention has been effective for three reasons. First, CBT addresses the inter-relatedness of thoughts, emotions, and behaviors, specifically related to sex offending and other problem behaviors (Mpofu, Athanasou, Rafe, & Belshaw, 2018). By modifying thinking errors, CBT has effectively addressed the cognitive distortions and dysfunctional schemas that lead to re-offending (Mpofu et al., 2018). Primarily, CBT develops positive ways to deal with emotions and impulses related to sex while building the offender's confidence to think and feel a negative inclination without acting on it. Second, through skill-building, reinforcement, and practice, CBT implements interventions centered around replacing maladaptive thoughts and unhealthy coping mechanisms with positive strategies that prevent re-

offending (Mpofu et al., 2018). Enhancing interpersonal skills is a CBT intervention that involves identifying maladaptive thoughts and maladaptive coping skills to replace them with healthy thoughts and positive coping skills (Mpofu et al., 2018). Communication, perspective-taking, and intimacy skills are taught to sex offenders using CBT methods to help offenders manage deviant sexual arousal or interest. Once sex offenders learn and implement the skills taught using this therapeutic modality, they can better increase appropriate sexual interactions and address their needs positively. Ultimately, with CBT interventions, sex offenders will be able to lead a productive, satisfying life that is incompatible with sex offending (DeSorcy et al., 2016). Relapse prevention helps individuals recognize the early warning signs of relapse (re-offending) and helps them develop coping skills to prevent relapse early in the process when the chances of success are highest (DeSorcy et al., 2016). Collectively these tenets of CBT and relapse prevention have consistently reduced the risk of recidivism for sex offenders.

Incarcerated sex offenders will someday return to the community and require sex offender treatment. Sex offender treatment programs must be based upon a clear and focused theoretical model of change (Bach & Demuth, 2018). Suppose the goal of treatment is to reduce recidivism risk for sex offenders and protect society from their sexually deviant transgressions. In that case, sex offender counseling must anchor treatment efforts using cognitive behavioral therapy principles. Moreover, cognitive behavioral therapy can be administered in various ways (Mpofu et al., 2018). The most effective modality includes all or a combination of individual therapy, couples or marital therapy, family therapy, or group therapy. Cognitive-behavioral group therapy has shown promising reductions in re-offenses at one year for child molesters compared with non-CBT treatments (Brooks-Gordon & Bilby 2006). When used in group settings, many cognitive-behavioral treatment programs for sexual offenders deliver promising

outcomes (Nwokeoma et al., 2019); however, research is lacking that pertains explicitly to individual counseling. Recent studies have shown 25% less recidivism in treated offenders than in untreated offenders (Losel & Schumaker, 2018).

Sex Offender Counselor Training

Despite an increase in sex offenders living in the community, many established counseling professionals and graduate-level counseling students do not receive training on sex offender-specific evidence-based practices (Generali, Foss-Kelly, & McNamara, 2013). Effective sex offender counselor training is critical in enhancing client outcomes in community practice. Sex offender counselors often lack training, have limited access to treatment manuals, lack research evaluation skills, and have limited professional supervision (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009; Chambless, 1999; Chan et al., 2010). Once established in the profession, counselors report insufficient time for training on evidence-based interventions and difficulty receiving training through continuing education (Chambless, 1999; Chan et al., 2010). With the increase in sex offenders living in the community, training is paramount for all counselors who may eventually have an offender assigned to their caseload. For this reason, sex offender training is beneficial in helping increase counselors' basic familiarity with sexual deviancy, victimization issues (Nelson, Herlihy, and Oescher 2002), and evidenced-based treatment options.

The sex offender counselor's primary purpose is to assist the client in determining the most effective approach to achieve their goals (Levenson et al., 2017). An increase in counselor training opportunities enhances their ability to deliver ethical and effective services (Levenson et al., 2017), maintain proper procedures, and allow the counselors to be flexible in their approach. Despite the importance of training, clients identified the therapeutic relationship's quality as the

most crucial factor in psychiatric care (Krieg & Tracey, 2016). The relationship was a better predictor of treatment outcome than more extensive experience, professional training, and the skills of the counselor (Hersoug et al., 2001). For that reason, training that promotes empathy, genuineness, and non-judgmental attitudes is essential. Empathy and genuineness are counselor traits introduced to the counseling profession by Carl Rogers (1980). He asserted that empathy and genuineness are the foundation for the working alliance.

Carl Rogers (1980) believed that the most effective counselor is trained to hear, reflect, and interpret the feelings of the client in a way that stimulates growth and positive change. He theorized that counselors must be attentive to both the client's state of mind and needs and be flexible and non-defensive, empathetic, genuine, and non-judgmental (Hovarth & Greenberg, 1994). When working with sex offenders, training that includes the premises taught by Rogers helps prepare counselors to form strong working alliances and provide objective treatment. As indicated earlier, client perception of the working alliance is integral when understanding how the relationship develops and is maintained in treatment (Blasko & Jeglic, 2w). When clients perceive counselors as flexible, non-judgmental, and empathetic, they are more likely to form a trusting relationship with the counselor (Krieg & Tracey, 2016). Sex offender assessments are imposing and delve into the cognitions and behaviors that the offender may want to keep hidden. Understanding the nature and motivation for the perpetrator's behavior and assessing it in a non-judgmental way motivates the offender to disclose in ways that mere confrontation would not (Mpofu et al., 2018).

With the broad spectrum of sexual offenders, sex offender counselors require adequate training to treat this population (Levenson et al., 2017). The deficit in these counselors throughout the United States demands a strategic shift to increase sex offender counselors in this

country. Treatment for sex offenders is highly specialized and requires national and state certification. Although some counseling professionals possess the knowledge and background to counsel sex offenders without extensive treatment, most do not require extensive training and supervision that enhances the counselor's ability to build the working alliance and follow treatment protocols. The Association for the Treatment of Sexual Abusers (ATSA), International Association of Trauma Professionals (IAFT), and National Association of Forensic Counselors (NAFC) are three agencies recognized for certifying sex offender counselors. When referencing sex offender counselors in this paper, the assumption is that they are certified.

Although sex offender counselors are certified after graduating and obtaining a license in their respective fields, it is safe to assume that counseling students would benefit from exposure to sex offender training principles while in their graduate programs. Training exposure would increase counseling students' awareness of underserved treatment areas to pursue after graduation, but it would also challenge their flexibility and sensibility with a highly stigmatized group. All counselors should be exposed to training opportunities that "enhance their ability to deliver ethical and effective services," (Levenson et al., 2017), maintain proper procedures, and allow the counselor to be flexible in their approach to exert maximum treatment benefits for the client.

Sex offender training enhances the counselor's ability to provide effective treatment by bringing awareness to the attitudes and perceptions that may negatively impact the working alliance (Levenson et al., 2017). This specialized training also promotes genuineness, unconditional positive regard, and empathy with sex offenders. Adequately trained counselors possess the skills to build a strong working alliance by providing objective and person-centered intervention (Zilcha-Mano et al., 2015). Cumulative research indicates that sex offenders who

receive treatment from adequately trained counselors recidivate at lower rates than those who do not receive treatment (Center for Sex Offender Management, 2010).

Effectiveness of brief training

As indicated previously, counselors report insufficient time for training when engaged in daily practice (Chan et al., 2010). A brief workshop-style training could be instrumental in community counseling practices. In a typical workshop, information is disseminated by an expert or group of experts via lecture and slide presentation (Walters et al., 2005). Treatment manuals and handouts are used as visual aids and material reinforcement. Workshops vary in duration and can last from 1 day to a week. One of the more productive activities in workshops involves opportunities for participants to practice and discuss the principles and skills in experiential and role-play activities (Baer et al., 2009). Training duration and effectiveness have not been adequately researched; however, research indicates that workshop training improves counselors' attitudes, knowledge, and confidence. Workshop training also has consistently failed to adequately equip counselors with skills to provide Evidenced Based Therapies to patients (Walters et al., 2005). This training aims to introduce the basic concepts of research, evidence-based methods, knowledge, and utilization (Chan et al., 2010) to current counselors and counselors-in-training. The training objectives will include The History of Sex Offender Legislation; Myths and Facts; Etiology of Sex Offending; Sex Offender Typologies; Barriers to Treatment; Best Practice and Clinical Interventions; and Treatment Planning. Although workshops are insufficient training mechanisms, they are useful and necessary to teach basic skills and principles that counselors can develop and improve with supervised practice experiences or certification programs.

Methodological Issues in Existing Research

The researcher identified several methodological issues in existing research during this literature review. In a qualitative study by Cartwright et al. (2018), the researchers noted that the study was limited to using a small sample of counselors with unknown training. Furthermore, some of the interviewed counselors had not had contact with sex offenders for several years; therefore, the counselors' perceptions of their experiences may have changed over time (Cartwright et al., 2018). These authors suggested that future studies explore the counselors' perceptions about working with sex offenders after a recent counseling interaction. Also, researchers should examine differences in the working alliance related to the counselors' training.

Morgan et al. (2016) also noted that their study was limited by the lack of information on any graduate or post-graduate training counselors may have received on working with sex offenders. The researchers asserted that any training received may have influenced counselors' perceptions of sex offenders (Morgan et al., 2016). As such, Morgan et al. (2016) suggested that future research should explore the role training plays in perceptions of sex offenders among counselors.

Bach and Demuth (2018) conducted a literature review of research focused on counselors' attitudes and experiences working with sex offenders to pinpoint methodological issues within the literature. One issue Bach and Demuth found related to population validity within the literature. Specifically, most research studies used a homogenous sample of counselors from associations centered on sex offender therapy, neglecting to consider the perceptions of counselors who come from a range of educational backgrounds (Bach & Demuth, 2018). Another methodological issue detected by Bach and Demuth was that most research on

the topic used cross-sectional and correlational research designs. The authors noted that further research is needed to go beyond investigating relationships and focus more on causality (Bach & Demuth, 2018).

The researcher plans to address the methodological issues in existing research using a quasi-experimental design to investigate changes in counselors' perceptions of sex offenders after training. Using this research design will focus on the training and causation issues noted by Morgan et al. (2016) and Bach and Demuth (2018). Furthermore, providing attitude and emotion assessments to counseling students directly after exposure to a sex offender scenario will address the issue noted by Cartwright et al. (2018) regarding potential changes in attitudes with time. Finally, using a sample of counseling students from different graduate programs will address the issue noted by Bach and Demuth (2018) regarding the need for studies to include counselors with diverse backgrounds.

Summary

Cognitive dissonance theory explains counselors' psychological struggle with treating sex offenders with decency or condescension. There is substantial research on sex offender counseling, including information on barriers to treatment progress. Many published works focus on recidivism and how individual sex offender attributes contribute to treatment noncompliance. While these studies offer valuable insight into why sex offenders are not compliant with treatment, they provide only partial insight into why sex offenders do not receive the treatment they need due to counselor dissonance. Research has not adequately explored how counselors' perceptions and attitudes about sex offenders contribute to treatment noncompliance. More specifically, there is a limited body of knowledge on how a counselor's cognitive dissonance about sex offenders prevents them from pursuing certifications in sex offender counseling.

The working alliance is a crucial factor in developing a productive relationship between the client and the counselor (Bordin, 1979). The counseling profession's consensus is that the working alliance between counselor and client is an essential indicator of successful therapeutic outcomes (e.g., Horvath & Symonds, 1991). The central issue addressed in this study is that the working alliance between counselor and sex offender is influenced by the counselor's perception of the crime committed and their ability to manage their countertransference (Cartwright et al., 2018).

The nature of the crime may predict the counselors' discomfort with the offender. However, sex offender training could ameliorate these negative perceptions, increase the counselor's self-efficacy, and improve the working alliance. Conversely, a lack of training about counseling sex offenders may cause counselors to be apprehensive. Effective treatment of sex offenders requires knowledge and objectivity (Bach & Demuth, 2018; Morgan et al., 2016; Paul & Paul, 2016). The consequence of harmful perceptions and attitudes toward sex offenders may result in counselor prejudice that impacts the working alliance. When counselor attitudes obstruct the working alliance, treatment efficacy decreases.

According to Rosselli and Jeglic (2017), training can be used to change perceptions and attitudes and provide new perspectives through learning. While searching the literature, training that addressed and clarified misconceptions about sex offenders was not found. As such, the specific problem is that it is unknown whether sex offender-specific training would help change emerging counselors' perceptions of sex offenders and the motivation to work with them. The notion is that mental health counselors who gain knowledge of sexual offenders through formal training will be more likely to form perceptions and make decisions based on critical and logical thinking than those who develop beliefs and values by assimilating media or societal viewpoints

(McCartan et al., 2015; Rosselli & Jeglic, 2017). Chapter 3 will provide a detailed description of the proposed research methodology.

CHAPTER 3: METHODS

Introduction

The purpose of this chapter is to provide detailed information regarding the research methodology and design for this study focusing on whether training effectively changes the graduate-level counseling student's perception about sex offenders. The elements within this chapter include an overview of the research problem and purpose, the research questions and hypotheses, justification for the chosen research methodology and design, a description of the population and sample, instrumentation, including reliability and validity, data collection procedures, data analysis techniques, and ethical concerns. The chapter concludes with a summary of its content.

