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**Development & evaluation of an introductory webinar training for mental health professionals working with perpetrators of child sexual abuse: a strengths-based sociocultural perspective**

Angie Yvette Reyes

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Pepperdine University  
Graduate School of Education and Psychology

DEVELOPMENT & EVALUATION OF AN INTRODUCTORY WEBINAR TRAINING FOR  
MENTAL HEALTH PROFESSIONALS WORKING WITH PERPETRATORS OF CHILD  
SEXUAL ABUSE: A STRENGTHS-BASED SOCIOCULTURAL PERSPECTIVE

A clinical dissertation submitted in partial satisfaction  
of the requirements for the degree of  
Doctor of Psychology

by

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March, 2023

Shelly P. Harrell, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

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DOCTOR OF PSYCHOLOGY

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## DEDICATION

This work is wholeheartedly dedicated to my loving family. A special feeling of gratitude to my parents, Irma Leticia Rocha and Juan Luis Reyes, thank you for everything you have done to help mold me into the person I am today. I carry your strength, struggles, and triumphs on my shoulders along with all the blood, sweat, and tears of my ancestors. Through your sacrifice, I have learned hard work, tenacity, and grit. You provided me with countless opportunities that have been instrumental in my success. My sister, Jennifer Mendoza, you are my rock and my best friend. Thank you for your constant support, words of encouragement, and believing in me during times that I did not believe in myself. I am forever grateful for everything that you have done for me and all you continue to do for me. My younger siblings, Jacklyn and Jonathan Reyes, you are my *chickalings*. You motivate me to accomplish my goals and to demonstrate that we can overcome anything. You push me to be better and pave the way for possibilities. My love, Edgar Lopez, your endless love and support have been a source of strength and courage for me. Thank you for reassuring me of my abilities and loving me for who I am. Lastly, this is dedicated to my son, Alexander Mateo Lopez. You have taught me selfless love, understanding, and patience. You have made me stronger, better, and more fulfilled than I could have ever imagined. I hope to always make you proud. I love you forever.

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## ABSTRACT

The purpose of this dissertation project was to develop an introductory webinar resource to provide training of mental health professionals (MHPs) to work with perpetrators of child sexual abuse (PCSA). The training utilizes a strengths-based approach with a focus on sociocultural considerations for working with this population. A literature review revealed a gap in resources, treatment, and clinical training pertaining to PCSA. The results of an initial training needs survey among MHPs indicated that MHPs do not receive education or training on PCSA and could benefit from training. Through this webinar training, MHPs acquire a basic understanding of PCSA and its complexities to work with this population in a manner that facilitates more adaptive functioning. The webinar training resource was evaluated by one general mental health evaluator and one expert mental health evaluator. Evaluation of the training indicated that the training was useful, informative, specialized for PCSA, and contributed to the readiness to work with PCSA. Additionally, the evaluators found the training to reflect a strengths-based perspective with attention to sociocultural issues. Limitations to the project were identified and future directions for the webinar training are discussed including suggestions for inclusion that would improve this introductory training resource. This training resource provides a different perspective to working with this highly stigmatized and marginalized population and can pave the way for providing treatment that humanizes and respects the dignity of PCSA while simultaneously address both the needs of PCSA and the safety needs of the community.

## Chapter 1: Introduction

Child sexual abuse (CSA) is a social issue and public health problem worldwide. This international problem can affect children of all ages, sexes, races, ethnicities, and socioeconomic classes (Collin-Vézina et al., 2013). CSA has been studied at length over the years. We know from the literature that CSA can have profound and long-lasting negative impacts on victims relating to their physical and mental health, social well-being, and other life domains (Collin-Vézina et al., 2013). PCSA are among those that invoke the most fear and concern. Children are typically warned to avoid strangers (Hanson et al., 2003). Many people view PCSA as monsters, suggesting that they are unsalvageable and should be left to be discarded.

While research consistently agrees that CSA is significant issue, most of the literature focuses on the effects and treatment for the victim. The second half of the equation is studying PCSA. In attempt to understand the full extent of the problem it is important to gather information about PCSA. People are often touched deeply by victims' stories of sexual abuse and generally find it difficult, naturally, to accept or care about those persons who perpetuate such offenses upon children or adolescents (Polson & McCullom, 1995). PCSA are often the target of public rage, hostility, and ostracism (Donohue & Moore, 2009). Several people believe PCSA should be strictly punished and are not worthy of help or treatment. However, it is necessary to do research to get a better understanding of perpetrators in order to provide help and to prevent or reduce the occurrence of CSA (Rueda et al., 2021). The truth is that most PCSA who are incarcerated will return to society; therefore, it is imperative to gain more insight into this population and find solutions to the problem.

Definitions used by researchers are a key element in terms of prevalence data, which can vary widely from one research study to another (Rueda et al., 2021). CSA and PCSA are

frequently defined and classified differently across literature which creates a challenge for capturing the full problem. Similarly, recidivism rates are also often conflicted in the literature, and it may be due to their operational definition of recidivism. Some studies report recidivism as any new criminal offense while others specifically consider only new sexual offenses. Furthermore, as with most data regarding CSA, data-based information about offenders is difficult to acquire, as most sexual assaults are not reported (Thomas et al., 2013).

### **A Note on Terminology and Scope of Study**

Given the large number of terms that exist to identify individuals who have engaged in sexual activity with a child, for the purposes of this dissertation, the description, PCSA is the chosen terminology used throughout this study. A PCSA is an adult who engages sexually with a minor, with or without physical contact. In attempt to avoid negatively charged terminology and maintain the strengths-based sociocultural perspective of this study, the author uses a neutral behavioral description as a label for individuals who have committed sex offenses instead of using labels that impose identity rather than the behavior. Although alternative phrases such as “individuals who have committed sex offenses on children” or “persons who have engaged in sexual activity with a child” would be acceptable, PCSA was more readily condensable. Using terminology that labels individual’s offense as part of their identity perpetuates the notion that the behavior in which they have engaged in defines the individual as a whole.

Despite the author’s attempt to use strengths-based language for perpetrators of child sexual abuse, the literature review may incorporate the terms *sex offender* or *offender*, as it is the most common label used across the literature. Similarly, the phrase *sex offender treatment* may be used when discussing treatment for perpetrators of child sexual abuse given its global use.



Additionally, it should be noted that the specific population classified as pedophiles are not included in this dissertation. Pedophiles refers to a narrow group of individuals diagnosed with pedophilia, which is a disorder defined in the Diagnostic and Statistical Manual of Mental Disorders 5th Edition, by the extended presence of intense, recurring sexual urges, fantasies, or behaviors involving sexual activity with prepubescent children (American Psychiatric Association, 2013). This specific population is beyond the scope of this study for an introductory training for MHPs interested in working with PCSA.

### **Definitions and Types of Child Sexual Abuse**

Definitions of CSA vary across literature and organizations. The American Psychological Association (APA, 2022) defines sexual abuse as “unwanted sexual activity, with perpetrators using force, making threats or taking advantage of victims not able to give consent” (para. 1).

The World Health Organization (WHO, 1999) states:

Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity, the exploitative use of child in prostitution or other unlawful sexual practices, and the exploitative use of children in pornographic performances and materials. (pp. 15–16)

The Rape, Abuse & Incest National Network (RAINN, 2022) indicates that, “Child sexual abuse is a form of child abuse that includes sexual activity with a minor” (para. 1). The definition explains that CSA does not need to include physical contact between a perpetrator and a child. They list forms of CSA to include:

obscene phone calls, text messages, or digital interaction; fondling; exhibitionism, or exposing oneself to a minor; masturbation in the presence of a minor or forcing the minor to masturbate; intercourse; sex of any kind with a minor, including vaginal, oral, or anal;

producing, owning, or sharing pornographic images or movies of children; sex trafficking; and any other sexual conduct that is harmful to a child's mental, emotional, or physical welfare. (RAINN, 2022, para. 1)

According to the Child Abuse and Neglect Reporting Act (2020), California Penal Code 11165 and 11165.1 defines a child as a person under the age of 18 years, and sexual abuse refers to sexual assault or sexual exploitation. Under this penal code, sexual assault is defined as, “rape, statutory rape, rape in concert, incest, sodomy, oral copulation, lewd or lascivious acts upon a child, sexual penetration, or child molestation” (Child Abuse and Neglect Reporting Act, 2020, para. 1). This penal code further defines sexual assault as including, but not limited to:

(1) Penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen, (2) Sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person, (3) Intrusion by one person into the genitals or anal opening of another person, including the use of an object for this purpose, except that, it does not include acts performed for a valid medical purpose, (4) The intentional touching of the genitals or intimate parts, including the breasts, genital area, groin, inner thighs, and buttocks, or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, except that it does not include acts which may reasonably be construed to be normal caretaker responsibilities; interactions with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose, or (5) The intentional masturbation of the perpetrator's genitals in the presence of a child. (Child Abuse and Neglect Reporting Act, 2020, para. 2)

### **Incidence and Prevalence Rates**

It is important to recognize the complexity of the issue in capturing statistical data on PCSA. It is challenging to capture an accurate account of sexual offending when there are numerous definitions of CSA and most sexual offenses are unreported. “Sexual abuse is the most underreported crime” (Dru Sjodin National Sex Offender Public Website [NSOPW], n.d., para. 1). Due to the taboo and shame that surrounds it, CSA is a problem universally silenced (Rueda et al., 2021). The statistics that are found in literature often come from reported incidents of CSA, while we know that not all incidents get reported. Usually, the only persons with firsthand

knowledge of this violation are the victim and the perpetrator (Faller, 2020). Despite not having the full picture, the literature suggests that “not all people who sexually abuse are the same and most people who sexually abuse are known to the victim” (NSOPW, n.d., para. 5).

According to the World Health Organization (WHO, 2022), “CSA is one of the most common types of traumas during childhood, with a higher rate for females than for males” (para. 2). The Centers for Disease Control and Prevention (CDC, 2022) indicates that about “1 in 4 girls and 1 in 13 boys in the United States experience child sexual abuse” (para. 2). CSA prevalence estimates in most studies range between 5.8% and 34% in girls and 2% and 11% in boys (Walker et al., 2004). Recent systematic reviews and meta-analyses that included studies conducted worldwide across hundreds of different age-cohort samples have consistently shown an alarming rate of CSA, with averages of 18%–20% for females and of 8%–10% for males (Collin-Vézina et al., 2013). Although prevalence ranges indicate that CSA is a significant public health problem, it is unknown how much CSA goes unreported. Research estimates that only 10%–15% of the cases are reported (Rueda et al., 2021). Therefore, the population of individuals who have experienced CSA may be much larger than current research documents.

Research states that children are most likely to be abused by adults (e.g., caregivers, relatives) they know and trust (Berliner, 2011; Tapia, 2014). Perpetrators are typically male, and victims are typically female (Putnam, 2003). Literature suggests that children are usually abused by individuals known to them who want continued access to them. Some research has shown that approximately half of CSA victims lived with the perpetrators at the time of the abuse (Tapia, 2014).

According to the Federal Bureau of Investigation crime statistics for sexual assaults in 2021 from the National Incident-Based Reporting System (NIBRS), there were 93,407 offenses

reported to 11,794 law enforcement agencies. The summary report indicates that the majority of sexual offenders were male ( $n = 84,160$ , 90%) and the majority of victims were female ( $n = 84,225$ , 90%). When comparing offender age and victim age, 64% of sexual offenders were under the age of 40 and 52% of victims were under the age of 19. The majority of sex offenders (58%) and victims (71%) identified their race as white. Results from the crime summary report indicates that 70% of the sexual abuse occurred in a residence home and 65% of the offenses were committed by someone known to the victim (Federal Bureau of Investigation [FBI], 2021).

The National Crime Victimization Survey (NCVS) was established by the Bureau of Justice Statistics (BJS) to provide information on the characteristics of criminal victimization in the United States. NCVS data indicates that most rape and sexual assault victims are female, white, and under age 30 (Morgan & Kena, 2018). In 2015 the United States Department of Justice Federal Bureau of Investigation released crime data from a study in 2013 regarding the sex offenses reported via the National Incident-Based Reporting System (NIBRS). Unlike summary reports of crime, this report included an in-dept review of all offenses related to sexual assault. This report subdivided sex offenses into six offense types: rape, sodomy, sexual assault with an object, fondling, incest, and statutory rape. Among all six offense types the most common race for the offenders was white and most of the sex offenses committed were committed by a family member or someone known to the victim: rape (91%), sodomy (81%), sexual assault with an object (81.1%), fondling (82%), incest (100%), and statutory rape (87.4%) (United States Department of Justice, 2015). The most common age of victim was approximately 14 years old with the exception of sodomy, which was 5 years old (United States Department of Justice, 2015).

Despite best efforts made by multiple reporting agencies, there are still many gaps in capturing the full extent of sexual offending due to no single definition of sexual offending used across studies, difference in the methods used to collect data, and given that most victims do not report sex crimes. The statistics gathered are only records of reported sex crimes and therefore, an accurate account of sexual offending is virtually impossible.

### **Recidivism**

“Recidivism refers to a person’s relapse into criminal behavior, often after the person receives sanctions or undergoes intervention for a previous crime” (National Institute of Justice [NIJ], n.d., para. 1). Recidivism is a difficult concept to measure since recidivism rates are typically based on officially recorded information such as an arrest, a criminal conviction or incarceration which means only those offenses that are reported are calculated and therefore does not capture true reoffense rates. Although underreporting continues to be a barrier to seeing the full picture of sexual offending, we can still gather some information from the literature to give us a better understanding of the issue.