Research Questions

This research study examined the differences between the control and training groups across time on the Discrete Emotions Questionnaire (DEQ) and Working Alliance Inventory – Short Revised Therapist (WAI-SRT) scores. While counselors can provide counseling to a variety of clients, a failure to provide help because of bias or prejudicial beliefs could be viewed as unethical. Giordano and Cashwell (2018) contended that a lack of training about offenders who display deviant sexual behaviors might be a barrier to providing effective mental health services. Furthermore, recent research findings revealed that counselors who were apprehensive about working with sex offenders felt that they did not have enough knowledge to provide effective counseling (Bach & Demuth, 2018; Morgan et al., 2016; Paul & Paul, 2016). To examine these issues, the current study examined the following questions:

RQ1: How does a 45-minute training about counseling sex offenders influence counseling graduate students' scores on the working alliance inventory?

RQ2: How does a 45-minute training about counseling sex offenders influence counseling graduate students' scores on the discrete emotional questionnaire?

Research Design

This study used a quasi-experimental, two-group pretest-posttest design. This design selected treatment and control groups from eligible graduate counseling students. Participant eligibility was determined by the demographic questionnaire responses discussed in the sampling section of this chapter. This study examined the relationship between a training intervention and outcome. This type of design allowed for the generalization to the studied population despite the participants' individual differences and personal attributes (Shadish., et al., 2002).

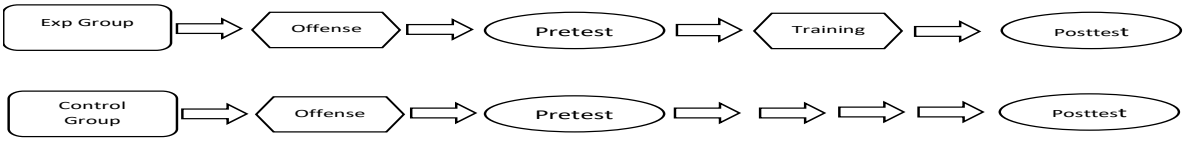
The graduate counseling students were divided into two groups and asked to evaluate the vignette of a client who committed a tier I sex offense (see chapter 2 for description). Next, the participants completed the DEQ and WAI-SRT as a pretest to establish a baseline comparison. The DEQ documents the emotional reaction of the participant, and the WAI-SRT assess the participants' willingness to form a working alliance with the client described in the vignette. Afterward completing these pretest materials, a 45-minute sex offender training intervention (independent variable) was given to treatment group, and the control group did not receive training. Next, all participants were given a vignette of a client who had committed a tier III sex offense. After reading the vignette, each group completed the DEQ and WAI-SRT posttests. The pretests and posttest scores were examined to assess the differences between groups, differences over time, and differences over time by group.

A priori power analysis was conducted to determine the number of participants needed for this study. Using G-power (2020), a sample size of 60 was required to determine the efficacy of counseling sex offenders. Using a split-plot Analysis of Variance (ANOVA), the mean

difference between the change in the WAI-SRT and DEQ over the training period was evaluated. For this study, the sample size was calculated using the following values: A partial eta square of .06 was used to indicate a medium effect size. Effect size is the variability in the outcome accounted for by the interaction between the training group and time (Sullivan, et. al., 2012). The power variable was set to .80, which is typical for social science experiments (Cohen, 1992). Power refers to the probability that a statistically significant finding will be found when it exists. The alpha level will be set as $p = 0.05$. There were two measures, pretest and posttest. Given these parameters, 60 participants (approximately 30 per group) were needed for the study.

Figure 1

Quasi-Experimental Design



Population

The participants included 20 full-time or part-time counseling graduate students. One university and participants from two programs responded (Rehabilitation Counseling and Clinical Counseling). The Clinical Counseling and Rehabilitation Counseling programs are both 62-credit-hour programs, including 4-credit hours of practicum and 12-credit hours of internship. Participation in the study was voluntary, and study participants did not receive any remuneration for their participation.

Table 2

Eligibility Inclusion and Exclusion Criteria for Participants

Project Portion	Inclusion Criteria	Exclusion
Assessment	**English language proficiency**	**Participant experienced sexual trauma with objections**
	Enrollment in graduate counseling program	
	>21 years old	**Participants report psychiatric disorders such as PTSD or GAD with objections**
Intervention	**Graduate-level student in clinical counseling program**	

Sample and Sampling Procedure

Participant selection for this study utilized a selective sampling method. Selective sampling is when participants are deliberately chosen by using a sampling plan that selects only those with relevant characteristics (Heppner, Wampold, & Kivlighan, 2008). Master's level counseling students are often undecided on their career concentration and lack exposure to specialized counseling opportunities. As indicated in previous chapters, the deficit between sex offender counselors and the number of sex offenders living in the community has grown over the last twenty years. This study endeavored to obtain a sample representative of all counseling students; however, the selection of the participants was not randomized. With selective sampling, this study attempted to recruit 60 participants who were currently full-time or part-time counseling students enrolled in a CACREP accredited master's in Rehabilitation Counseling, Mental Health Counseling, Licensed Clinical Social Work, or Substance Abuse and Clinical Counseling program. Two graduate counseling programs from one university responded (Rehabilitation Counseling and Clinical Counseling).

Instrumentation

The three instruments utilized for this study included the Working Alliance Inventory – Short Revised - Therapist (WAI-SRT), Discrete Emotions Questionnaire, and a Demographic

Form. The Working Alliance Inventory – Short Revised - Therapist (WAI-SRT) is a shortened version of the Working Alliance Inventory (WAI) developed by Horvath and Greenberg (1989). Tracey and Kokotovic (1989) shortened the WAI from 36 items to 12 and 10 items for the client and therapist versions. The Working Alliance Inventory – Short Revised - Therapist (WAI-SRT) is designed to assess the alliance scales: Goal, Task, and Bond. The Discrete Emotions Questionnaire developed by Harmon-Jones et al. (2016) is also used to denote participant responses to a tier III sex offense. The Demographic Form was used to collect participant characteristics that include race, age, language preference, graduate school enrollment status, graduate program, and psychiatric diagnosis. All instruments were given to all the participants, and the data were collected through self-report. The following sections give details on these instruments.

Working Alliance Inventory – Short Revised - Therapist (WAI-SRT). The 36-item Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and the 10-item Working Alliance Inventory Short Revised - Therapist (WAI-SRT; Tracey & Kokotovic, 1989) are measures created to assess the alliance between counselor and client in psychotherapy. The total score ranges from 10 to 50, with higher scores reflecting a stronger working alliance. The Working Alliance Inventory – Short Revised - Therapist (WAI-SRT) was adapted for this study and was used to assess the participants' responses to two vignettes. Participants were given a vignette for the pre-test that described a client who had committed a tier I sex offense. For the posttest, the participants were given a vignette for a client who had committed a tier III sex offense (Appendix D). Completing the WAI-SRT takes between 5 and 10 minutes. The WAI-SR is the most frequently used tool to assess the therapeutic alliance (Hall et al. 2010), and the chosen version of WAI-SRT was revised for the therapist (Tracey & Kokotovic, 1989).

Furthermore, higher scores on the WAI-SRT are associated with better treatment outcomes, confirming the WAI-SRT's construct validity by Bordin's Theory (Falkenstrom, 2013). The WAI-SRT has psychometric characteristics (validity and reliability) that can detect the change in the working alliance scores of the participants. Also, its interpretability will help the researcher assign a qualitative description of the working alliance based on the instrument's scores. In this study, the pretest WAI-SRT internal consistency reliability was $\alpha = .93$, and for the posttest, the internal consistency was $\alpha = .94$.

Discrete Emotions Questionnaire. The Discrete Emotions Questionnaire is a composite measure of self-reported eight different emotional reactions to stimuli, consisting of 32 items that have a logical or empirical relationship (Harmon-Jones et al., 2016). With the DEQ, the researcher can assign a score (32 to 224) to place participants on a continuum describing various emotional reactions. The DEQ has the psychometric characteristics necessary to detect the change in the participant's emotions. Discrete emotions can be categorized along dimensions, including valence (positivity/negativity), arousal (high/low), and motivational direction (approach/avoid). Its interpretability also helps the researcher assign a qualitative description of discrete emotions based on the instrument's scores.

Participants were asked to rate the degree to which they experienced these emotions after reading each vignette. Each of the 32 emotion items were rated on a 7-point Likert-like scale, where one represents *not at all,* and seven represents *an extreme amount* (Harmon-Jones et al., 2016). The DEQ was completed in approximately 5-10 minutes and was used soon after participants read the emotional content of each vignette (Harmon-Jones et al., 2016).

In previous studies, the DEQ subscales' internal consistency reliability estimates (i.e., each of the eight primary emotions) ranged between $\alpha = .82$ and $\alpha = .97$ (Harmon-Jones et al.,

2016). These ranges are considered high and indicate excellent reliability (Heale & Twycross, 2015). In terms of validity, results from three repeated studies revealed that the DEQ had adequate construct validity (Harmon-Jones et al., 2016). To determine construct validity, the DEQ authors manipulated participants' emotions through images and written scenarios, then provided them with the DEQ (Harmon-Jones et al., 2016). In this study, the DEQ subscales' internal consistency reliability estimates (i.e., each of the eight primary emotions) ranged between $\alpha = .75$ and $\alpha = .95$ (Harmon-Jones et al., 2016).

Individuals who expressed interest in participation were screened using a Demographics Questionnaire created by the researcher. The demographic characteristics collected include race, age, language preference, graduate school enrollment status, graduate program, and psychiatric diagnosis. Race was assessed to determine whether participants respond differently to sex offenses based on their race. Age was obtained to ensure participants have the legal capacity to report their mental health status, consent to treatment options, and make a legal decision without parental consent. Language preference was self-reported and was collected to ensure the participant understood the instructions from the researcher. Language also provided a wide range of information about people, such as their geographic origin, social status, and cultural influence (Labov, 1976, 2001). The reason why language can be considered in this study is threefold: (1) it drives social preferences related to sexual deviance, (2) it is a social marker for affiliation, and social interaction, and (3) language is a vector for social and cultural learning. Graduate school enrollment status and the graduate program may influence the participant's administrative and clinical perception of sex offenders and their perceived ability to counsel them. Psychiatric diagnoses were collected because people with mental illness may be vulnerable to the content

presented in this study and may require debriefing after the research has concluded. Although debriefing was offered, that option was not utilized by participants.

The researcher suggests that the attribute variables will not influence the effect of training on counseling sex offenders. Therefore, ex post facto repeated measures ANOVA tests were conducted to explore the differences in the attribute variables of race, gender, age, and language preference on participants' scores on the WAI-SRT and DEQ.

Table 3

Measures, Time Points, and Number of Items for Assessments

Measure	Timepoint	Number of Items
Discrete Emotions Questionnaire	**Pre-treatment and Post-treatment (Time 1 & 2)**	**8 emotions** **32 items**
Working Alliance Inventory – Short Revised	**Pre-treatment and Post-treatment (Time 1 & 2)**	**10**
Demographic information	**Pre-treatment**	**5**

Procedures

The researcher gained approval from the instructors of master's courses to contact students about volunteering to participate in a research study. The sample included students from the Rehabilitation Counseling and Clinical Counseling graduate programs within one university. A random number generator was used to assign the control group members and training group members using voluntary participants. The researcher sent an introductory email explaining the study, the requirements for those who agreed to participate based on their group assignment, an informed consent form, and the Demographic Questionnaire. The informed consent form and Demographic Questionnaire were completed before the participants received the training. Study data were collected and managed using REDCap electronic data capture tools hosted at East Carolina University. REDCap (Research Electronic Data Capture) is a secure, web-based

software platform designed to support data capture for research studies. It provided 1) an intuitive interface for validated data capture; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages, and 4) procedures for data integration and interoperability with external sources. Webex provided videotelephony services that allowed the researcher to train the students and conduct the research online. Participants were emailed a Webex link with their chosen study time. At the time of the study, each participant was given a packet containing the WAI-SRT, DEQ, and a vignette describing a tier I sex offense. The researcher asked the participants to read the vignette and took 15 minutes to complete the pretest packet, including the DEQ and WAI-SRT. Once complete, the DEQ and WAI-SRT will be automatically uploaded to the DocuSign storage for researcher analysis. The training group was given a 45-minute training (see table 4), and the control discussed counseling during the COVID epidemic for 45-minutes. Each group completed a post-test packet, which included a tier III sex offense vignette, the DEQ, and WAI-SRT. The categorical sex offender change attempts to elicit discrete emotional responses that the lower-level tier I offense did not. Upon completion, test scores were subsequently uploaded to RedCap for the researcher's review. The script for explaining the experimental design procedures used can be found in Appendix C.