In 2019, the BJS studied 412,731 prisoners that were released from state prisons across 30 states over 9 years (Alper & Durose, 2019). They measured recidivism as a return to prison. The study revealed a 7.7% sexual recidivism rate among those with prior sex offense convictions during the 9-year follow-up. Additionally, the study reported a 67% general recidivism rate among those with prior sex offense convictions over the course of 9 years, compared to 84% general recidivism for other released prisoners not previously convicted of sexual offenses (Alper & Durose, 2019). These rates are not an estimate of the recidivism rate based on statistical sampling, as is the case in most of the academic research in this area. The report relies on actual data from the entire population of the prisoners released in 30 states. Additionally, the arrest-

based sex offense recidivism rate reported (7.7% over 9 years) is lower than the estimated rates obtained by most meta-analytic studies.

There are different recidivism rates reported in the literature but most literature suggests that recidivism is comparatively low, indicating that about 12%–24% of sex offenders will reoffend (Hanson & Morton-Bourgon, 2005). When sex offenders do commit another crime, it is more often not sexual or violent (Drake & Barnoski, 2006). The research on sexual offense recidivism rate, which is the rate at which a sex offender recidivates sexually is relatively low—approximately 13% in an average follow-up period of 4–5 years (Looman et al., 2005).

### ***Definitions***

There are discrepancies in the literature regarding recidivism among PCSA. The literature reports recidivism rates ranging from 5%–15% over 5 years (Alper & Durose, 2019). This can be attributed, in part, to the operational definition of recidivism that is used. Recidivism has been defined from as general as ‘parole violations’ to as specific as ‘return to prison for the same crime’ that had been committed previously (Turner & Rubin, 2002). Some studies define recidivism as a violation of condition of release, a new arrest, a reconviction, or a return to prison. Additionally, some studies measure recidivism as *general recidivism* that often encompasses any new offense committed, while others measure *sexual recidivism* that includes only new sexual offenses. Most literature supports the fact that offenders are more likely to recidivate with a non-sexual offense than with a sexual offense. In 2001, Serin et al. found overall recidivism rates at 45.6% and a sexual recidivism rate at 13% for sex offenders after a follow-up of 7 years.

### ***Length of Follow-up Period***

Studies typically vary in the length of time the offender is tracked to determine recidivism. Studies that have tracked adult sex offenders for longer periods of time show the likelihood of reoffense for another sex crime, 5% after 3 years to 24% after 15 years (NSOPW, n.d.). A meta-analysis by Harris & Hanson (2004) generated recidivism estimates based on new charges or convictions for sexual offenses, using 5-, 10-, and 15-year follow-up periods for several categories of sex offenders and found that the sexual recidivism estimates for all sex offenders in the study were 14% at 5 years, 20% at 10 years, and 24% at 15 years. Recidivism rates will naturally increase as offenders are followed for longer time periods, because there is more time when they are at risk to reoffend and more time for recidivism to be detected. However, other sources in the literature suggest that most reoffenses are committed between 1 and 5 years after release, and the percentage of reoffenders declines rapidly after (Turner & Rubin, 2002). Despite this discrepancy, most agree that when offenders are tracked for a longer period of time, the rates go up because there is more time to commit a crime.

### ***Treatment***

Recidivism rates can also vary based on whether any treatment was provided and the type of treatment. A meta-analysis found that, the sexual offense recidivism rate for the treated sexual offenders was lower (12.3%) than the comparison untreated sexual offender group (16.8%) (Bradford et al., 2013). For general recidivism there was also a difference with the treatment group having a 27.9% recidivism rate and the comparison group 39.2% (Bradford et al., 2013). The recidivism rates were based on an average 46-month follow-up period. Recidivism rates can further vary depending on the type of treatment that was provided.

### *Type of Sexual Offense*

Recidivism can also look different for different type of sexual offenses. Empirical data suggests that recidivism rates vary for different types of offenders with PCSA recidivating less than rapists, and exhibitionists recidivating more than other types of sexual offenders, except for extrafamilial PCSA (Jung et al., 2011). However, the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Trafficking (SMART) states that the highest observed recidivism rates are found among PCSA who offend against boys and that comparatively lower recidivism rates are found for rapists, PCSA who victimize girls, and incest offenders (Przybylski, 2017a). Over 10 years, sexual assaulters and pedophiles reoffend sexually at a rate of only 10.4% and 6.2% respectively, whereas exhibitionists, reoffend most often at a rate of 20.5% (Turner & Rubin, 2002). Research reports a 25-year recidivism rate of 39% for rapists noting that this rate is still lower than the rates for nonsexual criminals (61%–83%) (Koss et al., 2003). As demonstrated across multiple studies, regardless of type of sex offense, there are higher rates of general recidivism than sexual recidivism.

Overall, the available data suggests that most sexual offenders do not recidivate, but it is important to remember, however, that many sexual offenses are never reported to police (Hanson et al., 2003). Lastly, it is worth mentioning that sexual charges are often dropped in court proceedings or through plea-bargaining (Turner & Rubin, 2002).

### **The Issue of Treatment and Training**

It is essential to note that there is still a lot to learn about PCSA, in fact, the literature states that research on PCSA is still in its infancy and at the present time, much of the knowledge of sexual violence appears incomplete, paradoxical, and inconsistent (Thomas et al., 2013). Undoubtedly, the overall goal is to prevent CSA and among those who have offended, prevent



the recurrence of sexual offending. Given that the majority of PCSA will be reintegrated into society, there needs to be a focus on treatment of PCSA. There is a gap in training of MHPs to work with PCSA. Academic and training programs have given little attention, if any, to prepare MHPs to work with this population. Current therapy treatments available typically operate through a one-size-fits-all approach with an emphasis on public safety over the needs of the PCSA, the client. There is a need for MHPs to work with PCSA from a framework that respects the dignity of the client and their pursuit for a better life while simultaneously reducing sexual offending.

### **Webinar Trainings**

The term “webinar” is a combination of the two words web and seminar. The basic idea of webinars is to conduct seminars online; however, the meaning of webinars in a broader sense is not restricted to online seminars only. They now also include meetings, conferences, demonstrations, training or teaching, or events that are designed to give information either one-way or interactively (Gupta & Sengupta, 2021). They are the multimedia resource for delivering education and training. Video, audio and textual communications are essential features of any webinar. Webinar provides an opportunity to take the physical class to an online portal using a video conferencing system (Gupta & Sengupta, 2021). The critical characteristic of webinars is interactivity, the ability to view, send, receive, and discuss information (Gegenfurtner et al., 2020; Nadama et al., 2019; Smironva et al., 2019).

Although webinars are not a new tool used for education and training, the outbreak of the COVID-19 pandemic caused educational institutions to close and created a massive shift from in-person instruction to the adoption of virtual learning. Since the start of the pandemic, webinars

have increased all over the world (Tanidir et al., 2021). Webinars have also been found to be very useful to continue students' education in the scenario of social distancing.

Using webinars for education and trainings is an effective way to share information and have many advantages, including low cost, reaching a high number of audiences, no travel or costs associated with travel, and being comfortable in your own home (Tanidir et al., 2021). Webinars are unique in terms of providing opportunities to discover educational content at an individual's own pace. One study found that participants were more likely to ask questions in a webinar than an in-person lecture, removing any barriers caused by shyness (Nadama et al., 2019). Webinars are commonly 60–120 minutes in duration. Research found that when webinars prolonged 90 minutes, the participants started to leave (Tanidir et al., 2021). Overall research suggests that most students are interested in attending some interactive online lectures and webinars are becoming the preferable site for reaching information (Gupta & Sengupta, 2021; Tanidir et al., 2021).

### **Overview and Rationale of Current Study**

This study proposed to develop an introductory webinar training for MHPs on PCSA. The aim of the webinar training was to integrate a strengths-based sociocultural perspective that will encourage MHPs to work with PCSA in a manner that facilitates more adaptive functioning. This webinar is unique in its strengths-based presentation that identifies resources and strengths to address sexual offending. A strengths-based perspective was selected for this training due to research that argues that treatment for perpetrators that builds strengths and treats offenders in a respectful, empathic, and rewarding manner is effective in reducing sexual reoffending (Marshall & Marshall, 2014). This webinar training aims to introduce MHPs to the complex and dynamic issues of PCSA, treatment, treatment barriers, and additional resources to consider when working

with PCSA. This webinar will incorporate a holistic view of treatment for PCSA that focuses on human dignity by helping them lead socially acceptable and satisfying lives and ensuring the safety of society, rather than just ensuring the safety of society. A webinar format is the chosen modality for this training due to its ease in accessibility and distribution along with its convenience and flexibility for MHPs.

## **Chapter 2: Review of Literature**

The component of CSA literature that is often neglected is the impact on the perpetrator and the clinical focus to address the impact. As mentioned, most PCSA will reintegrate into society, thereby it behooves us to gain more insight into this population and find solutions to the problem. An overview of perpetrator typologies and characteristics, theories of sexual offending, impact on the perpetrator, sociocultural factors, and treatment of PCSA are introduced and discussed below.

### **Perpetrator Typologies and Characteristics**

Researchers and society want to know who the PCSA are and if there is a profile for sex offenders. There is a belief that if we know who they are, we can be safer. The truth is, there is no profile and there is no such thing as a typical sex offender. PCSA can be any gender, young or old, any education level, married or single, strong ties or weak ties to their families and communities, and have a criminal record or no criminal record (Becker & Murphy, 1998). Although there is no sexual offender profile, the literature describes sex offender typologies, which are a classification system that can provide information regarding patterns among categories of offenders. Traditional typologies have been developed to provide a comprehensive understanding of deviant sexual behaviors required for treatment intervention and effective supervision. However, classifying sexual offenders has been shown to be problematic as indicated by inadequate definitions and inconsistent research findings (Simons, 2017). It is important to note that due to the overall heterogeneous nature of perpetrators, no classification system has universal validity. Although perpetrators of abuse can exhibit diverse characteristics, there are many commonalities in their clinical problems and offense patterns that can help aid in

research and treatment. The literature frequently discusses typologies for child sexual abusers, rapists, female offenders, and internet sexual offenders.

### ***Child Sexual Abusers***

*Child sexual abusers* is the term coined with the typology that focuses on perpetrators of child sexual abuse. This category of offenders has been difficult to classify as they vary in economic status, gender, marital status, ethnicity, and sexual orientation (Simons, 2017). When exploring the typology of child sexual abusers, the first distinction to make is whether or not they are pedophiles. There is a misconception that all PCSA are pedophiles. A person can be a PCSA without being a pedophile. In fact, most PCSA are considered situational offenders and do not have a genuine interest in children but may sexually offend for a number of complex reasons. A pedophile is considered a preferential offender who has a sexual preference for children. Pedophilia consists of a sexual preference for children that may or may not lead to child sexual abuse, whereas a PCSA engages in sexual activity with a child that may or may not be due to pedophilia (Camilleri & Quinsey, 2008).

A pattern found when examining the relationship between the PCSA and their victims is differentiating between intrafamilial and extrafamilial perpetrators. Intrafamilial perpetrators are those who exclusively select victims within their family, typically their own children or stepchildren. Intrafamilial perpetrators tend to be less psychopathic, have fewer victims, and less likely to be pedophiles. Researchers suggest that they are more likely to have female victims, cause less injury, and have lower recidivism (Rice & Harris, 2002). Although intrafamilial child sexual abusers substitute a child for an adult sexual partner, they often maintain their adult sexual relationships (Miner & Dwyer, 1997). Extrafamilial perpetrators are those who select their

victims from outside their family members. Extrafamilial perpetrators are more likely to be pedophilic and have more child victims. They likely have few or no adult relationships.

Another pattern to examine among PCSA is whether they are considered fixed or regressed perpetrators of child sexual abuse. Groth created the fixated–regressed dichotomy of sex offending in the 1980. Fixed PCSA are described as having a persistent, continual, and compulsive attraction to children. The fixated offender prefers interaction and identifies with children socially and sexually (Simon et al., 1992). These individuals often develop and maintain relationships with children to satisfy their sexual needs (Terry & Tallon, 2004). Research suggests that the majority of fixated PCSA are individuals who sexually assault male children who are not related (Simon et al., 1992). In contrast, regressed PCSA prefer social and sexual interaction with adults. Their sexual involvement with children is situational and occurs as a result of life stresses (Simon et al., 1992; Terry & Tallon, 2004). These stressors can include unemployment, marital problems, substance abuse, or can be related to negative affective states such as loneliness, stress, isolation, or anxiety. Regressed child sexual abusers often consist of incest offenders or offenders who sexually assault female adolescents (Simon et al., 1992). Regressed PCSA tend to victimize children they have easy access, and as such, they often victimize their own children (Robertiello & Terry, 2007).

There are some shared characteristics that PCSA exhibit. PCSA often have poor social skills, feelings of inadequacy or loneliness, low self-esteem, a sense of worthlessness, and/or depression. Researchers indicate that they abuse to alleviate anxiety, loneliness, and depression (Polaschek et al., 1997). They may be passive in relationships and have previously frustrating adult relationships (Maniglio, 2012). They may also see themselves as physically unattractive (Terry, 2006). Additionally, PCSA often believe that there is a mutual relationship with the

victims (Groth, 1983; Hayashino et al., 1995; Whitaker et al., 2008). Lastly, most PCSA tend to groom their victims. *Grooming* refers to the premeditated behavior intended to manipulate potential victims into complying with the sexual abuse (John Jay College, 2004). Types of grooming behavior include verbal and/or physical coercion, emotional manipulation, seduction, games, and enticements (Pryor, 1999).

### **Etiology and Theories of Sex Offending**

The etiology of adult sexual offending refers to the origins or causes of sexually abusive behavior, including the pathways that are associated with the behavior's development, onset, and maintenance. Even though questions about the causes of sexual offending have been asked for many years, our understanding of the causes and origins of sexually abusive behavior arguably remains rudimentary (Faupel & Przybylski, 2017). Theories of sex offending can be categorized as single-factor theories and multifactor/integrated theories of sexual offending.

#### ***Single-Factor Theories of Sexual Offending***

Single-factor theories of sexual offending offers insight into offending behavior based on individual theories. *Biological theories* of sexual offending focus on brain abnormalities, hormone levels, genetic and chromosomal makeup, and deficits in intellectual functioning (Faupel & Przybylski, 2017). To date, there is no clear causal relationship between abnormalities in the brain, hormonal abnormalities, genetic defects, and intellectual functioning on sexual offending. *Evolutionary theories* focus on sexual selection and sexual strategies to explain sexual aggression. Yet, researchers have largely disregarded these hypotheses due to the difficulties to empirically test the validity of evolutionary theories (Travis, 2003). *Personality theories* focus on principles of attachment theory to explain relationships between children and their primary caretaker, and how this early relationship affects later adjustment. Marshall (1989) found that

men who sexually abuse children often have not developed the social skills and self-confidence necessary to form effective intimate relations with peers. This failure creates frustration that causes them to seek intimacy with young partners (Marshall, 1989; Marshall & Marshall, 2000). Personality theories demonstrate that sex offenders have poor social skills and problems with intimacy, and that there is a connection between poor relationships with others (particularly caregivers) and sexual offending behavior; however, it does not provide a complete explanation of the cause of sexual offending (Stinson et al., 2008). *Feminist theories* focus on gender and the imbalance of power between men and women. They argue men are conditioned within a culture that accepts, tolerates, condones, and even perpetuates sexual violence toward women and children (Chung, 2005; Cossins, 2000). While feminist theories of gender imbalance may not capture the sole cause of sexual violence, there is evidence to support that it is a factor in sexual offending behavior (Faupel & Przybylski, 2017).

*Cognitive theories* focus on how an offender's thoughts affect their behavior. There is evidence demonstrating that sex offenders engage in cognitive distortions or thinking errors, and that these distorted thinking patterns have the capacity to drive deviant sexual behavior (Faupel & Przybylski, 2017). Cognitive theories serve as a core component of many sex offender treatment programs in existence today, and most treatment programs incorporate some type of intervention to help the perpetrator identify and correct his or her thinking errors (Faupel & Przybylski, 2017). *Behavioral theories* focus on the occurrence of continued deviant sexual behavior depending on reinforcement and punishment. Self-regulation is a behavior theory that states that the goal of engaging in sexually deviant behavior and the strategies employed to reach that goal become automatically integrated into the behavior of the offender because they have been consistently reinforced in the past (Ward & Hudson, 1998). *Social learning theories* focus



on the notion of environmental influences playing a role in sexual offending. Social learning theories suggest that children who are sexually abused grow into sexually abusive adults, and that sexually explicit material contributes to sexual offending behavior (Faupel & Przybylski, 2017). Much research has examined the impact of victimization on future victimizing behavior. The literature suggests that early childhood victimization does not automatically lead to sexually aggressive behavior. While sex offenders have higher rates of sexual abuse in their histories than would be expected in the general population, the majority of perpetrators were not abused as children (Berliner & Elliot, 2002; Putnam, 2003). Although social learning theories provide valuable insights for understanding sex offending and there is evidence to support that sexual offending is a learned behavior, it does not exclusively explain sexual offending behavior (Faupel & Przybylski, 2017).

### ***Multifactor Theories of Sexual Offending***

Multifactor theories of sexual offending argue that single-factor theories do not fully capture the cause of sexual offending. Multifactor theories integrate multiple factors to explain sexual offending behavior. *Finklehor's Precondition Theory* outlines four preconditions that must exist for child sexual abuse to occur including (a) the motivation to abuse such as lack of other sexual outlets (b) overcoming of internal inhibitions such as morals and values (c) overcoming of external inhibitors such as an opportunity for privacy with a child with poor boundaries and inadequate supervision, and (d) overcoming of victim resistance such as grooming a child and using bribes, trickery or manipulation (Faupel & Przybylski, 2017). Although there are some elements of this theory supported in literature, the preconditions are not direct causes of sexual offending.

*Marshall and Barbaree's Integrated Theory* suggests that prominent causal factors of sexual offending are developmental experiences, biological processes, cultural norms, and the psychological vulnerability that can result from a combination of these factors. The theory argues that several factors are responsible for sexual offending including early negative childhood experiences that result in feelings of worthlessness, low self-esteem, poor interpersonal skills, and weak coping skills (Marshall & Barbaree, 1990). Also, the presence of antisocial and misogynist attitudes in the home can create messages of positions of power and dominance. Lastly, the theory suggests that sex meets several psychological needs beyond sexual gratification and that mood states may become conditioned with sexual arousal such as someone using masturbation to cope with loneliness and eventually the state of loneliness creates sexual arousal (Faupel & Przybylski, 2017).

*Hall and Hirschman's Quadripartite Model* groups sex offender personality traits and characteristics derived from other studies into four factors they believed to be most significant in the etiology of sex offending: (a) sexual arousal, (b) thought processes, (c) emotional control, and (d) personality problems or disorders (Hall & Hirschman, 1991). They believe that sexual arousal is not the only factor to deviant sexual behavior but that an individual's thought process including cognitive distortions contributes to offending behavior. Hall and Hirschman believe negative emotional moods like anger and depression often precede sexual offending. Lastly, they found that negative childhood experiences contributed to personality disorders characterized by selfishness, manipulative and explosive personality, lack of remorse and antisocial behaviors (Faupel & Przybylski, 2017). Some researchers suggest that although Hall and Hirschman identify traits of sex offenders consistent in research, the causal mechanism is missing and therefore serves to function more as a typology rather than explaining etiology (Ward, 2001).

*Ward and Siegert's Pathways Model* integrates aspects of other multifactor theories into five causal pathways for the development of problematic and abusive sexual behavior.

First, intimacy deficit pathway, describes an offender who uses sex to ease feelings of loneliness and takes advantage of an opportunity to offend if a preferred sexual partner is not available. Second, deviant sexual scripts pathway suggests that sex offenders have distorted thought processes that guide their sexual and intimate behaviors including confusion between sex and intimacy, as well as difficulty in determining when sexual contact is appropriate or desirable. Third, emotional deregulation pathway is the primary cause of abusive sexual behavior with children. Offenders in this category demonstrate significant problems regulating emotional states. Fourth, antisocial cognition pathway involves attitudes and beliefs supportive of criminal behavior including a significant sense of entitlement, little regard for the emotional and psychological needs of others, and cultural beliefs consistent with their offending lifestyle. Fifth, multiple dysfunctional mechanisms pathway involves all symptom clusters associated with the previous pathways, with no single prominent feature among them. (Faupel & Przybylski, 2017, p. 48)

As with most of the other theories, there is insufficient support of causality and critics argue that there is no empirical justification for grouping offenders into separate categories since research suggests that individuals in all five pathways share many of the same traits and they are not characteristic of only one pathway (Simon, 1997, 2002).

*Malamuth's Confluence Model* states that sexually aggressive behavior is a result of promiscuous-impersonal sex and hostile masculinity. The model argues that natural selection has created fundamentally different psychological mechanisms in the brains of women and men with regard to sex and intimacy, resulting in the male's preference for short-term over long-term mating patterns and unwilling sexual partners may entice sexual aggression in men (Faupel & Przybylski, 2017). Malamuth suggested that the level of dominance or nurturance traits develops as a result of the evolutionary process and early childhood socialization with the incorporation of familial and cultural messages (Dean & Malamuth, 1997; Malamuth, 1998). The limitations of Malamuth's Confluence Model include the shortcomings from evolutionary theory (Stinson et al., 2008).

*Stinson, Sales, and Becker's Multimodal Self-Regulation Theory* states that significant self-regulatory deficits resulting from negative childhood experiences is a factor in the development of deviant sexual interest and arousal. The theory suggests that when certain biological and temperamental vulnerabilities are also present, the individual is unable to manage his or her behavior and sexual offending can result (Stinson et al., 2008). A key component to this theory is the premise that sexual arousal becomes linked with a deviant or inappropriate stimulus through the mind's attempt to normalize the experience. Additionally, Stinson et al. (2008) suggested that behavioral conditioning in the development of abusive sexual behaviors also occurs and over time, the reinforcing effects of these practices, combined with a lack of negative consequences, will contribute to the development of a deviant sexual interest. Cognitive beliefs, personality traits, and external factors are also considered in this theory as contributors to the development of deviant sexual behaviors such as sense of entitlement, impulsivity and irresponsibility, and offense-supportive cognitive beliefs (e.g., a man's right to control a woman) (Faupel & Przybylski, 2017).

### ***Summary***

There is no single or simple answer to the question of why people engage in sexual offending behavior. The problem of sexual offending is too complex to attribute solely to a single theory and even though multifactor theories provide greater insight into the causes of sexual offending, the field of sex offender management has yet to find a clear explanation or cause for sexual offending behavior (Faupel & Przybylski, 2017). People who sexually abuse vary in the reasons they offend, who they offend against and the various sexual behaviors and crimes they commit. Although our understanding of the causes and origins of sexually abusive behavior is still developing, research clearly shows that in many cases sexual abuse is a learned

behavior (The Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Trafficking [SMART], 2017). There are a number of contributing factors, including negative or adverse conditions in early development leading to poor attachment to others. In addition, “many sex offenders have cognitive distortions or thinking errors to rationalize their sexually abusive behavior, and many have problems with self-regulation and impulse control” (SMART, 2017, para. 2).

### **Impact of Child Sexual Abuse on the Perpetrator**

#### ***Legal***

One of the first legal consequences that occurs following a report of CSA is incarceration of the perpetrator. Several states have passed civil commitment statutes to manage the small percentage of the most dangerous convicted sex offenders named sexually violent predators (SVP). SVP laws seek to identify a small group of extremely dangerous incarcerated sexual offenders who represent a threat to public safety if released from custody (DeMatteo et al., 2015; Sreenivasan et al., 2003). These laws allow for the indefinite civil psychiatric commitment of sex offenders after their criminal sentences have been served (Sreenivasan et al., 2020). However, most perpetrators do not meet the criteria for SVP and are released from prison after completing their sentence. It is estimated that 90% of all convicted sex offenders who serve time in prison are ultimately released back into the community (Phillips, 2003).

Upon reentry into society, perpetrators are required to register as convicted sex offenders. In 1994, the Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act was written to create convicted sex offender registries, and by 1999 all states had passed laws requiring sex offenders to register (Phillips, 2003). In 1996, Megan’s Law was passed regarding community notification of sex offenders who are released into the community

and by 1998, all states had passed laws that allowed for community notification or access to sex offender registration information (Phillips, 2003). Sex offender registration laws require offenders to provide their addresses, and other identifying information, to a state agency or law enforcement agency for tracking purposes with the intent of increasing community protection (California Sex Offender Management Board [CASOMB], 2007). Registered sex offenders are required to update their information annually with local law enforcement, within five working days before or after their birthday (Levenson & Cotter, 2005a).

Some states utilize a tiered registration system. “As of 2021, sex offender registration in California has transitioned from lifetime registration for all individuals who have been convicted of sex offenses, to a tiered registration system” (CASOMB, 2021, p. 10). The new sex offender registration system has three tiers: the lowest level sex offenders are tier one, which carries mandatory sex offender registration for a minimum of 10 years, mid-level sex offenders are assigned to tier two, which carries mandatory sex offender registration for 20 years, and highest-level sex offenders are tier three, which has mandatory lifetime registration. A key issue with registration and community notification laws is finding a balance between the public’s right to know about sex offenders in the community and the need to successfully integrate sex offenders back into the community (Phillips, 2003).

In addition to sex offender registration, some perpetrators of sexual abuse are required to be electronically monitored through a GPS tracking device. Jessica’s Law was passed in California in 2006 but is known nationally to increase punishment for perpetrators of sexual abuse by prohibiting probation for some sex offenses, extending parole, and allowing for GPS monitoring for many paroled perpetrators of sexual abuse (CASOMB, n.d.). The Chelsea King Child Predator Prevention Act of 2010, or Chelsea’s Law was passed in California which

“increased penalties for sex offender parolees, provided closer oversight of perpetrators of sexual abuse, required mandatory sex offender treatment, and longer parole periods for felony sex crimes involving physical contact with children” (California Department of Corrections and Rehabilitation [CDCR], 2022b, para. 6). Chelsea’s Law also “mandated the implementation of the containment model to be used to manage sex offenders under supervision, which includes a collaboration of multiple agencies for sex offender treatment and supervision” (CDCR, 2022b, para. 7). For more information on sex offender treatment utilizing the containment model refer to the literature under Sex Offender Management Programs.