Statistical Analysis

The data was analyzed using SPSS 28 (2021) software. A split-plot ANOVA was used to analyze the effects of the repeated measure and between-group effects in this study. With this statistical procedure, researchers can examine differences between two or more independent groups while subjecting participants to repeated measures. Specifically, with the split-plot ANOVA, the researcher compared the mean differences between groups (training, no training)

and participants' changes over time on the dependent variables (i.e., WAI-SRT, DEQ). The demographic variables' distributions of graduate students were examined with descriptive statistics (i.e., median, mean, standard deviation, and boxplots). Levene's Test of Equality of Error Variance was performed to determine if the assumption of the homogeneity of variance had been violated ($p < .05$). Similarly, Box's Test of Equality of Covariances was examined to determine if the assumption of the equality of covariances had been violated ($p < .005$).

Because the normality and equal variance assumptions were satisfied, a split-plot ANOVA was used to assess the effect of the training on the Discrete Emotions Questionnaire and Working Alliance-Short Revised -Therapist across two time periods (pre-intervention, post-intervention). All statistical tests were two-sided. A p-value of ≤ 0.05 was considered statistically significant.

Table 4

Training Schedule for Counselors of Sex Offenders

Topic	Objective	Duration
Overview	**Discuss the history of S/O legislation** **Discuss Myths and Misconceptions of S/O**	**15 minutes**
Etiology of sex offending	**Detail origins of sexually deviant behaviors**	**5**
Sex Offender typologies	**Discuss tiers of sex offenses in the US**	**5**
Treatment barriers	**Explain barriers to treatment**	**5**
Evidence-based practices and treatment planning	**Discuss CBT efficacy with sex offenders**	**15**

Ethical Considerations

Ethical considerations were a top priority throughout the study. The informed consent form was read by each participant before data collection, detailing the risks and privacy rights that govern the research study. The study was approved by the East Carolina University Institutional Review Board (IRB). The Informed Consent letter follows U.S. federal guidelines,

as outlined by Frankfort-Nachmias and Nachmias (2008). The risks to the participants associated with this study were minimal. All participants who reported a history of sexual trauma or psychiatric disorder and were disturbed by the content of this study were excluded. All participants were over 21-years of age and did not demonstrate any impaired mental capacity, as determined by their ability to be accepted into a graduate-level program. Although the topic could have triggered emotional distress or upset, no participant reported destructive negative emotions before, during, or after the study. The researcher emphasized to all participants that they could withdraw at any time without consequence. Furthermore, the researcher had a list of local mental health services available to participants who felt the need to talk to a professional following their experience. Participants who met these criteria were considered appropriate for the study.

Limitations, Assumptions, and Design Controls

Limitations are aspects of a study's design that potentially weaken research results (Simon, 2011). The most significant limitation of quasi-experimental studies was the lack of random selection. Random selection influences the external validity of the study; therefore, one cannot generalize the findings from the counseling students in this study. A quasi-experimental design lacks random assignment and may appear to be inferior to randomized experiments due to low internal validity. Another potential limitation stems from a fictitious scenario involving a sex offender instead of having an actual case study. The participants' knowledge that the vignette is fictional may impact their emotional response to the sex offense presented. Both the WAI-SRT and the DEQ are self-report instruments, and self-reported data can be influenced by response bias among the participants (Grös et al., 2007; Larson, 1988). Lastly, participants may have underestimated the time required to complete the study, resulting in impatience and frustration.

As with any research study relying on technology, participants may have experienced potential technical issues such as emails not being delivered appropriately and technical glitches with Zoom or DocuSign.

For this study, the researcher assumed that the characteristics of individuals in the control and intervention groups were similar. The researcher also assumed that using a fictional scenario of a sex offender adequately elicited emotional responses and perceptions of a working alliance among participants. Finally, the researcher assumed that participants were honest when answering the survey questions.

Design controls also referred to as delimitations, were set by the researcher to create boundaries within the research (Simon, 2011). This study is delimited to a convenience sample of counseling students in North Carolina in graduate counseling programs. Additionally, the Discrete Emotions Questionnaire and Working Alliance Inventory-Short Revised Therapist were the only instruments used to answer the research questions.

Summary

The goal of this chapter was to outline the research method used to answer the research questions. An overview of the research problem and questions was provided, and the chosen research methodology and design were justified. This chapter also included discussions of the study participants and sampling procedures, instrumentation, including reliability and validity, data collection procedures, data analysis techniques, and ethical considerations.

CHAPTER 4: DATA ANALYSIS AND RESULTS

Introduction

The chapter begins with a review of study participants' response rates. Following this review, the demographic information of the sample is described. Next, a discussion of descriptive statistics is developed to examine and compare the composition of the training and control groups. At this point, the chapter investigates the two research questions. The chapter concludes with a summary of the results.

Response Rate

The participants for this study were graduate students from a large public university in the southeastern United States. Measurement invariance analyses required complete data for each case. Therefore, respondents who did not complete all survey questions were not analyzed. Forty-four graduate students initially consented to participate; however, only 20 (45%) completed the study. These 20 participants were assigned randomly to the control (11) or treatment (9) group. The sample demographics are discussed in the following section.

Sample Demographics

Using selective sampling, this study recruited full-time or part-time counseling students enrolled in a master's in Rehabilitation Counseling and Clinical Counseling programs from one university. The demographic characteristics collected included gender identification, race, age, language preference, graduate school enrollment status, graduate program, and psychiatric diagnosis. Several independent chi-square analyses were performed to describe the demographic composite of the treatment and control groups. The contingency table rows contain the levels of the demographic variable being examined, and the columns correspond to the treatment levels of the independent variable. The following section details these Chi-square analyses.

Gender

Twenty participants (n = 20), comprised of 17 (85%) females and 3 (15%) males, completed surveys for this study (see Table 5). There was a significant difference in the gender composition of the treatment and control group χ^2 (1, N = 20) = 4.13, p = .038. The three males (100%) in the study were in the treatment group and represented 33.3% of the total participants receiving treatment and 0% of the participants in the control group. In contrast, of the 18 remaining participants, 100% (n=11) of the individuals in the control group and 66.7% (n=6) in the treatment group identified as female (see Table 5).

Table 5

Gender by Group

Gender	Groups		Total (%)
	Control (%)	Treatment (%)	
Male	0 (0.0%)	3 (33.3%)	3 (15.0%)
Female	11 (100%)	6 (66.7%)	17 (85.0%)
Total	11 (55%)	9 (45%)	20 (100%)

Table 6 shows that despite the significant difference in gender composition across groups, there was not a statistical difference between the pretest Working Alliance Inventory-Short Revised-Therapist (WAI-SRT) means for males (M = 40.00, SD = 5.57) and females (M = 40.76, SD = 6.82). Similarly, there was not a statistical difference on the posttest Working Alliance Inventory mean scores for males (M = 40.00, SD = 2.00) and females (M = 36.35, SD = 8.85).

Likewise, Table 6 also shows that despite the significant difference in gender composition across groups, there was not a statistical difference between the pretest DEQ mean for males (M = 56.67, SD = 7.02) and females (M = 64.29, SD = 24.80). Similarly, there was not

a statistical difference on the posttest DEQ mean scores for males ($M = 53.67$, $SD = 7.51$) and females ($M = 74.76$, $SD = 8.85$).

Table 6

Means and Standard Deviations of Scores by Gender

		Pre-WAI-SRT		Post-WAI-SRT		Pre-DEQ		Post-DEQ	
Gender	N	M	SD	M	SD	M	SD	M	SD
Males	3	40.00	5.57	40.00	2.00	56.67	7.02	53.67	7.51
Females	17	40.76	6.82	36.35	8.85	64.29	24.80	74.76	30.85
Total	20	40.65	6.53	36.90	8.26	63.15	23.04	71.60	29.45

*Note: Higher WAI-SRT scores (1= not at all, 5=very much) indicate a more positive view of the Working Alliance with the sex offender. Higher DEQ (1= not at all, 7 = an extreme amount) scores indicate stronger negative emotions about the sex offender.

Race

Fourteen participants, or 70% of the sample, identified as Caucasian, while two participants (10%) identified as Black / African American. Two participants (10%) identified as Latinx, one participant (5%) identified as Asian Pacific Islander, and one participant (5%) identified as Mixed Race (see table 7). There was not a significant difference in the racial composition of the treatment and control group $\chi^2 (4, N = 20) = 7.01$, $p = .135$.

Table 7

Participant Race

	Control		Treatment		Total (study)	
Race	N	%	N	%	N	%
African American	0	0.00	2	100.00	2	10.00
Asian Pacific Islander	1	100.00	0	0.00	1	5.00
Caucasian	9	64.30	5	35.70	14	70.00
Latinx	0	0.00	2	100.00	2	10.00
Mixed Race	1	100.00	0	0.00	1	5.00
Total	11	55.00	9	45.00	20	100.00

Table 8 shows a non-statistically significant difference between the pretest Working Alliance Inventory-Short Revised-Therapist (WAI-SRT) means by race. Similarly, there was not

a statistically significant difference in the posttest Working Alliance Inventory mean scores by race. In addition, there was not a statistically significant difference in DEQ pretest means by race. Likewise, there was not a statistically significant difference in the DEQ posttest mean scores by race.

Table 8

Means and Standard Deviations of Scores by Race

		Pre-WAI-SRT		Post-WAI-SRT		Pre-DEQ		Post-DEQ	
Race	N	M	SD	M	SD	M	SD	M	SD
African American	2	43.50	3.54	39.50	0.71	67.00	4.24	80.00	36.77
Asian/Pacific Island	1	40.00		40.00		72.00		60.00	
Caucasian	14	41.21	5.40	35.93	9.22	65.00	26.71	72.29	31.87
Latinx	2	42.50	10.61	43.50	2.12	47.00	4.24	51.50	13.44
Mixed Race	1	24.00		29.00		53.00		97.00	
Total	20	40.65	6.53	36.90	8.26	63.15	23.04	71.60	29.45

*Note: Higher WAI-SRT scores (1= not at all, 5=very much) indicate a more positive view of the Working Alliance with the sex offender. Higher DEQ (1= not at all, 7 = an extreme amount) scores indicate stronger negative emotions about the sex offender.

Age

The participants ages ranged from 22 to 50 (M = 32.3, SD = 9.28). The eleven participants (55%) in the control group were between ages 22 to 46 (M = 31.1, SD = 8.95), while the remaining nine participants (45%) who comprised the treatment group were ages 22 to 50 (M = 33.8, SD = 10.0). For the entire sample, statistically significant correlations between age and the scores of the WAI-SRT pretest (r =.14, p = .57) and posttest (r = .05, p = .84) were not found. For the entire sample, statistically significant correlations between age and the scores of the DEQ pretest (r = -.25, p = .30) and posttest (r = -.10, p = .67) were not found.

Primary Language and Educational Status

English was the primary language for participants in both the treatment and control groups χ^2 (2, N = 20) = 2.04, p = .36. Participants (N=20) were part of the same graduate

program, with nineteen participants (95%) enrolled full-time, and one participant (5%) enrolled part-time.

Psychiatric Diagnosis

Out of the 20 study participants, 10 (50%) responded yes when asked, “Have you ever been treated for an anxiety or mood disorder?”. Comparatively, 10 (50%) participants denied having been treated for an anxiety or mood disorder. Five participants (45.5%) out of the 11 in the control group responded “Yes”, while the other six participants (54.5%) in the control group responded “No”. Like the control group, approximately one-half of the five (55.6%) of the nine participants in the treatment group responded yes to having received treatment for an anxiety or mood disorder. The other four (44.4%) denied being treated for an anxiety or mood disorder. The number of participants who have been treated for an anxiety or mood disorder did not significantly differ between the treatment and control groups χ^2 (1, N = 20) = .20, p = .653.

Table 9 contains the pretest and posttest group means and standard deviations for both the intervention and control groups. Specifically related to the influence of the attribute variables, the interaction effect was explored. That is, did the WAI-SRT and DEQ scores change differently based on the participant's anxiety/mood disorder treatment history. The p-value of this interaction effect was not statistically significant [F(2, 17)= 2.66, p = .099, *partial* η^2 = .24]. However, an examination of these cell means suggested that possible trends in the effect of anxiety/mood disorder treatment history should be explored in the discussion chapter.

Table 9

Means and Standard Deviations of Scores by Anxiety or Mood Disorder

		Pre-WAI-SRT		Post-WAI-SRT		Pre-DEQ		Post-DEQ	
Diagnosis	N	M	SD	M	SD	M	SD	M	SD
Yes	10	40.50	5.48	33.70	9.26	70.80	23.06	78.00	34.92
No	10	40.80	7.73	40.10	5.95	55.50	21.43	65.20	22.81
Total	20	40.65	6.53	36.90	8.26	63.15	23.04	71.60	29.45

*Note: Higher WAI-SRT scores (1= not at all, 5=very much) indicate a more positive view of the Working Alliance with the sex offender. Higher DEQ (1= not at all, 7 = an extreme amount) scores indicate stronger negative emotions about the sex offender.