Lastly, while on probation or parole, sex offenders are supervised by an assigned probation officer or parole agent that monitors the offender to ensure they are abiding their condition of release. The condition of release is a list of requirements that the parolee must follow to prevent parole violations that could result in reincarceration.

### *Safety*

PCSA are part of a highly stigmatized group where hostility and aggression are routinely directed (Jung et al., 2011). In prison there is a hierarchical scale based on criminal offense and at the bottom of the stratification scale are thieves (who steal from other inmates), snitches, former law enforcement, and sex offenders. Due to personal feelings or prison politics, PCSA are often a target of violence in the prison system which often forces PCSA to go to protective custody. While some prisons house sex offenders in a different housing unit away from general population, other prisons are designed to integrate populations. In California, Sensitive Needs Yards (SNY) were created in the 1990s to create a separation of inmates from the general population. However, in 2018 a significant criminal justice reform within the California Department of Corrections and Rehabilitation (CDCR) system created Non-Designated

Programming Facilities that houses inmates together regardless of their designation SNY or General Population (GP) (CDCR, 2022a). The aim of the integration was to allow for greater access to self-help, educational, vocational, and rehabilitative programs that prepare returning citizens for greater personal success once they are released. PCSA tend to conceal their sex offense and create a cover story for safety while integrated with GP. Perpetrators seeking treatment while living in the GP of a prison may have to hide the very existence of the group so as not to jeopardize the lives of the participants (Schwartz, 2011). At the federal level, the “Federal Bureau of Prisons recognizes sex offenders as a vulnerable population within a prison setting and some sex offenders are designated to facilities where they receive specialized services” (Federal Bureau of Prisons, n.d., para. 1).

Once a PCSA is released back into society there is often a threat to their safety upon registry and community notification. Most communities are not fond of having registered sex offenders returning to their community. There is a sense of vigilantism where community members are punishing perpetrators of sexual abuse in their neighborhoods. Mercado et al. (2008) surveyed 137 registered Tier II/III sex offenders on the New Jersey Sex Offender Registry on the impact of registration and notification and found that 48% of the sample reported having been physically threatened or harassed. Another study by Tewksbury (2005), found that of the 121 registered sex offenders surveyed, nearly half (47%) reported being harassed in person.

### ***Employment and Housing***

Employment opportunities are limited to PCSA once released to the community (Mela & Ahmed, 2014). Having a criminal record can present challenges to finding employment, but even more so when the criminal record reflects a sex offense. There are further restrictions to



employment since many employers who may hire people with criminal records are less willing to hire someone with a sex offense. Several employment positions are also eliminated if the positions entail working with minors or place them in any other situation that would be a violation of their condition of release. For offenders who had employment upon release, many were terminated once their conviction was discovered. Mercado et al. (2008) found that 52% of the sample they surveyed reported having lost their job as a result of notification. Similarly, Tewksbury (2005), found that of the 121 registered sex offenders surveyed 43% of the sample reported job loss. The challenge of securing employment is stressful for these offenders returning to the community and often contributes to financial hardship.

In addition to the employment struggles, many communities have passed residency restrictions for perpetrators of sexual abuse (Schwartz, 2011). As of August 2007, 30 states have enacted housing restriction statutes which prohibit certain sex offenders from residing in close proximity to children. Specifically, these state laws may forbid perpetrators of sexual abuse from living in close proximity to schools, daycare centers, parks, and school bus stops (Schiavone & Jeglic, 2009). Not only are PCSA limited geographically where they can reside as enforced in housing restriction statutes, the challenge to find a place of residency is compounded when many landlords or rental properties deny the applicant housing as a result of their background check. Tewksbury (2005) found that of the 121 registered sex offenders surveyed 45.3% reported loss or denial of a place to live. Registered sex offenders frequently experience persistent stress because they are unable to find housing (Tewksbury & Lees, 2007). One study found that the majority of perpetrators reported experiencing difficulties with employment and housing, oftentimes losing a job because of risk status, while being continuously pushed out of neighborhoods by their communities (Zevitz & Farkas, 2000). Schwartz (2011) discusses the

consequences of the barriers to finding housing stating that half of all sex offenders were unable to live with their families; 39% were homeless; 22% were forced to relocate at least twice. Furthermore, sex offenders were forced into housing far from jobs, transportation, or treatment (Schwartz, 2011).

### ***Social and Interpersonal Relationships***

Literature suggests that many PCSA experience relationship problems (Tewksbury & Lees, 2006). Many perpetrators report losing relationships including family members, friendships, and marriages or romantic relationships as a result of their sex conviction. Often there is a separation in the family because the victim is a child or member in the family. As such, the offender's condition of release typically states that the offender cannot be in the presence of the victim and must remain an identified distance away from the victim and not have any communication with them.

Additionally, perpetrators frequently experience a loss in their friendships and acquaintances once they return to their community and their conviction is discovered. A study found that half of the offenders reported they lost a friend as a result of registration (Tewksbury, 2005). Furthermore, due to the residency restrictions, most perpetrators are displaced and have to move away from their family and friends who may be their only supportive contacts (Levenson & Cotter, 2005b).

Researchers also found that many PCSA interviewed (52%) indicated that their romantic relationships pre-conviction ended during or after the conviction process (Lytle et al., 2017). One study found that of the 17 offenders who described a low-quality pre-conviction relationship, 12 (80%) reported a breakup of the relationship as a result of their conviction. Only one out of the four offenders (25%) who described a high-quality relationship prior to conviction ended his

relationship due to the offense (Lytle et al., 2017). Nonetheless, studies indicate that most perpetrators want to develop romantic relationships but fear having to explain their situation to their potential partners (Harris, 2014). Social and interpersonal relationships are significant for rehabilitation as research indicates that relationship issues and intimacy deficits are related to recidivism rates (Hanson & Bussiere, 1998; Hanson & Morton-Bourgon, 2004; Meloy, 2005).

### ***Psychological and Emotional***

Registration and notification policies tend to increase the stigmatization, isolation, and alienation of PCSA. PCSA ostracized by angry community members have been found to experience a significant amount of stress, depression, and hopelessness (Tewksbury & Lees, 2006), which could affect their ability to function as successful members of society (Schivone & Jeglic, 2009). Levenson and Cotter (2005a) reported that the majority of the PCSA they surveyed reported experiencing hopelessness (72%), shame and embarrassment (67%), and stress that interfered with their recovery (71%). PCSA describe that policies in place for sex offenders hinder them from engaging in activities and decreased their chances to live a normal life (Levenson & Cotter, 2005a).

PCSA face numerous judgments, rejections, and emotional obstacles. They often have feelings of embarrassment, shame, guilt, and isolation (Schivone & Jeglic, 2009). The public often labels them as sexual predators, monsters, or perverts (Lanning, 2002). Someone who has committed a sexual crime, particularly against a child, is often labelled as “bad,” “evil,” and a “pervert,” and after a while many of them internalize this stereotype (Lancaster, 1997). If they see themselves as “sex offenders,” their criminal history becomes a part of how they define themselves (Looman et al., 2005). Therefore, many PCSA experience persistent feelings of stigma and vulnerability (Tewksbury & Lees, 2006).

The literature suggests that PCSA typically use cognitive distortions, such as denial, rationalization, and minimization, in order to maintain a positive sense of self and to relieve their underlying shame and anxiety. Cognitive distortions allow PCSA to misconstrue the nature of their sexual offending and defend against the full impact of their sexual arousal to children (Abel et al., 1989; Lanning, 2010; Murphy, 1990). Utilizing these distortions allows the offender to excuse his behavior to himself and others (Howitt & Sheldon 2007; Lanning 2010).

Some studies report a risk for suicide among PCSA. Brophy (2003) examined a large sample of 7,008 males from Ireland who were being investigated for sexual offenses and when comparing suicide risk with the general population of Irish males, perpetrators of sexual abuse who offended against children were 230 times more likely to commit suicide. Brophy's study found that the offender's shame and reputation were most closely linked to suicide (Brophy, 2003). Another study by Pritchard and King (2005) studied 374 male, child sex offenders and found that 16 committed suicide. The sample was composed of three groups: sex only (51%), multi-criminal (27%), and violent multi-criminal (22%) and 15 of the suicides occurred among the sex only offender group, who were 183 times more likely to die by suicide than the male general population (Pritchard & King 2005).

There are a number of factors that have been consistently reported to increase risk for suicide including feelings of helplessness, hopelessness, depression, anxiety, and *psychache*, as defined as intolerable emotional or psychological pain (Shneidman, 1993). In addition to coping with fear, stigma, shame, and isolation, PCSA lack a sense of belonging and might see themselves as a burden to society, having nothing to contribute. Additional factors include concerns about their future as it relates to their reputation or preventing further disclosure of additional victims, and/or escaping future prison time. Furthermore, to some offenders, the loss

of employment, home, reputation, and freedom, as well as family and friends likely seems inevitable and suicide might be viewed as the preferred alternative (Hoffer et al., 2010).

## **Sociocultural and Sociopolitical Considerations**

### ***Age and Gender***

By its very nature, CSA includes a power differential between adult and child. Adults are viewed as authority figures with power and children are powerless and meant to obey them. Although most PCSA do not use physical force or violence, they groom and manipulate vulnerable children to comply through the use of gifts, money, and undivided attention (Faller, 2020). Additionally, since most PCSA are men, sexual offenses are a gendered issue (Baum & Moyal, 2020). In a patriarchal system men dominate, and women are considered subordinate to men. In this way, sexual abuse of girls by men is more than an act; it is a systematic way to oppress and dehumanize girls, specifically, women and girls are viewed as property and objects for sexual use rather than equal human beings (Morris, 2009).

### ***Social Stigma and Stereotypes***

Social stigma includes the attribution of negative stereotypes, as well as endorsements of prejudice and intended discriminatory behavior toward negatively labeled persons (DeLuca et al., 2018). The label “sex offender” appears to be particularly associated with stigma and routinely conjures up feelings of anger, disgust, and fear (Olver & Barlow, 2010). Experimental research has demonstrated that the sex offender label is a strong heuristic that strengthens public support for various sex offender policies, when compared with the use of more neutral descriptive language (Harris & Socia, 2016).

Society endorses a host of negative stereotypes and myths about PCSA. There is a belief that all PCSA are dangerous pedophiles, whereas that is not the majority (Willis et al., 2010).

There is a small subset of PCSA who are exclusively attracted to children and a small group of PCSA that are considered “dangerous,” known as SVP. Within the sex offender community, there is a hierarchy of sex offenses where members try to separate themselves from those who commit acts on children, as a means of not being viewed as harshly. In society, sex offenders all get painted with the same brush. When a community member thinks of a sex offender, they often associate that person with the most horrendous thoughts and typically think of a pedophile. In reality, the most common PCSA is opportunistic, has one victim and is known to the victim.

Another stereotype includes the belief that most PCSA are strangers (Craun & Theriot, 2009). There is often an image associated with this idea of “stranger danger” and it usually includes some version of an older disheveled man wearing a trench coat in the alley or a man driving around a van handing out candy. The truth is that acquaintances, including family members, extended family members, neighbors, friends, or those in positions of care of children, have been found to account for around 75%–84% of child sexual abuse (Sanghara & Wilson, 2006).

Additionally, there is the myth that all perpetrators are unmarried and sexually frustrated men who turn to children because they are unable to achieve intimacy with adults. However, research results have shown that equal numbers of child sexual offenders were married as those who were not and the sexual encounters with children co-existed with sexual encounters with adults, rather than occurring as a substitute for them (Sanghara & Wilson, 2006).

Lastly, there is the myth that perpetrators are untreatable and have high rates of recidivism (Cohen & Jeglic, 2007). In reality, research supports that sex offender treatment can be effective (Hanson et al., 2003; Lösel & Schmucker, 2005). The effectiveness of treatment depends on a number of factors, including the type of offender, the type of treatment and how

much management, supervision and support the offender has. Most offenders can and will lead productive and offense-free lives after treatment (Davis, 2013). Additionally, numerous studies reveal that sex offender recidivism rates are quite low, especially sexual recidivism. In fact, their general recidivism rates are much lower than that of general criminals. Literature suggests that most perpetrators of sexual abuse are considered *situational offenders*, which refers to opportunists who engage in sexual offending under a certain set of circumstances. This includes adults who turn to children as sexual substitutes under various stressful conditions and adults who are relatively normal in other behavioral areas but may be socially inadequate. Such offenders usually do not have a genuine interest in children but may sexually offend for a number of complex reasons. This offending is often impulsive and opportunistic as compared to a *preferential offender* who have a particular sexual preference for children and may be identified as a pedophile (Davis, 2013).

## **Treatment of the Perpetrator**

### ***Punishment and Treatment***

Treatment for PCSA is often viewed as controversial. Many people have negative feelings towards PCSA and believe they are criminals needing punishment and should be locked away, warehoused, or exiled instead of receive treatment. A careful analysis reveals that sex offender treatment programs by their design have characteristics and values that are implicitly or explicitly similar to those of punishment than traditional treatment in mental health. This is necessarily so because the primary interest in these programs is the community, not the sex offender (Mela & Ahmed, 2014). Historically, sex offenders are managed through the use of restrictions, external controls, and punitive sanctions. However, for more than two decades,

research has strongly indicated that punishment-and-sanctions-based approaches are not effective in reducing recidivism (Bonta & Andrews, 2017; Latessa et al., 2014).

The ethical issue of infringement of the right to live as a free member of society is a real one (Mela & Ahmed, 2014). When PCSA complete their prison sentences and are released they are left to navigate a society that marginalizes them. They are faced with numerous obstacles that continue to have negative consequences on their quality of life including sex offender registration and notification, conditions of release, residency restrictions, employment challenges, GPS electronic monitoring, polygraph exams, and mandated sex offender treatment. Although treatment at face value does not appear punitive, it can be when treatment is framed as a requirement to avoid repercussions of returning to prison. Additionally, many sex offender treatment programs that do not operate from a strengths-based approach may have an aggressively confrontational style or focus on things the sex offender should not do (including things and places to avoid) rather than operating from a place that facilitates growth and living a better life. Researchers question the aim of public policies and whether these measures are in place as a means to prevent sexual abuse or as a means to punish the offenders. They elaborate to state that if we want to discourage perpetrators or sexual abuse from reoffending, the research indicates that we need to encourage positive support systems, employment, and property ownership (Schwartz, 2011).

### ***Treatment Providers***

MHPs who treat people who commit sexual offenses face a variety of difficulties, both individual and societal. The American criminal justice system has increasingly mandated that sex offenders be treated in outpatient settings rather than by incarceration alone. Consequently, more and more sex offenders are receiving treatment in their own communities from counselors who



work in community agencies and other outpatient facilities (Nelson et al., 2002). Given that more MHPs are treating PCSA, it is imperative that such professionals receive specialized training to provide treatment to PCSA. However, training programs have given little attention to preparing counselors to provide services to sex offenders (Scaletta, 1995). No academic programs in the United States are specifically designed to reach specialized therapy for sex offenders (O'Connell et al., 1990). There is a need to devise training programs that incorporate theoretical models and treatment strategies specific to providing services to this client population (Nelson et al., 2002). Additionally, MHPs providing treatment to PCSA are not precluded from their own biases. It is important for MHPs to discover factors that influence their perception of sex offenders, because their perceptions may cause them to view sex offenders as criminals needing punishment instead of clients needing counseling (Nelson et al., 2002). For more about MHPs biases see Treatment Barriers and Considerations.

MHPs that provide treatment to PCSA are also susceptible to negative opinions and treatment by the public and other MHPs. Researchers stated that therapists treating offenders may experience ostracism or criticism from members of their community. They may also experience some degree of censure or disapproval from other MHPs, especially those persons promoting victim treatment (Polson & McCullom, 1995).

Determining how to classify an offender, respect an offender's autonomy, and protect the public is premised on the conceptualization of the problem (Mela & Ahmed, 2014). Additionally, the primary goal of traditional mental health treatment is generally to reduce suffering by the client and almost always promotes the best interests of the patient; however, in the instance of sex offender treatment there is superiority of public safety over the interests of the client (Mela & Ahmed, 2014).

## **Therapy Treatment for Perpetrators of Child Sexual Abuse**

The aim of specialized sex offender treatment is reducing the risk of sexual recidivism (Woodrow & Bright, 2011). Researchers and treatment providers have placed an emphasis on determining whether treatment is effective in reducing sexual recidivism and what treatment approach is most effective with sexual offenders (Serran et al., 2007). While there is strong scientific evidence that therapeutic interventions work for criminal offenders overall, the effectiveness of treatment for sex offenders remains subject to debate (Przybylski, 2017b). Researchers found that in six meta-analyses published in the late 1990s to early 2000s, sexual recidivism was reduced by roughly 10% in treated samples, and that five meta-analyses published from 2002–2009 found that sexual recidivism was reduced by 22% in treated samples (Kim et al., 2016). The bulk of the evidence in literature favors the idea that sexual offender treatment can be effective (Hanson et al., 2003; Lösel & Schmucker, 2005).

### ***Relapse Prevention***

Relapse prevention (RP) was originally developed as a treatment for substance abuse and has been the most common framework for treating sexual offenders (Schwartz, 2011). RP is aimed at helping individuals to improve their management of situations in which they are at increased risk of sexual offending (Barnett et al., 2014). It assumes that the inability to effectively cope with high-risk situations results in offending, and it emphasizes skills training to improve various specific coping skills (Serran et al., 2007). RP work is based on the notion that the identification of the thoughts and actions that lead from a lapse to a relapse helps an individual intervene before a relapse occurs (Barnett et al., 2014). It teaches sexual offenders new, more effective specific strategies to cope with identified future risks (Serran et al., 2007).

Present day RP with perpetrators of sexual abuse is most commonly delivered in a way that adheres to the Risk-Needs-Responsivity model (Barnett et al., 2014).

### ***Risk-Need-Responsivity***

The Risk-Need-Responsivity (RNR) model outlines the basic principles of risk, need, and responsivity to generate effective interventions for offender populations with the ultimate goal of reducing recidivism (Andrews & Bonta, 2010b). The *risk principle* has two important components: (a) use of a reliable and validated risk assessment to predict criminal behavior and (b) appropriately matching level of service to the assessed level of risk (Viglione, 2018).

According to this approach, the highest-intensity treatment should be offered to the highest-risk offenders (Harkins et al., 2012). The *need principle* suggests treatment programs should focus on criminogenic needs, or those factors directly relating to offending behavior that are amenable to change (Andrews & Bonta, 2010b). Criminogenic risk factors such as pro-criminal associates, anti-social attitudes, substance abuse, limited work opportunities, and dysfunctional relationships have all been associated with reoffending and are the most frequently targeted risk factors (Andrews & Bonta, 2010a; Andrews et al., 1990, 2006; Dowden & Andrews, 2004). The *responsivity principle* provides guidance on how to maximize the offender's ability to learn from a rehabilitative intervention by providing cognitive behavioral treatment and tailoring the intervention to the learning style, motivation, abilities, and strengths of the offender (Andrews & Bonta, 2007).

### ***Cognitive-Behavioral Therapy***

Cognitive-behavioral therapy (CBT) has dominated treatment programs for sex offenders over the past 40 years (Marshall & Marshall, 2014). CBT is referenced as an evidence-based therapy for sex offenders. Treatment programs adopting a cognitive-behavioral approach were

deemed most effective in reducing both general and sexual recidivism (Serran et al., 2007). CBT is based on the premise that cognition, affect, and behavior are closely linked, with each influencing the other (Yates et al., 2010). CBT is often implemented within the framework of relapse prevention and can include elements of motivational interviewing. The focus of treatment is on altering patterns of behavioral, cognitive, and affective responding associated with sexual offending, such that problematic, deviant, and/or criminal behavioral patterns and responses are replaced with adaptive, non-deviant, pro-social responding (Yates, 2013). CBT addresses cognitive distortions including denial or minimization of guilt, problematic sexual interests, harm to victims, responsibility for the offenses, and need for treatment (Ly et al., 2020). Research suggests that many CBT programs for sexual offenders have become considerably more cognitive and less behavioral over time and researchers believe programs would benefit from a better balance between cognitive and behavioral strategies (Fernandez et al., 2006).

### ***Self-Regulation Model***

The self-regulation model (SRM) of sex offending is an alternative approach to the traditional RP model and based off the self-regulation theory that is specific to the sexual offending process (Yates et al., 2010). The SRM describes the offense progression or the chain of events that occurs during a specific sexual offense or series of offenses, in order to identify the cognitive, behavioral, emotional, and situational factors that culminate in offending (Yates et al., 2010). In brief, the SRM contains four pathways, representing different combinations of offence-related goals (i.e., is the aim to approach or avoid the sexual offense), and the use of distinct self-regulation styles in relation to sexually offensive contact (under-regulation, misregulation and effective regulation). The major clinical implication of this research has been a call to move

away from a one-size-fits-all approach to an appreciation of the need to adopt interventions to match offenders' individual constellations of vulnerability factors (Ward, 2007).

### **Risk Assessments**

Risk assessments estimate the likelihood that an offender will recidivate (Baldwin, 2017). PCSA encounter risk assessments frequently. Risk assessments are often used in the sentencing and adjudication process to determine appropriate levels and periods of confinement. In the case of civil commitment of the small group of PCSA that are SVP, risk assessments are used to argue for and against indefinite confinement (Doren, 2002). Risk assessments are also used to determine treatment needs, setting, and modality.

There are a several type of risk assessments including those classified as: (a) unguided (or unstructured) clinical judgment that includes using personal experience to arrive at a risk estimate, (b) guided (or structured) clinical judgment that includes drawing from both personal experience and theory to estimate risk, (c) research-guided clinical judgment that includes a list of factors identified in professional literature as being related to risk, (d), pure actuarial approach that includes a standard of finite, weighted set of factors (generally static, or relatively unchanging and historical in nature) identified in the literature as being associated with risk, and (e) adjusted actuarial approach that administers an actuarial instrument and then employs a list of considerations that can be used to raise or lower the assessed risk level. (Baldwin, 2017, p. 135)

Recent research suggests that pure actuarial assessments should be favored over other approaches (Hanson, 2009). However, empirical research has yet to identify a single best risk assessment instrument and is moving toward measures of risk that incorporate both static and dynamic risk factors (Baldwin, 2017; Doren, 2002; Hanson, 2009, 2011). Static risk factors are factors that are relatively unchangeable such as age at first offense and number of previous convictions. Dynamic risk factors are more fluid and changeable such as employment status and cooperation with supervisor (Baldwin, 2017).

## **Sex Offender Management Programs**

### ***Comprehensive Approach to Sex Offender Management***

Sex offender management continues to be a priority for the public, policymakers, and professionals. The concept of sex offender management has been conceptualized under the construct of a Comprehensive Approach to Sex Offender Management (CASOM) by the Center for Sex Offender Management (CSOM). CSOM is a national resource center under the Department of Justice's Office of Justice Programs that provides training, technical assistance, and information to professionals who work with sex offenders (Center for Effective Public Policy [CEPP], 2022). CASOM involves identifying the stakeholders and the tasks they must perform in order to have the greatest impact on the reduction of sex offender recidivism (Center for Sex Offender Management [CSOM], 2008). The guiding principles of the Comprehensive Approach are victim-centeredness (consideration of the impact that policies and practices may have on past and potential victims and their families); specialized knowledge (knowledge about the risk and needs specific to sex offending behavior); public education about sex offenders and offender management strategies; monitoring and evaluation of the sex offender management practices; and collaboration among various disciplines and agencies (CSOM, 2007). The core components of a Comprehensive Approach to sex offender management are investigation, prosecution, and disposition; assessment; treatment; reentry; supervision; and registration and notification (United States Department of Justice, 2008).

### ***California Sex Offender Management Board***

Several states have created boards or committees that oversee the development and implementation of sex offender management and treatment programs (Phillips, 2003). The CASOMB was developed to decrease sexual victimization and increase community safety.

CASOMB has adopted the evidenced based concept, RNR within the containment model approach (CASOMB, 2021). Treatment typically includes individual therapy and weekly group therapy. The *containment model* is a comprehensive model for community management of sex offenders that highlights victim-centered, public safety model; uses multidisciplinary partnerships; external controls for sex offenders (polygraph); informs public policy; and employs quality control mechanisms (CASOMB, n.d.). The model incorporates assessment, monitoring, supervision, intervention, and treatment into a comprehensive program (Phillips, 2003). Collaboration takes the form of intra-agency, interagency, and interdisciplinary teams made up of professionals who specialize in sex offender cases (California Coalition on Sexual Offending [CCOSO], 2001). The collaboration between parole agent, treatment provider, polygraph examiner, and other relevant agencies is a vital aspect of this model and regular meetings are held to discuss treatment progress, develop treatment strategies, and share resources (English, 1998; Pimentel & Muller, 2010).

While the use of polygraph assessment with sexual offenders is somewhat controversial, the containment model utilizes polygraph examinations to review the offender's compliance with supervision and treatment conditions (Lobanov-Rostovsky, 2017). In addition to using polygraph exams, GPS monitoring is another component of the model that allows officers to monitor movements within the community, identify risky behavior, and intervene appropriately (English, 1998; Pimentel & Muller, 2010).

There is some preliminary support for the containment approach (Lobanov-Rostovsky, 2017). One study found a recidivism rate of 8.8% for offenders in the containment group based on a follow-up period of at least 1 year, while the rates for the comparison groups were 15% and 26.7%, respectively (Aytes et al., 2001). Another study of the containment approach had a

statistically significant lower recidivism rate (16.1%) than the comparison group (29.3%) (Lowden et al., 2003).

### ***CDCR Sex Offender Management Program***

The California Department of Corrections and Rehabilitation has a Sex Offender Management Program (SOMP) that is designed to provide services to inmates in prison categorized as high-risk sex offenders (HRSOs) and offenders categorized as non-high risk sex offenders (non-HRSOs) as determined by their Static-99R score that measures the risk of sexual recidivism among adult male sexual offenders (Basinger et al., 2022). “SOMP is an evidence-based approach to sex offender management utilizing the containment model, which incorporates supervision, treatment, polygraph, and victim advocacy” (CDCR, 2022b, para. 2). Offenders are required to attend a minimum of one individual therapy session per month, as well as one group session per week (two if designated an HRSO). SOMP utilizes a CBT approach which incorporates cognitive restructuring methods, including addressing criminal thought patterns, and behavioral techniques directed at increasing pro-social skills. Additionally, offenders have individualized treatment plans that aims to address their assessed dynamic risks (Basinger et al., 2022).