Experienced a Sexual Assault

A Pearson chi-square test was conducted to determine if there was a significant difference in the composition of the groups based on having experienced a sexual assault. Of the study sample, 10 (50%) reported a sexual assault against themselves or family members. Six members from the control group (54.5%) and four from the treatment group (44.4%) had personal or family sexual assault history. Comparatively, both the control and treatment groups had five participants (50%) with no reported personal or familial sexual assault history. The participants' history of sexual assault did not significantly differ between groups $\chi^2 = (1, N=20) = .20$, $p = .653$, indicating similar group composition.

Table 10 contains the pretest and posttest group means and standard deviations for both the intervention and control groups. Specifically related to the influence of the attribute variables, the interaction effect was explored. That is, did the WAI-SRT and DEQ change differently based on the sex assault history of the participant and their family. The p-value of this interaction effect was not statistically significant [$F(2, 17)= 2.97$, $p = .079$, *partial* $\eta^2 = .26$]. However, an examination of these mean scores suggests that possible trends in the effect of sexual assault history need to be explored in the discussion chapter.

Table 10

Means and Standard Deviations of Scores by Sexual Assault History

		Pre-WAI-SRT		Post-WAI-SRT		Pre-DEQ		Post-DEQ	
Diagnosis	N	M	SD	M	SD	M	SD	M	SD
Yes	10	41.40	5.91	34.40	9.80	66.90	23.61	75.10	33.38
No	10	39.90	7.32	39.40	5.83	59.40	23.08	68.10	26.24
Total	20	40.65	6.53	36.90	8.26	63.15	23.04	71.60	29.45

*Note: Higher WAI-SRT scores (1= not at all, 5=very much) indicate a more positive view of the Working Alliance with the sex offender. Higher DEQ (1= not at all, 7 = an extreme amount) scores indicate stronger negative emotions about the sex offender.

Statistical Analyses for the Research Questions

Based on the recommendation of Cramer and Bock (1966), a repeated-measures ANOVA was conducted to help protect against inflating the Type 1 error rate in the follow-up ANOVAs. However, before performing the ANOVA, six Pearson correlations were performed between the four dependent measures (i.e., Pre-WAI-SRT, Post-WAI-SRT, Pre-DEQ, and Post-DEQ) to test the ANOVA assumption that the dependent variables would be correlated with each other in the moderate range (i.e., .20 - .60; Meyers, Gampst, & Guarino, 2006). The WAI-SRT and DEQ scores were measured for master's students twice. Once, after reading the first case study (Tier I sex offense) and again, after reading the second case study (Tier III sex offense). While the treatment group received a 45-minute training, the control group did not receive any training.

The total score on the WAI-SRT ranges from 10 to 50, with higher scores reflecting a stronger working alliance (Horvath, 1986). For the entire sample, there was a significant correlation between the pretest WAI-SRT and posttest WAI-SRT ($r = 61$, $p = .004$). The mean score for the entire sample on the WAI-SRT during the pretest ($M = 40.65$, $SD = 6.52$) was higher than the posttest ($M = 36.90$, $SD = 8.26$). Although not statistically significant, this decrease in WAI-SRT scores might suggest that participants were not as confident about establishing a working alliance during the posttest as they were during the pretest.

For the entire sample, there was a statistically significant positive correlation between scores on the WAI-SRT pretest and posttest ($r = .61$, $p = .004$). Interestingly, while this same significant positive correlation was found for the control group ($r = .74$, $p = .009$), for the treatment group, there was not a statistically significant correlation between pretest and posttest WAI-SRT scores ($r = .05$, $p = .90$).

The total score on the DEQ scale ranges from 32 to 224, with higher scores reflecting more intense negative emotions (Harmon-Jones, Bastian, & Harmon-Jones, 2016). The descriptive statistics of the sample indicated that DEQ scale scores increased from the pretest DEQ ($M = 63.15$, $SD = 23.04$) to the posttest DEQ ($M = 71.60$, $SD = 29.45$). The increases in posttest DEQ scores indicate an increase in discreet emotions (anger, disgust, fear, anxiety, sadness, joy) that influence valence (positivity/negativity), arousal (high/low), and motivational direction (approach/avoid). For the entire sample, there was a significant relationship between the pretest and posttest DEQ scores ($r = .643$, $p = .002$). Although not statistically significant, the increase in DEQ scores also presented a trend worth discussing. The results might suggest that participants felt stronger negative emotions after reading the posttest vignette despite training. Perhaps the effect would have been significant if more people had participated in the study.

Interestingly, the correlation between the pretest and post-test scores for the control group was not statistically significant ($r = .55$, $p = .08$). However, there was a significant positive correlation between the pretest and posttest DEQ scores ($r = .80$, $p = .01$). A meaningful pattern of correlations was observed among most dependent variables. That is, the pretest WAI-SRT and pretest DEQ had a moderate negative correlation ($r= -.29$, $p = .224$). Likewise, the posttest correlation of posttest WAI-SRT and the posttest DEQ also had a moderate negative correlation

(r = -.66, p = .002), supporting the appropriateness of the repeated measures ANOVA to answer the research questions. Additionally, the Box's M value of 12.06 (see table 11) was associated with a p-value of .528, which was interpreted as non-significant based on Huberty and Petoskey's (2000) guideline (i.e., p < .005). Thus, the covariance matrices between the groups were assumed to be equal for the ANOVA.

Table 11

Box's Test of Equality of Covariance Matrices

Box's M	12.06
F	0.90
df1	10
df2	1390.54
Sig.	0.53

Before conducting follow-up univariate analyses, the homogeneity of variance assumption was tested for the dependent measures. Based on a series of Levene's F tests, the homogeneity of variance assumption was considered satisfied. Specifically, Levene's F test suggested that the variances associated with the Pre-WAI, Post-WAI, Pre-DEQ, and Post-DEQ were homogenous.

The time * group interaction (i.e., the within-subject changes in WAI-SRT and DEQ scores over time for each group) was assessed using a repeated-measures ANOVA. The results indicated that the interaction between treatment type and score changes over time was not statistically significant (Λ = .98, F (2, 17) = .81, p = .825, partial η^2 = .02). This finding suggests that differences in pretest to posttest scores on the WAI-SRT and the DEQ did not depend on the type of training. Likewise, the univariate effect of the treatment group was statistically non-significant (Λ = .10, F (2, 17) = .97, p = .398, partial η^2 = .10). However, interesting within-

group trends were observed over time in the WAI-SRT and DEQ scores. That is, although a statistically significant multivariate within-effect was not found ($\Lambda = .71$, $F\ (2, 17) = 3.48$, $p = .056$, partial $\eta^2 = .29$), the differences in WAI-SRT and DEQ mean scores from pretest and posttest suggest that the changes of scores over time should be noted.

Table 12

Working Alliance Inventory-Short RT

	Pretest		Posttest	
WAI-SRT Item(s)	*M*	*SD*	*M*	*SD*
Agree about the steps	3.65	0.99	3.55	1.00
Concerned for the client's welfare.	4.05	1.00	4.00	0.86
Work towards mutually agreed-upon goals.	4.15	0.67	3.85	0.88
Feel confident about usefulness	4.30	0.80	3.85	1.14
Appreciate the client as a person.	4.00	0.92	3.25	1.25
Establish an understanding	4.15	0.59	3.75	0.91
Feel mutual respect.	4.05	0.94	3.55	1.05
I feel a common perception of their goals.	3.95	0.83	3.25	1.07
Respect the client, even when doing things that I do not approve of.	4.20	0.83	3.90	1.02
Agree with the client on what to work on.	4.15	0.75	3.95	0.94
Total Scale	40.65	6.52	36.9	8.26
Cronbach's Alpha		*0.93*		*0.94*

*Note: Higher WAI-SRT scores indicate a more positive view of the Working Alliance with the sex offender described in the vignette.

The within-group differences indicate that the WAI-SRT scores of the participants changed from pretest to posttest. That is, WAI-SRT scores (see table 12) decreased from Time 1 to Time 2. The difference between the pretest WAI-SRT ($M = 40.65$, $SD = 6.52$) and the posttest WAI-SRT ($M = 36.90$, $SD = 8.26$) was statistically significant [$F(1,18) = 5.76$, $p = .027$, *partial* $\eta^2 = .24$]. Irrespective of the training, there was a decrease in the Working Alliance Inventory-SRT Total Score when the sexual offender vignette changed from a Tier I to a Tier III offense. These results suggest that the counseling students were more confident working with the Tier I

sex offender depicted in the first vignette than the Tier III sex offender depicted in the second vignette. The training was designed to increase participant objectivity and establish mutuality between the client and counselor. Regardless of the tier classification, the researchers expected the training to create cognitive dissonance that positively influenced WAI-SRT scores. The reduction in WAI-SRT scores was unforeseen. There may have been several reasons for this outcome. The reasons were explored in the discussion chapter.

Table 13

Discrete Emotions Questionnaire

Scale		Pretest			Posttest		
	DEQ	*M*	*SD*	*α*	*M*	*SD*	*a*
Anger	Anger	2.75	1.74	0.92	4.05	2.01	0.94
	Rage	1.75	1.21	0.92	2.75	2.15	0.94
	Mad	2.40	1.90	0.92	3.55	1.99	0.94
	Pissed-off	2.50	2.06	0.92	3.25	2.07	0.94
Joy	Happy	1.40	0.82	0.91	1.25	0.79	0.77
	Enjoyment	1.50	0.95	0.91	1.10	0.45	0.77
	Liking	1.55	1.05	0.91	1.10	0.45	0.77
	Satisfaction	1.85	1.31	0.91	1.40	0.99	0.77
Fear	Terror	1.50	0.95	0.87	2.05	1.64	0.95
	Scared	1.60	0.94	0.87	2.00	1.65	0.95
	Panic	1.75	1.29	0.87	1.75	1.45	0.95
	Fear	1.70	1.03	0.87	2.15	1.60	0.95
	Dread	1.85	1.23	0.92	2.60	2.01	0.93
Anxiety	Anxiety	2.60	1.90	0.92	2.55	1.90	0.93
	Nervous	2.40	1.64	0.92	2.10	1.71	0.93
	Worry	2.55	1.57	0.92	2.70	1.87	0.93
Sadness	Sad	2.40	1.76	0.75	3.40	2.21	0.85
	Grief	1.90	1.52	0.75	2.25	2.12	0.85
	Lonely	1.30	0.98	0.75	1.50	1.40	0.85
	Empty	1.60	1.27	0.75	1.45	1.36	0.85
Relaxation	Chilled-out	2.50	1.57	0.90	2.30	1.81	0.91
	Easygoing	2.55	1.76	0.90	2.40	1.93	0.91
	Relaxed	2.85	1.87	0.90	2.80	2.04	0.91
	Calm	3.65	2.01	0.90	3.35	1.95	0.91
Disgust	Grossed-out	2.35	1.79	0.90	3.20	2.12	0.92

	Nauseous	1.65	1.31	0.90	2.10	1.86	0.92
	Sickened	1.85	1.18	0.90	3.35	2.32	0.92
	Revulsion	2.00	1.34	0.90	3.15	2.11	0.92
Desire	Wanting	1.15	0.49	0.85	4	0	0.94
	Desire	1.15	0.49	0.85	4	0	0.94
	Craving	1.25	0.64	0.85	4	0	0.94
	Longing	1.35	0.93	0.85	4	0	0.94
	DEQ Total Scale	63.15	23.04	0.91	71.6	29.44	0.93

*Note: Higher DEQ scores indicate stronger negative emotions about the sex offender described in the vignette.

Similarly, the within-group differences indicate that the DEQ scores of the participants also changed from the pretest to the posttest (see Table 13). DEQ scores increased from Time 1 to Time 2. There was a difference between the pretest DEQ Total Score (M = 63.15, SD = 23.04) and the posttest DEQ Total Score (M = 71.60, SD = 29.45) which was not statistically significant [$F(1,18) = 2.72$, $p = .12$, *partial* $\eta^2 = .01$]. That is, regardless of the treatment group, there was not a statistically significant increase in the DEQ Total Score when the sexual offender vignette changed from a Tier I to a Tier III offense. The Discrete Emotions Questionnaire (DEQ) is sensitive to eight distinct state emotions: anger, disgust, fear, anxiety, sadness, happiness, relaxation, and desire.

Table 13 shows that regardless of the Discrete Emotion and group designation (control versus treatment), the participants' mean score increased for each discreet emotion analyzed. Although statistical analysis of the individual DEQ items was outside of the research questions, it appears that irrespective of the training regime, the counseling students felt more negative emotions after reading the Tier III vignette than the Tier I vignette. This finding was unexpected because the training was designed to stabilize the counselor's emotional responses regardless of tier classification. The possible reasons for this outcome are discussed in the next chapter.

Summary

A total of 20 students enrolled in CACREP accredited master's in Rehabilitation Counseling and Clinical Counseling programs were participants in this study. The Demographic Questionnaire and pretest (i.e., Tier I sex offense vignette, DEQ, WAI-SRT) were completed by each participant. The participants were randomly assigned to a control group or training group. The training group received a 45-minute sex offender training, and the control group did not. After the training, participants from both groups completed the Tier III sex offense vignette, DEQ, and WAI-SRT.