### ***Sex Offender Treatment & Management Services in the Bureau of Prisons***

The Federal Bureau of Prisons’ Sex Offender Management Programs is a program for sex offenders at designated institutions in the federal system that provides services to minimize offender’s risk for sexual reoffense (Federal Bureau of Prisons, 2013). The primary goal of the SOMP is to help sexual offenders manage their behavior in order to reduce sexual re-offending. The programs operate with a cognitive-behavioral emphasis and encourages its participants to change their criminal lifestyle and become honest, responsible, and law-abiding citizens with



effective self-control skills (Federal Bureau of Prisons, 2013). The sex offender treatment programs are separated into two program levels, the high-intensity, Residential Sex Offender Treatment Program (SOTP-R) and the moderate intensity, Non-Residential Sex Offender Treatment Program (SOTP-NR). Psychological evaluations and risk assessments are completed on all participants to develop an individualized correctional management plan (CMP) with treatment recommendations (Federal Bureau of Prisons, 2013). Prior to release, through community release planning, staff prepare a comprehensive discharge packet with specific recommendations regarding community supervision and monitoring (Kenney, 2015).

### **Shortcomings of Current Therapy Treatments**

Although traditional treatments for PCSA have been found to be effective in reducing both general and sexual recidivism, there are areas in treatment that could use improvement. Several of the effective treatments for PCSA have been criticized. RP as applied to sexual offenders represents a one-size-fits-all approach and does not adequately address the multiple treatment needs (Yates, 2013). RP has been criticized for assuming that all sex offenders commit sex offenses as a maladaptive response to a negative emotional state. It has been assumed that they are trying to avoid offending but do not have effective interventions (Schwartz, 2011). RP fails to appeal to many sexual offenders (and even produce resistance, in some cases) because of the apparently exclusive focus on avoiding relapse (Mann, 2004). Although reducing reoffending rates is always the primary goal for the treatment provider, offenders themselves often have other priorities. Traditional RP programs fail to engage offenders because they impose a primary goal on them rather than negotiating and agreeing on the goal of the intervention (Marshall et al., 2005). Typically, RP plans consists of a lot of things the offender should not do, including a list of people, places, and activities to be avoided. Some argue that if PCSA are simply required to

avoid children, then all we have done is take away their only pathway to the goals they were achieving by sexual offending without providing them with alternative prosocial pathways for meeting their needs (Marshall et al., 2005).

In recent years, clinicians and researchers have challenged certain aspects of the RNR model and have argued that concentrating on reducing dynamic risk factors (criminogenic needs) is a necessary but not sufficient for effective correctional interventions (Ward & Stewart, 2003b). One of the major concerns is the perceived narrowness of the RNR model and its failure to adopt a more constructive or strengths-based approach to treatment. It has been argued that it is necessary to broaden the scope of correctional interventions to take into account the promotion of human goods (i.e., approach goals as well as avoidance goals) (Ward, 2007).

CBT for sex offenders has been criticized for devaluing the human experience (i.e., emotions) of sex offenders. Offenders are complex and dynamic, and their treatment should reflect that complexity (Schwartz, 2011). Many CBT programs focus almost exclusively on cognitive interventions. Although such approaches are suitable for clients who are above average intelligence and university-educated, most sex offenders seen in prisons and other institutions do not have high levels of education (Marshall & Marshall, 2014). Targeting cognitive distortions has historically been a common component of sexual offender treatment. However, cognitive schema represents individuals' underlying views and attitudes, while cognitive distortions are the products of these underlying schema; therefore, treatment should focus more on identifying and altering schemas (e.g., sexual entitlement, a general view that the world is a hostile place, or the belief that children can consent to sexual activity), rather than focusing solely on cognitive distortions (Yates, 2013). Furthermore, a critical response to manual-based CBT programs is that

sometimes they can become overly prescriptive and inflexible and do not allow for individual adjustments to be made when needed (Ward & Maruna, 2007).

There are also general concerns about current treatment approaches. These general concerns include: (a) an excessive emphasis on negative issues in both the targets of treatment and the language used by treatment providers, (b) a failure to explicitly encourage optimism in clients and encourage their belief in their capacity to change, (c) a general absence of an explicit attempt to work collaboratively with clients, and (d) few attempts to provide clients with goals that will result in them leading a more fulfilling and prosocial life (Marshall et al., 2005).

### **Strengths-Based Treatment Approaches**

A strengths-based treatment approach requires collaboration and a trusting relationship that empowers and motivates clients to build on their existing strengths to make positive changes (Marshall, 2015). The values associated with strengths-based approaches includes the well-being of all human beings, including PCSA with a focus on human dignity and the ability to live better lives (Ward, 2007). It incorporates themes of resiliency, well-being, thriving in the context of adversity, post-traumatic growth, wellness, and overall quality of life. Some topics within strengths-based approaches include self-esteem, hope, guilt, empathy, coping, relationships, healthy sexuality, motivation, approach goals, knowledge, agency, autonomy, mastery, relatedness, creativity, mindfulness, and relaxation (Marshall, 2015). MHPs that operate from a strengths-based treatment approach typically embody features that enhance treatment effectiveness such as: empathy, warmth, trust, respect, support, genuineness, directiveness, flexibility, emotional responsiveness, and attentiveness. They also encourage participation, are rewarding, and make use of humor in treatment (Marshall, 2015). Strengths-based approaches help address both the needs of PCSA and those of the community (Ward, 2007).

The language we use influences not only the clients' perceptions but also how we view aspects of treatment. Negative labels for the components of treatment may draw us to focus on negative (or avoidance) goals. Renaming relapse prevention strategies as "self-management" or "respectful living" or renaming treatment that targets deviant sexual arousal as "healthy sexual functioning," helps to focus on strengths and healthy goals (Fernandez, 2006). The approach to treating PCSA should involve enhancing many skills, instilling prosocial attitudes, and increasing the client's sense of self-worth; however, most sex offender programs outline their treatment strategies in rather negative terms such as elimination of negative attitudes, the reduction of cognitive distortions, the extinction of deviant sexual interests, and the list of people, activities, and places to avoid (i.e., relapse prevention) (Marshall et al., 2005). Adopting more positive language in therapy can help PCSA identify their existing strengths and find ways to adapt these strengths to meet their needs more appropriately. One particularly valuable way to do this is to refrain from describing clients as "sexual offenders," "rapists," and "child molesters," but rather distinguishing people from their behaviors (i.e., "person who committed a sexual offense") to avoid shame and seeing themselves as unchangeable (Fernandez, 2006).

Research on sex offender treatment tells us that simply targeting deviance, addressing non-criminogenic targets, only utilizing relapse prevention, and being aggressively confrontational is not effective (Marshall, 2016). Studies have found that the therapist features that are related to significant treatment-induced changes are warmth, empathy, rewarding, and directive (Marshall, 2015). The model that is most highly recognized as a strengths-based approach for perpetrators of sexual abuse is the Good Lives Model. Strengths-based sex offender treatment is not inconsistent with CBT, RNR, or RP, but rather complementary. It has been suggested that the GLM may converge with the principles of RNR via responsivity (Ogloff &

Davis, 2004; Ward & Stewart, 2003b). Research suggests that effective treatment of PCSA utilize the RNR model while integrating the GLM, focuses on building strengths, and treats offenders in a respectful, empathic, and rewarding manner (Marshall & Marshall, 2014).

### ***Good Lives Model***

The Good Lives Model (GLM) takes a positive psychology approach to the treatment of perpetrators of sexual abuse. It is a strengths-based rehabilitation approach that augments the risk, need, and responsivity principles with a focus on developing a healthy and satisfying lifestyle. It assists PCSA to develop and implement meaningful life plans that are incompatible with future offending (Ward, 2002; Willis et al., 2013). GLM is based on the pursuit of better lives and the goals of treatment are on the attainment of good lives, which is achieved by enhancing hope, increasing self-esteem, developing approach goals, and working collaboratively with the offenders (Marshall et al., 2005; Ward & Stewart, 2003a). This does not entail ignoring the needs of the community for security and safety; it simply reminds us that all human lives should reflect the best possible outcomes rather than the least worst possibilities (Marshall et al., 2005).

The GLM of rehabilitation is proposed as an adjunct to (or possibly an alternative to) the current risk management model. Ward suggests that his GLM approach to the treatment of sex offenders complements the RNR model (Marshall & Marshall, 2014). The risk management model's primary aim is to avoid harm to the community, the GLM augments this with a second, equally important aim: to give offenders the capabilities to secure important personal and social experiences "goods" in acceptable ways. In other words, "the way to reduce offending is to give individuals the necessary conditions to lead better lives (i.e., good lives) rather than simply

to teach them how to minimize their chances of being incarcerated'' (Ward & Stewart, 2003a, p. 23).

The GLM states that human beings are goal-directed and seek certain experiences, outcomes, and states of being in their lives, which are termed *primary goods* (Yates et al., 2010). Specifically, primary goods are essentially activities, experiences, and/or situations that are sought for their own sake and that benefit individuals and increase their sense of fulfilment and happiness (Barnao et al., 2016). The GLM outlines these areas of functioning in which people attempt to maximize satisfaction across their lifespan (Marshall & Marshall, 2014).

The primary goods include: (a) *life* (including healthy living and functioning); (b) *knowledge* (desire for information and understanding about oneself and the world); (c) *excellence in play* (including hobbies/recreational pursuits); (d) *excellence in work* (including mastery experiences); (e) *agency* (i.e., autonomy, independence, and self-directedness); (f) *inner peace* (i.e., freedom from emotional turmoil and stress); (g) *friendship* (including intimate, romantic, and family relationships); (h) *community* (connection to wider social groups); (i) *spirituality* (in the broad sense of finding meaning and purpose in life); (j) *happiness* (feeling good in the here and now); and (k) *creativity* (desire to have novelty or innovation in one's life). (Yates et al., 2010, p. 38–39)

Most of these areas (e.g., satisfactory intimate relations, healthy sexuality) map nicely onto the factors that have been shown in research to be criminogenic deficits among sex offenders (Marshall & Marshall, 2014). There is evidence from a wide range of literature that the attainment of primary human goods is associated with higher levels of well-being and their absence related to psychological problems of various kinds (Emmons, 1999; Ward & Maruna, 2007).

According to GLM, sexual offending arises as a result of an attempt to obtain these goods in an inappropriate manner, out of frustration at being unable to achieve these goods, or out of an imbalance between the goods so that some goods are prioritized over others (e.g., sexual gratification over emotional intimacy) (Harkins et al., 2012). It has been suggested that they

choose inappropriate pathways (i.e., sexual offending) to achieve these goals because they do not have the skills, attitudes, and self-confidence to achieve them by prosocial pathways. Treatment, therefore, should provide sexual offenders with the attitudes and self-confidence necessary for them to meet their needs in appropriate ways (Marshall et al., 2005).

A characteristic of the GLM is the ability to adapt to various cultures. Although the model has a focus on autonomy, the client can customize the weight they attribute to each primary good. A client who has a more collectivistic culture may choose to put less weight on autonomy than a person from a more traditionally western culture. However, this is not to say that collectivist cultures do not desire personal choice and freedom, but rather the client is able to make their own decisions about what they value. The GLM can be implemented in a way that respects all individuals, in their communities, and with respect to their cultures.

Treatment begins with an assessment and the development of a comprehensive case conceptualization that forms the basis of the treatment plan. A GLM treatment plan considers each person's strengths, goals, and personal circumstances, accepts the client as an autonomous individual, and respects his capacity to make certain decisions himself (Yates et al., 2010). Overall, from a GLM perspective, the aim of treatment is to equip offenders with the knowledge, skills, and competencies to obtain their primary goods in socially acceptable ways, overcome flaws in their good life plans, and to reduce and/or manage their risk of future reoffending (Barnao et al., 2016).

### ***Circles of Support and Accountability***

Inspired from a restorative justice approach in Canada, several states in the United States have established programs referred to as Circles of Support and Accountability (CoSA) (Schwartz, 2011). CoSA adheres to the principles of RNR and is used to help reduce a person's

likelihood of reoffending, thereby increasing public safety (The Counsel of State Governments Justice Center, 2022). The premise of CoSA operates from a strengths-based perspective as it recruits community volunteers to assist sex offenders with obtaining the basic necessities for life in the community and appropriate social contacts (Schwartz, 2011). The circles of CoSA consists of volunteers who establish relationships with core members (i.e., the person who was convicted of a sex offense) that are based on mutuality, equality, and an agreement (i.e., a “covenant”) to work toward building a lasting and responsible friendship. The model utilizes a group of volunteers who meet with the core member daily or on a weekly basis to discuss the various challenges of reentry. This support may pertain to obtaining housing, a job, providing company, and adjusting to life out of prison. Community professionals such as psychologists, law enforcement officers, supervision agents, and social workers are also essential to ensuring these projects are running effectively; they provide training and support to volunteers while also hold core members accountable (Gesser, 2021; The Counsel of State Governments Justice Center, 2022). The National Reentry Resource Center (2017) provides tips for being an effective CoSA volunteer which includes: be open, maintain boundaries, recognize your limitations, share, guide don’t direct, celebrate milestones, model appropriate behavior, collaborate, debrief, and believe in possibilities. These programs have resulted in very significant reductions in reoffense rates (Schwartz, 2011).

## **Treatment Barriers and Considerations**

### ***Mandated Treatment and Confidentiality***

Unlike most therapy, PCSA rarely enter sex offender treatment programs voluntarily. Most often, participants are mandated into treatment as part of the criminal sentence. As a result of mandating treatment, individuals may enter treatment with resistance, lack of interest, denial



of offense, and/or lack of participation. This presents clinicians with the task of assessing and addressing motivation and encouraging the client to engage in the treatment process. When PCSA are mandated to seek treatment, they may enter at earlier stages of change (e.g., prior to recognizing that they have a serious problem). Thus, they are less motivated to participate and may drop out if permitted (Koss et al., 2003). Many times, PCSA face serious repercussions such as parole being revoked and are sent back to prison should they not abide by treatment. Another unique challenge of sex offender treatment is confidentiality. Unlike treatment or therapy in non-correctional or non-criminal justice settings, individuals in sex offender treatment are not afforded complete confidentiality. In addition to the traditional limits of confidentiality, additional details may be shared with probation/parole officers and other members of the treatment team to maximize community safety and help address challenges. This is often a barrier in treatment since many times the participants are reluctant to be open and discuss things in treatment for fear of what might be shared with their parole agent that could ultimately result in a parole violation.

### ***Establishing and Maintaining Rapport***

The barriers of mandated treatment and confidentiality make it especially challenging to establish and maintain rapport with participants in sex offender treatment. There is substantial research that indicates that establishing positive therapeutic relationships with clients improves treatment outcomes (Fernandez et al., 2006; Mann et al., 2004; Marshall et al., 1999, 2003; Witte et al., 2001). Specific therapist characteristics that have been shown to maximize alliance and treatment gains include demonstrating empathy, respect, warmth, friendliness, sincerity, genuineness, support, emotional responsiveness, flexibility, directness, confidence, and interest in the client (Fernandez, 2006; Marshall et al., 1999, 2003; Yates, 2013). Rogerian attributes of

genuineness, accurate empathetic understanding, and unconditional positive regard are important attributes for mental health professionals working with offenders. MHPs will most likely disapprove of the offending behaviors and may find it to be difficult to feel positive regard for PCSA, due to the harmful and socially unacceptable nature of their offenses; yet, it is crucial to be able to express genuine regard for PCSA as human beings (Nelson et al., 2002). MHPs should express a concern for the offender's wellbeing, respect the dignity and agency of the offender, and express the need to understand the life goals of offenders (Ward, 2007). Lastly, being a pro-social model, communicating clearly, listening actively, being firm but fair, reinforcing and encouraging clients, creating opportunities for success, dealing appropriately with frustration and other client difficulties, being appropriately challenging without being aggressively confrontational, and creating a secure treatment atmosphere, all contribute to treatment alliance and outcome (Yates, 2013).

### ***Mental Health Professional Biases***

MHPs working with PCSA are not immune to their own biases. MHPs may still endorse negative stereotypes of sexual offenders. It is imperative that MHPs, if they are to provide services effectively to sex offenders, explore their own biases about providing treatment to this population. It is important for MHPs to discover factors that influence their perception of sex offenders, because their perceptions may cause them to view sex offenders as criminals needing punishment instead of clients needing counseling (Nelson et al., 2002). This perceptual bias may contribute to the difficulty of treating sex offenders and have important implications for service delivery, including impact on quality of care, choice of intervention, and quality of the therapeutic relationship (Nelson et al., 2002).

Research argues that MHPs need specialized training and knowledge in order to provide services effectively to this population. Previous research suggests that professionals' attitudes toward sex offenders differ depending on the experience and specialist training. MHPs with more experience and training generally rate their attitudes towards sex offenders more positive than MHPs with less experience and training (Nelson et al., 2002). Another study found that experienced professionals endorsed negative stereotypes less, had more positive attitudes towards sex offenders, and expressed more knowledge of child abuse than the inexperienced group. Therefore, the less knowledge of child abuse, the more stereotypical one may be about potential child sex offenders (Sanghara & Wilson, 2006).

Literature suggests that MHPs may find it easier to treat offenders if they focus on the offender's strengths and their vulnerabilities, including those life experiences in which the offender was also a victim (Barnard et al., 1989; Haugaard & Reppucci, 1988). MHPs can strategically use cognitive frames to nurture a positive view of the perpetrators they treat. Researchers found that therapists who gather information that exposes the offender as vulnerable, impaired, or human are better able to view perpetrators as victims, realize that their families still love them, defend their right to treatment, and view perpetrators as individuals with problems (Polson & McCullom, 1995).

### ***Secondary/Vicarious Trauma and Burnout***

Most MHPs, at various points in their career, will encounter uncomfortable feelings, reactions, thoughts, and behaviors related to their work with those who sexually offend (Moulden & Firestone, 2010). Professionals working with PCSA have the potential to be deeply affected by the stories and the images they are exposed to during their work (Catanese, 2010). The cost of caring has been studied under a variety of rubrics, most commonly: burnout,

compassion fatigue, vicarious traumatization, and secondary traumatic stress. Although each has its own specific sources, processes, and manifestations, the concepts overlap and are often used interchangeably (Sabin-Farrell & Turpin, 2003). Vicarious trauma and secondary traumatic stress are frequently used interchangeably to refer to the indirect trauma that can occur when we are exposed to difficult or disturbing images and stories second-hand (Tend Academy, 2018).

Vicarious or secondary trauma occurs in someone who is not the primary person experiencing the trauma. Vicarious traumatization was coined by Pearlman & Mac Ian (1995) to describe the profound shift in world view that occurs in helping professionals when they work with individuals who have experienced trauma (Tend Academy, 2018). Secondary Traumatic Stress is a concept that was developed by trauma specialists Beth Stamm, Charles Figley and others in the early 1990s as they sought to understand why service providers seemed to be exhibiting symptoms similar to PTSD without having necessarily been exposed to direct trauma themselves (Tend Academy, 2018). Compassion fatigue is another term which is also sometimes used interchangeably with secondary traumatization (Baum & Moyal, 2020). Burnout is a state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations marked by depression, cynicism, boredom, loss of compassion, and discouragement (Office for Victims of Crime [OVC], n.d.).

Over time, repeated exposure to difficult content can have a negative impact on functioning and overall mental health (Tend Academy, 2018). MHPs working with PCSA endorse increased levels of anxiety, including avoidance of disturbing material in the session; hypervigilance regarding their own and others' behavior, particularly toward children; intrusive images and thoughts about case material; and changes in their mood, characterized by feelings of depression, cynicism, mistrust, hopelessness, irritability, anger, and frustration (Edmunds, 1997;

Farrenkopf, 1992; Kassam-Adams, 1995; Moulden & Firestone, 2010; Pearlman & Mac Ian, 1995; Steed & Bicknell, 2001). Such disturbance in emotion regulation may lead to emotional hardening, or conversely, sensitization to the details of a case (Edmunds, 1997; Farrenkopf, 1992; Moulden & Firestone, 2010). Furthermore, therapists working with PCSA reported higher rates of disturbed cognitions regarding intimacy and described a decreased sense of trust and perception of the world as less safe compared to before working in this area (Farrenkopf, 1992; Jackson et al., 1997; VanDeusen & Way, 2006). MHPs report being more protective of their children, extremely aware of how others interact with their children, and more fearful for their children's safety. Research suggests that female therapists feel more vulnerable, fearful, and cautious and are more concerned about their safety in personal relationships than their male counterparts and described being more hypervigilant around others and more protective of their own or their family's safety (Baum & Moyal, 2020). In a study of vicarious trauma, 50% of therapists working with perpetrators and survivors reported trauma reactions in the clinical range of the Impact of Event Scale-Revised (Way et al., 2004). Steed and Bicknell (2001) found that 46% of their sample of sexual offender therapists reported moderate-to-high risk of developing burnout. Another study found that 25% of the therapists endorsed feeling generalized high stress, exhaustion, depression, or burnout; 29% reported increased hypervigilance, suspiciousness, and protectiveness of their own or their family's personal safety; and that some saw potential abusers everywhere (Baum & Moyal, 2020).

Resilience is an important factor in how MHPs handle the indirect exposure to a traumatic event. Research suggests that resilient people tend to have a more optimistic outlook on life in general, which encourages better social interactions and helps to reduce stress experienced from vicarious trauma (Catanese, 2010). The negative consequences of secondary

trauma and/or burnout, such as anger, fear, and the experience of emotional hardening, are likely to compromise the therapist's ability to genuinely engage with clients and undermine the benefits of the treatment delivered (Moulden & Firestone, 2010). Literature supports the argument that self-care is a necessary element of ethical practice and that care providers have an ethical duty to care for themselves before they care for others (Moulden & Firestone, 2010). It is imperative for MHPs working with PCSA to engage in self-care. The literature suggests maintaining a light and humorous work environment, having healthy relationships, taking time to enjoy activities, and avoiding negative coping skills such as alcohol consumption, risky behaviors, or isolation (Catanese, 2010). Lastly, training and education on vicarious trauma should be provided to individuals working in the specialized area of sexual offenses to lower the risk of developing vicarious trauma, as well as being familiar with the warning signs so that they may take proper action before symptoms get too severe (Catanese, 2010).

## **Training of Mental Health Professionals**

### ***Child Abuse Mandated Reporter Training***

Every state has statutes identifying persons who are required to report child maltreatment under specific circumstances. The California Child Abuse and Neglect Reporting Act (CANRA) Penal Code sections 11164-11174.4 requires certain professionals, known as mandated reporters, to report known or suspected instances of child abuse or neglect (Child Abuse and Neglect Reporting Act, 2020). MHPs along with other professionals are designated as mandated reporters. CANRA's basic reporting provisions indicate that a mandated reporter must make a report whenever, in his/her professional capacity or within the scope of his/her employment, he/she has knowledge of, or observes a child (a person under 18) whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect (Los Angeles

Community College District Human Resources Division, 2009). All jurisdictions have provisions in statute to maintain the confidentiality of abuse and neglect records including the identity of the reporter (Child Welfare Information Gateway, 2008). Many employers provide their employees with in-person or online child abuse mandated reporter training. Additionally, California Department of Social Services (CDSS) Office of Child Abuse Prevention (OCAP) offers free online mandated reporter trainings tailored to specific professions and meets the training requirements of the CANRA (California Department of Social Services [CDSS], 2016). Vignette-based scenarios are embedded at the end of the training and requires an 80% pass-rate to complete certification (CDSS, 2011).

### ***Perpetrator of Child Sexual Abuse Training***

Research argues that MHPs need specialized training and knowledge in order to provide services to PCSA. Training can increase general knowledge base of perpetrators, help build clinical skills in working with PCSA, overcome biases, and lessen the risk of developing vicarious trauma or burnout by learning warning signs and ways to buffer against it. However, education and training programs have given little attention to preparing MHPs to provide services to PCSA. MHPs that obtain a degree in mental health, social work, counseling, and psychology are unlikely to have much or any education or training on working with sexual perpetrators. It may be offered as an elective course or might be a topic in a forensic class, but generalist programs do not touch the subject (Mela & Ahmed, 2014). There is a need for educational and training programs to incorporate theoretical models and treatment strategies specific to providing treatment to people who commit sexual offenses (Nelson et al., 2002). Most, if not all, training on PCSA is completed upon hire at a sex offender treatment center.

Specialized training and maintenance of certification are strongly recommended for those working with sex offenders and vary from site to site (Mela & Ahmed, 2014).

### ***California Sex Offender Management Board Training***

The California Sex Offender Management Board has developed standards and procedures in accordance with California Penal Code Section 9003a, which states that “all professionals who provide sex offender management programs and risk assessments, pursuant to Penal Code Section 290.09, shall be certified by the board according to these standards” (Sex Offender Management Board, 2011, para.1). CASOMB is the only agency in California to certify qualified treatment providers and to supervise and monitor programs and providers who are certified (CASOMB, 2022). CASOMB treatment programs provide services using the containment model which values the collaboration, communication and teamwork between treatment providers, parole agents, probation officers, polygraph examiners, victim advocates, and other stakeholders for the effective management of sex offenders (CASOMB, 2019). For more about the containment model see Sex Offender Management Programs.

CASOMB regulates initial and ongoing training for professionals who provide treatment services to registered offenders and responsibilities vary by provider type (CASOMB, 2022). *Apprentice* or *Student Provider* is a designation that describes individuals who are beginning to work in the field of sex offender evaluation and treatment and are currently enrolled in a graduate level program in mental health or related services. *Associate Provider* designation describes individuals who are not licensed by the state to independently deliver mental health services and *Independent Provider* designation describes individuals who qualify for the highest level of CASOMB certification and are licensed MHPs (CASOMB, 2022). Providers that are unlicensed are under supervision of a licensed MHP and meet for weekly supervision by an



independent provider at their place of employment. Prior to being certified at any designation, all providers must complete a series of trainings and obtain passing scores on training modules. All providers are required to complete continuing education and training to recertify every 2 years or annually for apprentice/student providers. CASOMB training consists of topics related to the core domains: sex offender characteristics and dynamics, sex offender assessment, sex offender treatment, human sexuality related to sex offender dynamics, sex offender management, and other core topics not specifically related to sex offenders (CASOMB, 2013).