Repeated measures ANOVA and follow-up comparisons were conducted on the total scores to assess the influence of a training program designed to increase cognitive dissonance about counseling sex offenders. This chapter provides descriptive statistics for each item and the total pretest and posttest scores for the 20 participants who completed both tests. The difference between these means (calculated as posttest means minus pretest mean) is also presented, along with the univariate test results conducted on the demographic attribute variables. Contrary to the expectations, the 45-minute training did not significantly increase the WAI-SRT total score from the pretest to the posttest. Likewise, the participants' DEQ scores did not significantly change after the 45-minute training. However, the tier III offense described in the posttest seemed to influence scores on the WAI-SRT and DEQ more than the training. The study revealed that participants were more reluctant to establish working relationships with offenders about whom they felt more negative emotions (tier I versus tier III). The main explanation for participant reluctance can be explained by increased posttest DEQ scores, which signify more negative emotions after the tier III offense is presented. Based on these findings, the study failed to support the efficacy of a 45-minute sex offender training creating enough cognitive dissonance to

influence the participants' knowledge, perceptions, and attitude toward sex offenders. There was evidence from these results to conclude that more or alternative training is needed to influence WAI-SRT and DEQ scores. Chapter five will further explain the results and implications of this study.

CHAPTER 5: DISCUSSION

Introduction

This chapter includes a summary of the study, variables, sample, and data collection procedures. Following this summary, the sample demographics, descriptive statistics for the study variables, and research questions and hypotheses analyses are discussed. Next, the limitations of the study are presented, followed by a discussion of the implications for counselor educators, clinical practitioners, and future researchers. A final summary concludes this chapter.

Summary of the Study

Yearly, a disproportionate number of the offenders convicted of a sex crime are released from prison (Levenson & Tewksbury, 2009), compared to the number of counselors certified to treat them. The rise in sex crimes and the "#MeToo" movement have increased public awareness and concern about sexual violence (Brown, 1999; Leary, 2020). Despite improved policies and guidelines designed to help sex offenders integrate into society, many community members prefer to oppose any actions perceived as offering leniency toward sex offenders, thereby ostracizing the offender for life (Valliant, Furac, & Antonowicz, 1994). Ironically, this community stigmatization could increase the need for sex offenders to receive treatment in their communities from counselors who work in community agencies and other outpatient facilities.

With over 800,000 sexual offenders registered in local, state, and federal databases in the United States (NCMEC, 2018) and less than 2500 counselors across the nation who provide court-mandated sex offender treatment (Dockterman, 2018), there are not nearly enough counselors or treatment programs to accommodate the needs of this population. Without informative sex offender training, counselors may steer away from pursuing this specialization and perpetuate attitudes that destabilize the working alliance (Polson & McCullom, 1995). Sex

offenders are often perceived as the most despised offenders within the criminal justice system. Sex offenders frequently elicit extreme negative emotional reactions, including fear, disgust, and moral outrage (Oliver & Barlow, 2010). Mental health counselors are expected to set aside their negative emotions and show empathy with sex offenders, despite their true feelings. Research regarding sex offender treatment has shown that counselors have complex emotional and practical characteristics that shape their views (Church et al., 2011). Despite efforts to verify counselor attitudes towards sex offenders, current research fails to adequately explore the relationship between cognitive dissonance, counselor emotion, the working alliance, and treatment of sex offenders.

The psychological battle between personal attitudes and professional expectations can create cognitive dissonance in counselors. As noted earlier, researchers have created dissonance in participants by identifying the hypocrisy (i.e., the inconsistency between attitudes and behavior) in identifying a serious problem (sex offender counseling deficits) while failing to be a part of the solution (counseling sex offenders). The dissonance motivated participants to challenge the discrepancies in their paradigm, and accept responsibility for correcting the problem (Fried & Aronson, 1995). The current study assessed the influence a 45-minute training had on the participants' dissonance. In essence, the training was designed to challenge the cognitive discrepancies in participants' paradigms, leading to improved scores on the WAI-SRT and DEQ. The WAI-SRT and DEQ were used to document participants' changes over time. The change in the WAI-SRT and DEQ scores align with previous studies' findings of counselor attitudes towards sex offenders. The 45-minute sex offender training used as the intervention in the study was adapted from an 8-hour sex offender training designed to educate mental health professionals in the community.

The purpose of this study was to explore the effect of a 45-minute sex offender training on graduate counseling students' scores on the Working Alliance Inventory – Short Revised - Therapist (WAI-SRT) and Discreet Emotional Questionnaire (DEQ). A quasi-experimental, two-group pretest-posttest design was used to compare test results in the treatment and control groups. A split-plot Analysis of Variance (ANOVA) measured the mean differences in WAI-SRT and DEQ changes over the training period. This chapter will discuss the utilization of Festinger's (1957) cognitive dissonance theory (CDT) as the theoretical framework for understanding and interpreting the study results, limitations, and directions for future research.

Cognitive dissonance theory was used to explain cognitive changes in graduate counseling students from a social psychology standpoint. Festinger (1957) asserts people reduce their cognitive dissonance in four ways:

1. Change the behavior or the cognition
2. Justify the behavior or the cognition, by changing the conflicting cognition
3. Justify the behavior or the cognition by adding new behaviors or cognitions
4. Ignore or deny information that conflicts with existing beliefs

Cognitive dissonance theory can be broken down into three theoretical paradigms important in attitude change. These paradigms include (a) forced compliance from an outside authority, (b) ambiguity in decision making, and (c) when the expended effort to achieve a goal does not match the desired result (Festinger and Carlsmith, 1959; Brehm, 1956; Aronson and Mills, 1959).

This study intended to determine if a 45-minute training could create cognitive dissonance by justifying the practice of counseling sex offenders. This study focuses on two essential dimensions of the counseling experience: the working alliance with the client, and the counselor’s emotions while reviewing a vignette describing the client. The WAI-SRT assesses

three critical aspects of the therapeutic alliance: (a) agreement on the tasks of therapy, (b) agreement on the goals of therapy, and (c) development of an affective bond. As WAI-SRT scores increased, the participants' belief in establishing a stable and positive therapeutic relationship with the sex offender also increased.

Conversely, the Discrete Emotions Questionnaire (DEQ) is a self-report tool that measures eight distinct state emotions: anger, disgust, fear, anxiety, sadness, happiness, relaxation, and desire. Higher DEQ scores reflect more negative emotions in each category. If the training successfully reduced participant dissonance, higher scores on the WAI-SRT and lower scores on the DEQ were expected. In theory, cognitive dissonance resolution would have decreased the participants' discreet negative emotions and increased the likelihood of participants forming an alliance with sex offenders.

This study attempted to recruit 60-100 currently enrolled full-time or part-time masters' counseling students. Despite offering extra credit for participating and providing multiple opportunities, only 20 students completed the study. The participants were full-time or part-time counseling students enrolled in CACREP accredited masters of Rehabilitation Counseling and Clinical Counseling programs. The 20 participants ($N = 20$), were comprised of 17 (85%) females and 3 (15%) males. The participant ages ranged from 22 to 50 ($M = 32.3$, $SD = 9.28$). There were 11 (100%) female participants in the control group were female between ages 22 to 46 ($M = 31.09$, $SD = 8.95$). The treatment group members were ages 24 to 50 ($M = 33.78$, $SD = 10.00$). The three males (100%) in the study were in the treatment group and represented 33.3% of the total participants receiving treatment. The remaining six participants in the treatment group were female (66.7%). English was the primary language for participants in both the treatment and control groups. The graduate school enrollment status was similar among the 20

participants, with nineteen participants (95%) enrolled full-time and 1 (5%) enrolled part-time. Ten participants had been diagnosed and treated for an anxiety or mood disorder. Finally, 10 of the 20 participants (50%) have either been sexually abused or had family members who have been sexually abused.

The data was collected during two semesters. While some students participated in the study during June and July, other participants completed the study in September. The 20 participants were randomly assigned to either the control or treatment group. The study was conducted in two phases, the pretest and the posttest. During the pretest, the participants completed the demographic questionnaire, reviewed the Tier I case study, and answered the Working Alliance-SRT (WAI-SRT) and the Discrete Emotions Questionnaire (DEQ). The control group did not receive training, while the treatment group received a 45-minute sex offender training. Lastly, the posttest took place over three weeks in September 2021, wherein the participants reviewed a Tier III case study and completed the WAI-SRT and DEQ. Lack of participation is possibly related to topic sensitivity, traumatic personal experiences, negative perceptions about ex-offenders, or lack of incentive. Study limitations will be discussed later in the chapter.

As indicated earlier, the control and treatment groups had a similar demographic composition aside from the small number of males who took part in the study (n = 3; 15.0%). The difference in participation by gender may be due to a disproportionate graduate school enrollment with a clear majority of females. According to the Council on Graduates (2021), the gender disparity in favor of females is significant, especially in social and behavioral science majors. Females earned more than 60% of all master's degrees in 2020 and earned 151 master's degrees for every 100 degrees earned by men. The gender differences in many social and

behavioral programs trend above the national average. In the 2016-17 academic year, the ECU DARS program was 86.4% female and 13.6% male (MS Assessment Plan and Report 2016-17). In 2018-19, the same graduate program was 89% female and 11% male (MS Assessment Plan and Report 2018-19).

To determine if the demographic variables may have confounded the analysis, four split-plot ANOVA were conducted. Differences in the change over time for each variable on the WAI-SRT and DEQ were evaluated using the attribute variables, race, language preference, graduate school enrollment status, graduate program, and psychiatric diagnosis. Despite the gender disparity, the treatment and control groups had a similar demographic composition on each of these demographic variables. Moreover, there were no significant differences in mean scores on the WAI-SRT or DEQ because of gender. While there was no significant difference in the WAI and DEQ mean scores, it appeared the diagnosis and sex assault history may have influenced the outcome.

Two research questions were formulated for this study.

RQ1: How does a 45-minute training about counseling sex offenders influence counseling graduate students' scores on the working alliance inventory?

RQ2: How does a 45-minute training about counseling sex offenders influence counseling graduate students' scores on the discrete emotional questionnaire?

We determined that the 45-minute training did not effect participant scores on the WAI or DEQ. However, it is not clear why the training was ineffective. The training may have failed due to the sample choice and size, methods and instruments used to collect the data, self-reported data, and time constraints. Moreover, the emotional intensity of the content covered may have negatively influenced participant scores. When evaluating the results through a cognitive dissonance lens,

we assume that the 45-minute sex offender training in this study did not significantly reduce cognitive dissonance in the participants. Cognitive dissonance theory suggests that people have an inner drive to maintain congruent attitudes and behaviors (Festinger, 1957). That is, they would have higher scores on the WAI and lower scores on the DEQ if they held positive attitudes towards sex offenders. Conversely, if the training had successfully changed any negative attitudes held by the participants, then the WAI-SRT and DEQ scores would likely have trended more positively in the training group. An increase in WAI-SRT and a decrease in DEQ scores would have also suggested that a brief training could encourage graduate students to consider sex offender counseling as a specialty area.

Application

Training is paramount in community practice; however, sex offender counselors often lack training, have limited access to treatment manuals, lack research evaluation skills, and have limited professional supervision (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009; Chambless, 1999; Chan et al., 2010). Practicing counselors report insufficient time for training on evidence-based interventions and difficulty receiving training through continuing education (Chambless, 1999; Chan et al., 2010). Given counselor time constraints, brief specialized training is needed. Despite its brevity, during the 45-minute sex offender training, six objectives were discussed, (1) the history of sex offender legislation, (2) myths and misconceptions of sex offenders, (3) detailed origins of sexually deviant behaviors, (4) tiers of sex offenses in the US, (5) barriers to treatment, and (6) cognitive-behavioral therapy efficacy with sex offenders. The 45-minute sex offender training was created to present knowledge about sex offenders to graduate counseling students under the premise of Gottfried et al. (2021), which explains that individuals who received some knowledge about sex offenders reported more positive attitudes toward working

with them. Hypothetically, improved scores would demonstrate more willingness/motivation to work with sex offenders. Surprisingly scores on the WAI-SRT and DEQ suggested a decline in willingness to work with sex offenders despite the training.

Influence of training as measured by the WAI-SRT

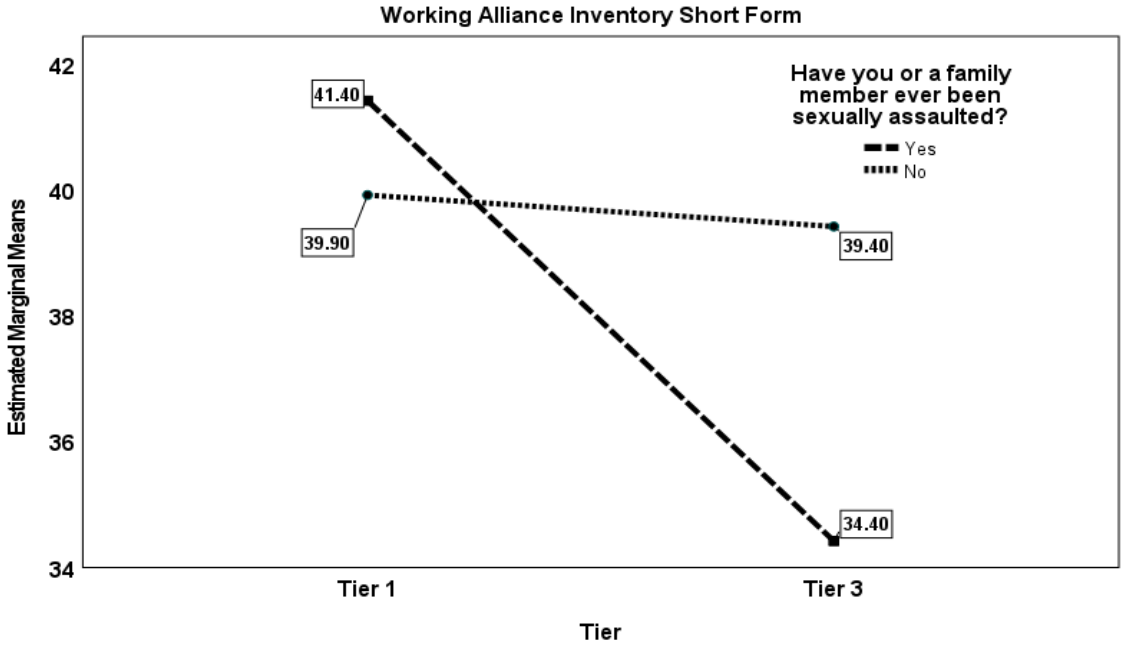
Comparing WAI-SRT mean scores obtained from groups or individuals provide useful but not objective aspects of the working alliance (Horvath, 1992). Although WAI-SRT scores are not standardized, they reflect the propensity of the helper and client to collaborate. Based on previous research, the researcher believed that participants who received the 45-minute training would have higher WAI-SRT scores than those who did not. Likewise, the researcher assumed that the 45-minute training would introduce information that resolved cognitive dissonance in participants. The WAI-SRT mean scores decreased in both the control and treatment groups. That is, despite receiving training, the treatment group's WAI-SRT mean scores decreased similarly to the control group, which did not receive training. All conditions between and within the groups were constant in the pretest and posttest, except tier classification (tier I versus tier III) and training. This unexpected change suggests that participant dissonance and WAI-SRT scores were more influenced by the offender's tier classification than a 45-minute training. Thus, the training did not effectively alter cognitive dissonance in participants. Higher scores on the WAI-SRT would have suggested a greater willingness to collaborate with sex offenders on therapy tasks, therapy goals, and forming an affective bond.

Although the change in WAI-SRT scores (pretest to posttest) was not statistically significant, a confounding variable was observed that suggested the participants were more willing to work with tier I offenders than tier III. Explicitly, the participants who answered "yes" on the sexual assault history question (see Figure 1) were less inclined to form a working alliance

with the tier III sex offender. For the participants who answered "no" to the sexual assault history question, there was only a small difference between the WAI-SRT mean scores for tier I (M = 39.90) and tier III (M = 39.40). These participants did not appear to make a distinction between a tier I and tier III sexual offense. By contrast, the mean WAI-SRT scores of participants who answered yes to the sex assault history question indicated a significant difference between tier I (M = 41.40) and tier III (M = 34.40). This finding suggests that participants with a sexual assault history were more willing to establish a working alliance with a tier I sex offender than with a tier III. Interestingly, based on their WAI-SRT scores, participants with a sexual assault history seem to distinguish between a tier I and tier III offender more clearly than participants without a history of sexual assault.

Figure 2

History of sexual assault

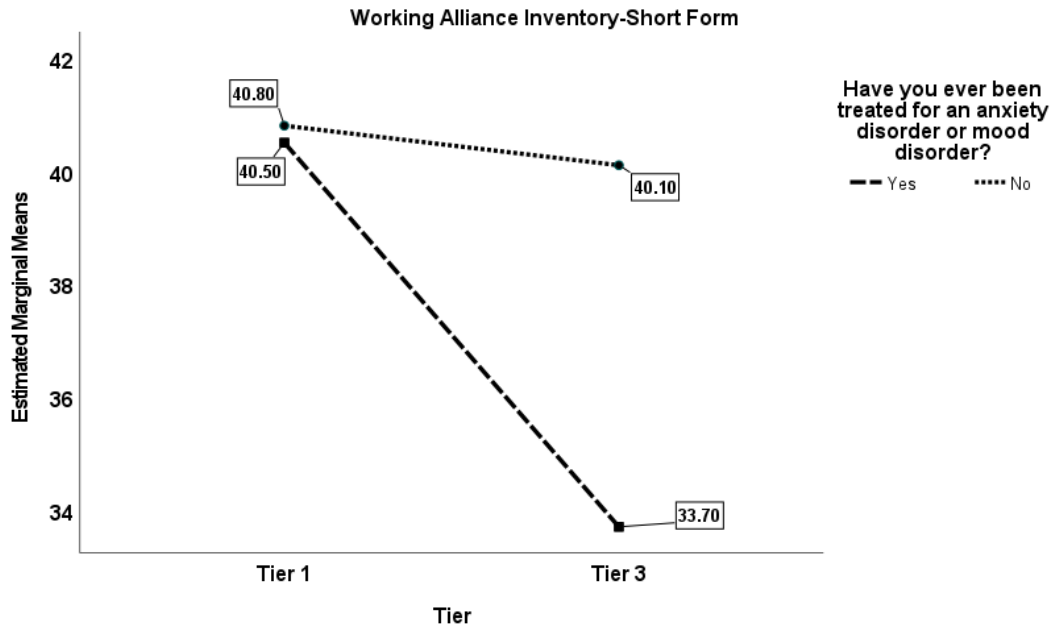


When assessing the tier III sex offense in the posttest, the participants encountered a narrative of violence, abuse, and perversion far more intense than the tier I offense in the pretest.

Counselors are tasked with listening to the graphic and often detailed accounts of the crime committed by their clients and engaging empathically with them (Slater & Lambie, 2011; Steed & Bicknell, 2001; Way, VanDeusen, Martin, Baum & Moyel, 2018). In past research, continual engagement with graphically violent sex crimes created a cognitive shift in sex offender counselors, which drastically influenced their empathy with sex offenders and view of humanity (Cunningham, 2003; Ellerby, 1997; Iliffe & Steed, 2000; Lea, Auburn, & Kibblewhite, 1999; Baum & Moyel, 2018). Some counselors reported increased fear for themselves and their children, while others reported increased protectiveness of their children and families (DeCarvalho Petry, 2005; Farrenkopf, 1992). Counselors who experience emotional distress from their work with sex offenders have difficulty showing empathy and believing the client will change (e.g., Moulden & Firestone, 2007). Likewise, studies have shown that clinicians' feelings toward their sex offender clients were often associated with how dangerous they perceived the client (DeVogel & DeRuiter, 2004; Hancock, 2019). As suggested by mean score changes in this study, the participants in both the treatment and control groups may have found the tier III sex offender more dangerous than the tier I.

Figure 3

Anxiety or mood disorder



For the participants who answered "no" to the diagnosis of an anxiety or mood disorder question (see Figure 2), there was only a slight difference between the WAI-SRT mean scores for tier I (M = 40.80) and tier III (M = 40.10). These participants did not appear to make a distinction between a tier I and tier III sexual offense. By contrast, the mean WAI-SRT scores of participants who answered "yes" to the anxiety disorder question indicated a significant difference between tier I (M = 40.50) and tier III (M = 33.70). There was little difference between the diagnosis status groups for the tier I sex offense (i.e., No Diagnosis, M = 40.80; Diagnosis, M = 40.50). However, there was more than a six-point difference between the WAI-SRT mean score on tier III, (i.e., No Diagnosis, M = 40.10; Diagnosis, M = 33.70). This finding suggests that participants with a diagnosis history were more willing to establish a working alliance with a tier I sex offender than with a tier III. Interestingly, based on their WAI-SRT scores, participants with a diagnosis history seem to distinguish between a tier I and tier III

offender more clearly than participants without a diagnosis history. There was not a statistical difference in the groups within training variable. However, the researcher was able to find interaction by examining the difference between the groups within Tier variable. Although these findings were secondary, the implications are significant for future research.

The findings show that the participants' beliefs about sex offenders parallel social attitudes that sex offenders are more dangerous and less likely to improve than other offender groups (Rosselli & Jeglic, 2017; Christensen et al., 2021; Tewksbury, Mustaine, & Payne, 2012). Tewksbury, Mustaine, and Payne (2012) found that sex offender support professionals possessed more positive attitudes about sex offenders than the general public. Still, those support professionals continued to possess attitudes that have internalized negative cultural perceptions of sex offenders, despondent beliefs in offender change potential, and perceptions of high dangerousness (Tewksbury et al., 2012).

Similarly, Lowe & Willis (2020) found that individuals who questioned the sex offenders' change potential were more likely to be timid and uncomfortable working with sex offenders. As noted in previous research, despite training and supervision, sex offender counselors are subject to strong negative feelings associated with their clients' traumatic disclosure (McCann & Perlman, 1990). As a result, counselors may become suspicious, more cynical, pessimistic, or distrustful of sex offenders (Pearlman & Mac, 1995), which negatively impacts their willingness to establish a working alliance. This finding underscores the point that many mental health counselors have negative attitudes toward sex offenders that influence their decisions to provide them counseling (Nelson et al., 2002). The WAI-SRT score changes in the current study suggest that, despite the proposed training, participants may have been more skeptical about allying with tier III sex offenders than tier I. The overall WAI-SRT mean scores

(pretest $M = 40.65$; posttest $M = 36.90$) indicated that the participants demonstrated above-average willingness to form an alliance with the sex offender in the vignettes, regardless of tier classification. The WAI-SRT scores range from 10 to 50. This finding might suggest that the counseling students in the sample possessed above-average empathy, positive regard, and genuineness, despite their cognitive dissonance.

Further analysis of the pre and post-WAI-SRT scores show the smallest decrease in the mean score ($M = 4.05$ to $M = 4.00$) was on item two, "Concerned for the client's welfare", and the greatest decrease ($M = 4.00$ to $M = 3.25$) was on item five "Appreciate the client as a person". Comparable pretest and posttest scores on item two indicate that despite the change from a Tier I to Tier III sex offender designation, participants continued to have a similar concern for the client. This level of concern indicates empathy, which is a critical component of the working alliance (Horvath, 2001). Interestingly, the alliance's components (flexibility, hopefulness, optimism) were more negatively influenced by the Tier III vignette. This change in attitude was empirically demonstrated by more pronounced changes in the question five pretest and posttest responses.

Rogers (1957) believed effective counselors must have unconditional positive regard and empathy and genuinely communicate their attitudes. However, the counselor may have more difficulty demonstrating these positive skills and attitudes when a client has violated the norms and mores of society. While item two mean scores were based upon possessing empathy for the offender, item five required the counselor to appreciate the client as a person. The difference between *empathy for* and *appreciation of* the client was most apparent when the participants evaluated the Tier III vignette. Specifically, item 5 is pertinent to counselor development because

it helps examine factors that influence "judgmental attitudes" about sex offenders (Kaplan, 1984; Ray, McKinney, & Ford, 1987).

Nelson and colleagues (2002) infer that counselor bias about sex offenders may contribute to the difficulties in the counseling process. In the present study, there appeared to be a link between the participant's perception about establishing a working alliance with a sex offender and the offender tier classification described in the vignette**.** The findings suggested that the participants had less cognitive dissonance about the tier I offender. When the vignette described a tier III sex offense, the participants' cognitive dissonance likely increased, causing them to score their ability to form an alliance with the offender more stringently.

Influence of training as measured by the DEQ

Currently, the research is sparse regarding the link between counselor dissonance and sex offender categorization. Counselor bias is often shaped by negative beliefs, perceptions, and attitudes. Counselors rate the offense more emotionally when the offense is viewed more negatively (Nelson et al., 2002). The participants' responses in this study exemplify this point perfectly. The differences between the Tier I and Tier III vignettes could be understood by examining the emotions with the Discreet Emotional Questionnaire. This section analyzes the effect of a 45-minute sex offender training and sex offender categorization status on participants' emotions.

Like the WAI-SRT total mean scores, the change in DEQ pre and posttest total mean scores (M = 53.16 to M = 71.6) suggested a more negative attitude toward the tier III sex offender in the control and treatment groups. The 45-minute training did not positively influence the participants' discreet emotions. In fact, the treatment group had a greater mean score change *(*M = 54.78 to M = 65.78) than the control group (M = 70.00 to M = 76.36). These results might

indicate that participants' emotions were more influenced by the intensity of the sex offense than the training designed to increase objectivity and mitigate emotional responses. This study's pretest and posttest DEQ results are consistent with Hancock (2019), and Gillespie, Centifanti, & Brewer (2018), wherein individuals who expressed more anger, anxiety, fear, and disgust emotions about sex offenders were less inclined to work with sex offenders. The correlation between WAI-SRT and DEQ results indicated that as the participants' negative emotions as measured by the DEQ increased, their confidence about forming a working alliance with the client decreased. As noted earlier, the overall DEQ and WAI-SRT mean scores on the pretest and posttest showed that the participants had above average emotional objectivity concerning the sex offenders in the vignettes, regardless of tier classification. Essentially, DEQ mean score changes (M = 63.15 to M = 71.60) suggested that participants' dissonance increased when the tier III offender was presented in the post test (Festinger & Carlsmith, 1959); however, the increased mean scores were well below the maximum score on the DEQ (224).

Nelson, Herlihy, and Oescher (2002) surveyed 437 counselors who were members of the Association for Mental Health Counselors or the International Association of Addictions and Offenders Counselors. These counselors completed the Attitudes Toward Sex Offenders Scale (Hogue, 1993) and had positive or neutral attitudes towards sex offenders (Nelson et al., 2002). Like this study, the results were influenced by variables that included victim status, counselor experience, and training preparation (Nelson et al., 2002). Comparatively, other studies only consider the past histories of sex offenders and their influence on counselor attitudes (Carone & LaFleur, 2000). Carone and LaFleur (2000) asserted that counselors were more likely to view sex offenders positively if the offender had been abused as a child or was a trauma-survivor. The authors contended that counselors viewed offenders more positively and believed they could be

rehabilitated when linking the offender's behavior with past trauma (Carone & LaFleur, 2000). Unlike these studies, the current study did not analyze these variables. Although the referenced studies did not specifically address cognitive dissonance, new information (e.g., victim status, counselor experience, training preparation, history of childhood trauma) was used to change participants' attitudes and decrease cognitive discrepancies in each study. Tier changes were a confounding variable to be explored concerning its influence on the participants' responses over time on the DEQ. The pretest and posttest DEQ scores suggested that emotional variation may be reflected by tier categorization changes from tier I to tier III.

Limitations

This chapter discusses the implications of this study. This research has four limitations: sample choice and size, methods and instruments used to collect the data, self-reported data, and time constraints. One university and participants from two counseling programs (Rehabilitation Counseling and Clinical Counseling) were included in this study. The sample contained fewer individuals than the minimum recommended by G*power analysis. As a result of low participant recruitment, representativeness cannot be assumed, and statistical inference may have been compromised in terms of statistical power. Without representativeness, the study may not epitomize the reference population. The sample choice and size limitation are evidence of the difficulty of collecting data from graduate counseling students. The limited access to respondents also contributed to the reduced sample size. Although the researcher used power analysis to calculate the number of subjects required, the sample size expectation was not met.

Also contributing to sample size constraints, the study was conducted during the summer session, when enrollment numbers were substantially reduced. The decreased number of students who completed the survey may have influenced the findings due to a lack of variability and non-

response. In essence, there may have been an unexpected sampling bias. The researcher understands that increasing the number of participants would have increased the power of the study, thereby increasing the certainty of the findings. However, at the cost of needing substantially more participants and increasing the study time, only 20 participants were surveyed. The small sample size influenced the study results by increasing the probability of committing a Type II error. Therefore, the smaller sample size may not represent the counselors-in-training population and compromise the study's generalizability.

The second limitation involves the methods and instruments used to collect the data. Study data were collected and managed using REDCap electronic data capture tools. REDCap (Research Electronic Data Capture) is a secure, web-based software platform designed to support data capture for research studies (Harris et al., 2019). Despite the robust nature of this system, there were operational errors that prevented the accurate dissemination of surveys. When sending surveys to participants, several reported they could not complete the demographic questionnaire, open surveys, or navigate between surveys. Potential participants dropped out of the study when met with technical difficulty, contributing to the small sample size. REDCap also allows the researcher to create surveys and data-gathering instruments. The instruments created for this study effectively captured data; however, some participants reported that the browser moved slowly. This limitation could have influenced the participants to rush their responses when the software moved more quickly, influencing the survey results. For future research, REDCap training is recommended before starting a study. Training decreases the likelihood of user error and improves opportunities to develop tools and methods for efficiently collecting data. Although REDCap has staff available at most universities, access to REDCap staff is limited. Improving access to REDCap technicians may yield more optimal results in future research.

Self-reported data is the third limitation. The WAI-SRT and DEQ are self-report instruments. One possible source of error is collecting information through a self-report with potential bias. Participants are often biased when they report their own experiences (Devaux & Sassi, 2016). Counselors and counselors-in-training are expected to be empathetic, non-judgmental, and genuine (Corey, 2011). To meet these expectations, those participants may consciously or unconsciously be influenced by social desirability. They are more likely to report socially acceptable or preferred perceptions by the profession. Pope and Kline (1999) categorized empathy, acceptance, and warmth as important characteristics of counselors. Because the participants may see themselves as possessing the characteristics of counselors, they possibly responded to the WAI-SRT and DEQ to appear empathic, accepting, and skillful.

Counselors are presented with several motivators ranging from professional responsibility and moral obligation to impairments shaped by personal experience. These motivators create the cognitive dissonance we attempted to explore in this study, wherein the training increases the participants' willingness to form an alliance with sex offenders, despite personal feelings (Gruber, 2003). As noted earlier, the training did not effectively accomplish this goal. However, the study findings suggest that participants in both groups maintained a high degree of empathy. Additionally, the participants' emotional responses on the DEQ correlate with their propensity to form a working alliance. This finding suggests that the participants may have recognized that the sex offender needed treatment but did not consider it their moral responsibility to treat the sex offender. The study could have been improved by asking two questions to explore the participants' cognitive dissonance: What are the reasons you would be willing to counsel this offender? What are the reasons you would not be willing to counsel this offender?

The reported emotions on the DEQ and theoretical propensity to form an alliance on the WAI-SRT may not have been assessed accurately. Also, the surveys were taken independent of the researcher, not allowing the participants to seek guidance if uncertain. Some participants experienced interpretation bias in that they found survey questions confusing and selected answers based on their limited understanding. Although the researcher was available to answer questions, the participants felt they had to complete the survey alone. Given more time to conduct the study, the participants would have had more precise instructions regarding investigator support.

Likert scales can also limit study results. The WAI-SRT and DEQ use Likert scales to obtain data, and individual responses are typically treated as ordinal data. Although the response levels have a relative position, we cannot presume that participants perceive the difference between selection options to be equal (Uebersax, 2007). Expressly, one cannot guarantee to ensure that participants will view the difference between "agree" and "strongly agree" the same as they viewed the difference between "agree" and "neutral." Finally, self-reports are subjective and permit the researcher to infer rather than verify the validity of the participant's responses (Pannucci, 2010).

Finally, the fourth possible limitation was study time constraints. The time available to conduct the training intervention and measure change over time was constrained by student availability, researcher availability, WebEx technical errors, and scheduling methods. Graduate counseling students, especially during the summer semester, are required to complete more coursework over an abbreviated 10-week semester. Thus, time for non-course activities is reduced from the typical 15-week semester. Students were given multiple opportunities to complete various aspects of the study; however, many failed to comply with scheduling,

complete surveys, or receive training. The students were reminded through email and given opportunities to make up missed study components. Time constraints over the summer seemingly created fragmentation and burnout in students leading to prioritizing class assignments over the study. As mentioned earlier, time constraints contributed to sample size limitations over the summer. Future research that includes longer times for training and survey completion may significantly change study results.

Implications and Future Applications

Counselor Education

Counselors may be required to treat incarcerated populations and perpetrators of abuse. Despite the emotional stress this treatment may cause, counselors are expected to show empathy, positive regard, and genuineness when treating complex populations. However, research is scarce on the attitudes and training of graduate counseling students working with stigmatized populations. Assessing graduate counseling student attitudes about difficult populations will permit graduate programs to explore student bias and design the counselor education curricula to address the practical application of theory with discounted criminal populations. The counseling curriculum, particularly at a graduate level, will benefit from exploring how student perceptions and emotions influence the choice of this counseling specialization. Also, further studies on the influence of offender training at the graduate level could reveal new insights into the relationship between student development and bias exploration. These curriculum changes would be essential, especially if the student seeks a counseling specialization.

Research on the link between graduate students' mental health (anxiety, trauma, mood) and their willingness to counsel offensive clients, namely sex offenders, is sparse. Figure 2 shows that participants who answered "yes" to *having a mood or anxiety disorder* were less

willing to form an alliance with the tier III sex offender in the posttest. The trend observed was parallel to that in Figure 1, wherein the participants answered "yes" to *sexual assault history*. The results suggest that an anxiety or mood disorder can negatively influence the working alliance. Future research is recommended to evaluate the relationship between a counselor's mental health and the working alliance.

The current study concludes that gaps may exist in the graduate counseling program curriculum, specifically relating to sex offender counseling and graduate student attitudes. For many experienced counselors, sex offenders are contemptible clients that may trigger feelings of frustration, fear, anger, or disgust. Effective counselors show compassion and empathy even when working with difficult clients like sex offenders. Study results suggest the continued need for an expanded curriculum concerning sex offenders at the graduate level. Research addressing graduate student emotions and sex offenders is not readily available.

To help graduate students explore and remove emotional barriers about sex offenders, graduate programs can benefit from research that assesses student responses to various sex offenses. Study results can develop a foundation for individualized training for graduate students to improve emotional skills, social perceptiveness, decrease bias, and improve problem sensitivity. With a broader range of participants, future studies could improve their external validity to provide more generalizable information about students' preparedness and comfort levels with counseling sex offenders.

Clinical Practice

Current research suggests that counselors experience positive and negative emotions when counseling convicted sex offenders. Finding empathy and compassion for sex offenders can be difficult for counselors when the offender's experiences and choices are viewed

negatively. Without logically or morally understanding a sex offender's experience, the counselor's ability to help may be severely limited by dissonance. The current study's analysis revealed shifts in the cognitive schemas of the sample to accommodate the traumatic material to which they were exposed. Specifically, the participant scores on the WAI-SRT and DEQ suggested more understanding of tier I than tier III offense. Interestingly, participant attitudes parallel those of counselors in the community. Counselors' negative emotions about higher-tiered sex offenders may prevent or limit them from treating this complex population. The relationship between counselor emotion and sex offender tier classification needs to be researched systematically. Given that all participants had a more negative reaction to the tier III sex offender when compared to the tier I offender, future research should explore the link between tier classification, counselor attitudes, and counselor compassion.

Conclusion

The need for sex offender treatment has increased in the United States over the past 20 years. Each year over 31% of the offenders convicted of a sex crime are released from prison (Levenson & Tewksbury, 2009). The rise in sex crimes, highlighted by the #MeToo movement, has increased public awareness and concern about sexual violence (Brown, 1999; Learly, 2020). Due to increasingly mandated sex offender treatment in the community, more offenders are receiving treatment from counselors who work in community agencies (Barnard, Fuller, Robbins, & Shaw, 1989; Thorton, 2013). Recently graduated counselors often lack the mental and clinical preparation required to treat sex offenders. Without informative sex offender training, counselors will perpetuate countertransferential attitudes that undermine the therapeutic process (Polson & McCullom, 1995). Counselors' attitudes and perceptions about sex offenders can influence whether they view sex offenders as criminals needing punishment versus clients

needing counseling (Kaplan, 1984; Ray, McKinney, & Ford, 1987). Currently, there is a lack of practical approaches that mitigate the differential between sex offenders and counselors who treat them (Charles, 2010). This study attempts to address sex offender counseling deficits with counselors-in-training.

A sample consisting of 20 students enrolled in a CACREP accredited master's in Substance Abuse and Clinical Counseling program participated in this study. The Demographic Questionnaire and pretest (i.e., tier I sex offense vignette, DEQ, WAI-SRT) were completed by each participant. The training group received a 45-minute sex offender training, and the control group did not. After the training, participants from both groups completed the posttest (tier III sex offense vignette, DEQ, and WAI-SRT). Using the WAI-SRT and DEQ mean scores, this study explored whether the integration of a 45-minute training, based on the cognitive dissonance theory, would increase the graduate counseling student's willingness to ally with a tier I and tier III sex offender. The study found that the training had minimal influence on participants, as evidenced by similar training and control group scores. Perhaps the most important finding of this study is that tier intensity variation, which was constant within both groups (tier I versus tier III), created a dynamic whereby participants showed more negative emotion and adverse views of the working alliance with the tier III sex offender. In short, the study found that counseling students possessed distinct emotions that were changed by sex offense tier intensity. Interestingly, counselor emotion (measured by the DEQ) and willingness to form a working alliance (measured by the WAI-SRT) with the client were positively correlated in both the treatment and control groups. These findings underscore the importance of training, experience, and supervision when counseling sex offenders (Cumming & McGrath, 2005; Newstom et al., 2018). The 45-minute training applied in this experimental design lacked

efficacy based on the study's result. More comprehensive training is recommended. Recommendations also include collegiate and clinical exploration of counselor emotion on the working alliance.

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APPENDIX A: Demographic Questionnaire Form

Demographic Questionnaire Form

Instructions: Please respond to each of the following questions:

1. What is your age?

2. With which gender do you identify?

   ☐ Male ☐ Female

3. With which racial or ethnic category do you identify?

   ☐ African American ☐ Asian/Pacific Islander ☐ Caucasian ☐ Latino

   ☐ Other:

4. What is your dominant language?

5. What is your graduate school enrollment status?

   ☐ Full-time ☐ Part-time

6. In which graduate program are you enrolled?

7. Have you ever been treated for a Mood Disorder or Anxiety Disorder?

   ☐ Yes ☐ No

APPENDIX B: Clinical Vignettes

Vignette: Tier I Sex Offense

Mark (36) and Jenny (35) decided to get drinks one night after work. Both Jenny and Mark drank a little too much but felt fine to drive home afterward. While walking Jenny to her car, Mark grabbed Jenny's buttocks, breasts, and thighs without her permission. This made Jenny very uncomfortable and she immediately pushed him away and asked him to stop. Marked pulled Jenny towards him and pressed his penis against her. Again Jenny pushed Mark and asked him to stop. Mark stopped and apologized before shamefully walking to his car. The next day police officers were waiting at the job for Mark and he was charged with sexually assaulting Jenny

Vignette: Tier III Sex Offense

John, 53, began sexually molesting his stepdaughter "Cindy" in 2002 when she was seven years old. He started having intercourse with her when she was 12 and, within two years, he was raping her four or five times a week. John threatened to kill her mother and younger brother if she mentioned the rape to anyone. Cindy became pregnant by John and he secretly took her for an abortion. Despite the scare, John continued to sexually assault Cindy for another two years before she informed authorities. John was arrested in 2019 and is awaiting trial. He is required to receive counseling from a community agency until he is tried and sentenced.

APPENDIX C: Working Alliance Inventory – Short Revised - Therapist (WAI-SRT)

Instructions: Below is a list of statements about experiences counselors might have with their clients. Some items refer directly to your client with an underlined space. As you read the sentences, mentally insert the name of the Tier III sex offender used for this scenario.

IMPORTANT!!! Please take your time to consider each question carefully.

1. I believe that the client and I can agree about the steps to be taken to improve his/her situation.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

2. I am genuinely concerned for the client's welfare.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

3. The client and I can work towards mutually agreed-upon goals.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

4. I feel confident about the usefulness of therapy.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

5. I appreciate the client as a person.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

6. The client and I can establish a good understanding of changes that would be good for him/her.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

7. I feel that the client and I will respect each other.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

8. I feel the client and I will have a common perception of his/her goals.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

9. I can respect the client even though he/she has done things that I do not approve of.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

10. The client and I can agree on what is important for the client to work on.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

APPENDIX D: Discrete Emotions Questionnaire

Discrete Emotions Questionnaire

Please indicate your response using the scale provided.

While *(undergoing the emotional experience, e. g., viewing the photographs, reading the story, etc.)* to what extent did you experience these emotions?

1	2	3	4	5	6	7
Not at all	Slightly	Somewhat	Moderately	Quite a bit	Very much	An extreme amount

Anger (Ag)	Scared (F)
Wanting (Dr)	Mad (Ag)
Dread (Ax)	Satisfaction (H)
Sad (S)	Sickened (Dg)
Easygoing (R)	Empty (S)
Grossed out (Dg)	Craving (Dr)
Happy (H)	Panic (F)
Terror (F)	Longing (Dr)
Rage (Ag)	Calm (R)
Grief (S)	Fear (F)
Nausea (Dg)	Relaxation (R)
Anxiety (Ax)	Revulsion (Dg)
Chilled out (R)	Worry (Ax)
Desire (Dr)	Enjoyment (H)
Nervous (Ax)	Pissed off (Ag)
Lonely (S)	Liking (H)

Ag = Anger items, Dg = Disgust items, F = Fear items, Ax = Anxiety items, S = Sadness items, Dr = Desire items, R = Relaxation items, H = Happiness items.

APPENDIX E: IRB Approval

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board
4N-64 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** ·
rede.ecu.edu/umcirb/

Notification of Exempt Certification

From: Social/Behavioral IRB
To: Kendrick Britton
CC: Stephen Leierer
Date: 4/8/2021
Re: UMCIRB 21-000469
THE EFFECT OF BRIEF SEX OFFENDER TRAINING ON GRADUATE COUNSELING STUDENTS

I am pleased to inform you that your research submission has been certified as exempt on 4/7/2021. This study is eligible for Exempt Certification under category # 1 & 2ab.

It is your responsibility to ensure that this research is conducted in the manner reported in your application and/or protocol, as well as being consistent with the ethical principles of the Belmont Report and your profession.

This research study does not require any additional interaction with the UMCIRB unless there are proposed changes to this study. Any change, prior to implementing that change, must be submitted to the UMCIRB for review and approval. The UMCIRB will determine if the change impacts the eligibility of the research for exempt status. If more substantive review is required, you will be notified within five business days.

Document	Description
Consent for Participation (0.01)	Consent Forms
Email Script and recruitment docs(0.01)	Recruitment Documents/Scripts
Survey and questionnaire (0.01)	Surveys and Questionnaires
Training Objectives(0.01)	Interview/Focus Group Scripts/Questions
Vignette.docx(0.01)	Interview/Focus Group Scripts/Questions

For research studies where a waiver or alteration of HIPAA Authorization has been approved, the IRB states that each of the waiver criteria in 45 CFR 164.512(i)(1)(i)(A) and (2)(i) through (v) have been met. Additionally, the elements of PHI to be collected as described in items 1 and 2 of the Application for Waiver of Authorization have been determined to be the minimal necessary for the specified research.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

IRB00000705 East Carolina U IRB #1 (Biomedical) IORG0000418
IRB00003781 East Carolina U IRB #2 (Behavioral/SS) IORG0000418

APPENDIX F: IRB Amendment Approval

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board
4N-64 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** ·
rede.ecu.edu/umcirb/

Notification of Amendment Approval

From: Social/Behavioral IRB
To: Kendrick Britton
CC: Stephen Leierer
Date: 7/30/2021
Re: Ame1 UMCIRB 21-000469
UMCIRB 21-000469
THE EFFECT OF BRIEF SEX OFFENDER TRAINING ON GRADUATE COUNSELING STUDENTS

Your Amendment has been reviewed and approved using expedited review on 7/30/2021. It was the determination of the UMCIRB Chairperson (or designee) that this revision does not impact the overall risk/benefit ratio of the study and is appropriate for the population and procedures proposed.

Please note that any further changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must adhere to all reporting requirements for this study.

If applicable, approved consent documents with the IRB approval date stamped on the document should be used to consent participants (consent documents with the IRB approval date stamp are found under the Documents tab in the study workspace).

The approval includes the following items:

Document	Description
There are no items to display	

For research studies where a waiver or alteration of HIPAA Authorization has been approved, the IRB states that each of the waiver criteria in 45 CFR 164.512(i)(1)(i)(A) and (2)(i) through (v) have been met. Additionally, the elements of PHI to be collected as described in items 1 and 2 of the Application for Waiver of Authorization have been determined to be the minimal necessary for the specified research.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

APPENDIX G: Research Study Email Script

Email Script

Subject Line: The Effect of Brief Sex Offender Training on the Graduate Counseling Students' Scores on the Discrete Emotions Questionnaire and Working Alliance Inventory

Hi,

I am a doctoral candidate at East Carolina University (ECU) in the Department of Addictions and Rehabilitation Studies. I am conducting a research study under the direction of Dr. Stephen Leierer, as a requirement of my doctoral degree in Rehabilitation Counseling. I am asking you to take part in my research study entitled "The Effect of Brief Sex Offender Training on the Graduate Counseling Students' Scores on the Discrete Emotions Questionnaire and Working Alliance Inventory." The purpose of this research study is to examine the effect of a 45-minute sex offender training on graduate counseling students as measured by the Working Alliance Inventory and Discrete Emotional Questionnaire. Your participation is voluntary.

The results from this research study can be used to influence curricula in higher education. We also hope the results will be used to demonstrate that training on the collegiate level can influence student perception leading to an increase in sex offender counseling as a career choice. If you would like to participate, please log into REDCap.ecu.edu to consent.

Please contact Kendrick Britton at 252-717-4074 (text/call) or brittonken01@students.ecu.edu or Stephen J. Leierer at 252-744-6298 or leierers@ecu.edu for any research or accessibility related questions.

Thank you!

Kendrick Briton

APPENDIX H: Consent to Participate

Title: The Effect of Brief Sex Offender Training on the Graduate Counseling Students' Scores on the Discrete Emotions Questionnaire and Working Alliance Inventory

Principal Investigator: Kendrick Britton, LCMHC, LCAS, CCS, CSOTP

Faculty Supervisor: Stephen J. Leierer Ph.D.

Purpose

You are being invited to participate in a research study conducted by Kendrick Britton, a PhD candidate at East Carolina University in the Department of Addictions and Rehabilitation Studies. The purpose of this research study is to examine the effect of a 45-minute sex offender training on graduate counseling students as measured by the Working Alliance Inventory and Discrete Emotional Questionnaire. Master's level counseling students are often undecided on their career concentration and lack exposure to specialized counseling opportunities. The results from this research study can be used to influence curricula in higher education. We also hope the survey results will be used to examine the effect of a training about counseling sex offenders on the graduate students' decisions to counsel sex offenders.

Participants

Individuals who express interest in participation will be screened using a Demographics Questionnaire created by the researcher. The demographic characteristics collected include race, age, language preference, graduate school enrollment status, graduate program, and psychiatric diagnosis. Race is assessed to determine whether participants respond differently to sex offenses based on their race. Age is obtained to ensure participants are 18 years old and have the legal capacity to report their mental health status, consent to treatment options, and make a legal decision without parental consent. Language preference is self-reported and will be collected to ensure the participant understands the instructions from the researcher. Graduate school enrollment status and the graduate program may influence the participant's administrative and clinical perception of sex offenders and their perceived ability to counsel them. Psychiatric diagnoses will be collected because people with mental illness may be vulnerable to the possible materials presented; others may require follow-up after the research has concluded.

Survey Information

Prior to taking the survey, you will complete a demographic questionnaire. The two survey instruments utilized for this study include the 10-item Working Alliance Inventory – Short Revised - Therapist (WAI-SRT) and 8-item Discrete Emotions Questionnaire. If you decide to participate, the surveys will take approximately 10-20 minutes to complete for the pretest and posttest. The survey will be completed online through Research Electronic Data Capture, or REDCap. Taking this survey in a private, distraction-free place is recommended. Please make sure to exit the browser when you finish the survey.

Confidentiality

Your responses will be kept confidential. No identifying information is asked to ensure anonymity and confidentiality. REDCap will be used for the data collection and storage through an online survey. REDCap is compliant with both the Health Insurance Portability and Accountability Act (HIPPA) and the Family Educational Rights and Privacy Act (FERPA). Data will be exported to IBM SPSS® Statistics with the data stored online under encryption instead of in the SPSS cloud.

Accessibility

REDCap has a text-to-speech function that will be enabled for this study. This survey also includes fonts in larger sizes with high-contrast and response options formatted vertically with radio buttons. Two questions will have response options as checkboxes, and one question will have response options as a dropdown. If you experience accessibility concerns, please contact Kendrick Britton or Stephen J. Leierer.

Potential Risks

We do not anticipate any risks for taking part in this survey. If you feel uncomfortable when answering questions, you can exit the survey at any time.

Voluntary Participation and Withdrawal

Your participation in the research study is voluntary. You may choose not to answer any or all questions, and you may stop at any time. There is no penalty for not taking part in this research study.

Potential Benefits

The results from this research study will be provided to the graduate offices in higher education. We hope the research study results will be used to increase student success.

Participation may not benefit you. We will not be able to pay you for the time you volunteer while being in this research study. The results will be shared via a dissertation defense. If you are interested in attending the defense or receiving a recording of the defense (whether or not you participate in the survey), please contact Kendrick Britton or Stephen J. Leierer.

Contact Persons and Information

Please contact Kendrick Britton at 252-717-4074 (text/call) or brittonken01@students.ecu.edu or Stephen J. Leierer at 252-744-6298 or leierers@ecu.edu for any research or accessibility related questions. Also, contact the University & Medical Center Institutional Review Board (UMCIRB) at 252-744-2914 for questions about your rights as a research participant.

Resources

- East Carolina University Counseling Center, (252) 328-6661

Umstead Residence Hall, Greenville, NC 27858

- ECU Family Therapy Clinic, (252) 737-1415

612 E 10th St, Greenville, NC 27858

- Eastern Psychiatric, (252) 756-4899

925 Conference Dr, Greenville, 27858

Copy of Consent Form

If you agree to participate in this research study, you agree to this consent form. You may save or print a copy of this form for your records.

Agree to Participate

Do you understand what you have read and agree to participate in this research study?

- Yes
- No