### ***Risk Assessment Training***

Training and monitoring of evaluators who administer risk assessments is needed to ensure that risk assessment procedures and instruments are used appropriately and with integrity (Hanson et al., 2015; Storey et al., 2012). In California, State Authorized Risk Assessment Tools for Sex Offenders (SARATSO) is the training organization that oversees the training and certification of evaluators who administer risk assessments to sex offenders. California uses three different evidence-based risk instruments that assess risk of reoffense by adult males, using (a) static (unchanging factors) such as criminal history; (b) dynamic factors in the offender's life affecting reoffending, such as current alcohol abuse; and (c) risk factors which predict future violence (SARATSO, n.d.-a). SARATSO offers online and in-person trainings on the STATIC-99, JSORRAT-II, STABLE-2007/Acute-2007, and LS/CMI. Upon completion of training and certification, the certified trainer is required to attend trainings to re-certify every 2 years (SARATSO, n.d.-b).

### **Integration of the Literature**

When reviewing the literature on PCSA, it is evident that there are several areas in need of improvement. While the field of working with PCSA is still in its infancy, there are a number

of themes that emerge in the literature including discrepancies in statistical data, varied definitions of PCSA, methodological issues related to sample population, rehabilitation challenges for PCSA, limitations of current treatments for PCSA, and lack of education and training of MHPs to work with PCSA.

The literature frequently reflects different incidence, prevalence, and recidivism rates of PCSA (Walker et al., 2004). It is noted that the likely contributor of the discrepancies in the literature relates to the methodology of studies, including the data collected based on the various definitions used for CSA and PCSA. Another large contributor to the inconsistencies of data is the issue of underreporting of CSA. Similarly, the literature reflects various recidivism rates for perpetrators (Alper & Durose, 2019). A methodological issue when collecting recidivism data is that many researchers combine perpetrators of different sexual offenses together in their sample population when different subgroups of perpetrators have been shown to reoffend at different rates. Studies suggest that recidivism rates are different for different type of sexual offenses (Jung et al., 2011). This inclusion of all subgroups in studies alters the statistical outcome of recidivism. Additionally, various studies collect data on recidivism that includes general recidivism and/or sexual recidivism. Therefore, when critiquing the literature, it is frequently misleading to refer to recidivism without specifically identifying if it is referring to general or sexual recidivism. Given these challenges, it is difficult to capture the full extent of the issue.

PCSA are a highly stigmatized and marginalized population with a significant number of barriers that make reintegration challenging, which is not conducive of reducing recidivism. The literature on PCSA focuses on the multitude of practices that are in place for PCSA upon reintegration as a means of protecting the community and in hopes of reducing recidivism (Bonta & Andrews, 2017; Latessa et al., 2014). While the focus of public safety is of utmost importance

to society, it highlights the lack of attention and care to PCSA and their overall well-being. Contrary to most people's belief, punishment is often not the biggest influence of change behavior. PCSA undergo a multitude of obstacles to secure employment and housing and experience several socio-emotional and psychological challenges. As such, these challenges do not aid in reducing recidivism and may in fact, contribute to more stress and possibly future recidivism.

Additionally, there are limitations to current therapy treatments typically used with perpetrators. The literature outlines a variety of factors that reduce quality of care for PCSA and hinder clients from making positive changes. There is an excessive emphasis on negative issues in both the targets of treatment and the language used by treatment providers, a failure to explicitly encourage optimism in clients and encourage their belief in their capacity to change, a general absence of an explicit attempt to work collaboratively with clients, and few attempts to provide clients with goals that will result in them leading a more fulfilling and prosocial life (Marshall et al., 2005). These limitations highlight a need for treatment for PCSA that fosters positive changes and the ability to live a satisfying life; thereby, simultaneously, protecting the community by reducing recidivism.

Furthermore, the literature consistently agrees that mental health professionals receive little to no education and training to work with PCSA (Nelson et al., 2002). There is a significant need for MHPs to become more acquainted with the literature on PCSA to help manage any biases and be trained to effectively work with this population and all its complexities. More specifically, training that emphasizes human dignity and overall quality of life for the perpetrator while operating from a warm, empathic, and respectful approach. This strengths-based approach to treatment helps address both the needs of PCSA and the safety needs of the community.

## Chapter 3: Methodology

### Introduction

The primary goal of this dissertation project was to develop an introductory webinar resource for MHPs that increases understanding and competence with respect to working with PCSA. The rationale for this introductory webinar training was to address the gap in available literature, resources, treatment, and clinical training pertaining to the impact of CSA on the perpetrators of abuse.

A webinar format was selected as the platform for this introductory training resource due to its ability to reach a vast amount of people while providing flexibility and convenience to the users. A webinar, or web seminar, is a presentation, seminar, lecture, or workshop transmitted over the internet (Zoumenou et al., 2015). Zoumenou et al. (2015) noted that webinars reach a greater amount of people, are cost-effective, and are an equally useful way of disseminating information. Webinars have attracted increasing attention for training and development purposes in recent years (Gegenfurtner et al., 2020). The use of online education has become popular with the rise of advances in technology and even more so during the coronavirus (COVID-19) pandemic when schools closed resulting in the need for distant learning. Online education was growing slowly and steadily, but COVID-19 has overcrowded the online education space (Agarwal et al., 2021). The COVID-19 pandemic has had a significant impact on business, personal life, and education. With each aspect of life affected by extended lockdowns, “stay at home” and “shelter in place” orders, quarantine, and social distancing, people turned to the internet for remote work, virtual meetings with friends, family, and co-workers via various communication platforms, health care in the form of tele (remote) consultancy, and online teaching (Kubacz-Szumaska & Szumski, 2021). In a study on the effectiveness of webinars in

higher education and professional training, researchers found that webinars and face-to-face classroom teaching are comparable in their effectiveness to promote student learning (Gegenfurtner & Ebner, 2019). In a 2013 study, findings indicated that mental health clinicians expressed a growing desire to receive online training, citing the ability to take a training course at home at a convenient time and at their own pace as motivators to receive training through web-based platforms (Powell et al., 2013). Technology makes these connections possible, allowing connection with professionals and experts around the world outside of typical work hours, at school, or in the comfort of one's home (Buxton et al., 2012; Coiffe, 2012). Webinars can utilize live audio and video presentation, or a pre-recorded audio voiceover synced with a visual presentation. Research indicates that integrated web platforms, audio, video, and chat features can be a helpful addition to making a successful, engaging, and informative presentation (Carucci et al., 2014).

This chapter describes the methodology that was used in the development of the introductory webinar. It is worth noting that this project was initially part of a three webinar series for the development of an introductory webinar training for MHPs on the treatment of sexually exploited minors, PCSA, and families of sexually abused children in the United States. The two sub-populations of sexually exploited minors (SEMs) and families of sexually abused children (FSAC) have been completed to date (Arredondo, 2019; Janicic, 2018). The overall goal of the three-part webinar series was to provide MHPs with a strengths-based training resource that encompasses the treatment needs and challenges faced by the different sub-populations affected by CSA. The extent of this specific dissertation project only includes the development of the webinar curriculum related to working with PCSA. This project utilized a program development methodology with the main purpose being to provide the content of the training

webinar for MHPs that is strengths-based and culturally congruent with the needs, presentations, and contextual treatment factors faced by PCSA. This webinar training aims to prepare MHPs to effectively address the clinical needs of PCSA.

The first component of this project included an extensive review of the existing literature, research studies, and online resources that will provide a framework and content of the webinar training. Literature was collected on CSA regarding different types of CSA, prevalence rates, and disclosure of CSA. Literature was also gathered information pertaining to PCSA including an overview of PCSA, impact of CSA on PCSA, treatment approaches for PCSA, sociocultural and sociopolitical issues as they relate to PCSA, strengths-based approaches and concepts, and training of MHPs to work with PCSA. Lastly, a review of the literature was conducted on the usefulness of webinars for clinical training purposes.

The second component of this project was completed in 2018 in conjunction with the other researchers in the three webinar series. This phase used convenience and snowball sampling recruitment procedures to recruit MHPs by email to collect information regarding the adequacy of their clinical training of working with SEMs, PCSA, and FSAC and gathered their perceived gaps in training. The MHPs that consented and participated in the project were provided a survey that consisted of Likert-scale and open-ended questions regarding their clinical training and further training needs as it pertained to the sub-populations. The information collected from the literature review and the feedback from the MHPs informed the content for the introductory webinar training.

After developing the introductory webinar focused on PCSA, one general MHP and one expert MHP were recruited to evaluate the webinar for usefulness, effectiveness, and relevance of its content. After the evaluators consented to completing the review and evaluation of the

webinar, the webinar was sent and a survey that consists of Likert-scale and open-ended questions was provided that allowed the evaluators to rate how strongly they agree or disagree with the quality and content of the webinar with the ability to provide direct feedback regarding the training content and applicability.

### **Review of the Literature and Existing Resources**

The review of literature on CSA and PCSA was gathered to inform the content of the webinar training resource. Databases that were used to locate relevant research included PsycINFO, PsycARTICLES, ProQuest, Sage Journals Online, Science Direct, SpringerLink, PubMed, Dissertations and Theses, Education Full Text (Wilson), Scopus, books in print, and internet resources. Information from local and national organizations was incorporated, including American Psychiatric Association (APA), Rape, Abuse & Incest National Network (RAINN), Office of Child Abuse Prevention (OCAP), National Sexual Violence Resource Center (NSVRC), Office for Victims of Crime, National Center for Victims of Crime (NCVC), The United States Department of Justice, National Alliance on Mental Illness (NAMI), Centers for Disease Control and Prevention (CDC), The World Health Organization (WHO), Bureau of Justice Statistics (BJS), Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART), The United States Department of Justice Dru Sjodin National Sex Offender Public Website (NSOPW), National Incident Reporting System (NIBRS), National Institute of Justice (NIJ), The National Reentry Resource Center, State Authorized Risk Assessment Tools for Sex Offenders (SARATSO), Association for the Treatment of Sexual Abusers (ATSA), California Department of Corrections and Rehabilitation (CDCR), Federal Bureau of Prisons (BOP), Center for Sex Offender Management (CSOM), California Sex Offender Management Board (CASOMB), and Circles of Support and Accountability (COSA).

Specific keyword searches included a combination of the following: sexually abused children, youth, and minors; child sexual abuse; sexual victimization; child maltreatment; child molestation; perpetrator of child sexual abuse; sexual perpetrator; sexual offender; child sexual perpetrator; sex offender; perpetrator; molester; sexual predator; rapist; and pedophile.

Additional keywords searched related to cultural considerations, the legal system, and treatment of PCSA included the following: sociocultural and sociopolitical factors pertaining to PCSA; sex offense crime; sex offense conviction and sentencing; sex offense incarceration; parole/probation supervision; sex offender conditions of release; sexual recidivism; community notification; sex offender registry; sex offender three-tiered system; Megan's Law; Jessica's Law; sex offender treatment; Sex Offender Management Program (SOMP); Non-Residential Sex Offender Treatment Program (SOTR-NP); Residential Sex Offender Treatment Program (SOTP-R); Risk, Need, and Responsivity (RNR); Cognitive-Behavioral Therapy (CBT); Relapse Prevention Model (RPM); Self-Regulation Model (SRM); Revised Self-Regulation Model (SRM-R); Good Lives Model (GLM); risk and protective factors; and risk management/harm reduction. The focus of the literature review was on treatment approaches, specifically those with a strengths-based perspective with consideration to sociocultural issues which included a search of the keywords: strengths-based intervention; resiliency; posttraumatic growth; wellness enhancement; and positive psychology. The literature on MHP training on PCSA and the use of a webinar training platform for clinical training purposes was also reviewed.

### **Webinar Development**

Webinars are one of many technological training tools that serve the educational function of learning and teaching (Gegenfurtner et al., 2020). In recent years, webinars have attracted increasing attention for training purposes largely because of their ability to connect



geographically distant members by offering real-time training communication (Gegenfurtner et al., 2020). Additionally, there has been a significant proliferation of online trainings since COVID-19 with many options to record and disseminate video content. Several webinar infrastructures (e.g., Adobe Connect, Cisco, WebEx, Zoom) offer tools to increase participation levels and foster learner-centered instructional designs (Gegenfurtner et al., 2020).

For the purpose of this project, the webinar slides were developed using PowerPoint and a script was created that narrated each slide. Although the content of this webinar will not be presented publicly as part of this research, the webinar content can be easily shared on an online platform with the option to be disseminated across various platforms for future projects. The webinar training can be hosted on YouTube Live. YouTube Live is a user-friendly platform that can be utilized both during and after webinar airtime, without limiting the number of attendees, without payment of premium fees, and free from distracting advertisements (Gonzaga, 2014; Gottfried et al., 2015). YouTube Live allows the host to set a broadcast date and time with notifications emails sent to attendees. The plan for a future real-time presentation of the webinar can include live audio that accompanies the visual information. Research suggests that the optimal webinar duration is estimated at one hour (Zoumenou et al., 2015) and that trainees prefer webinars no longer than 90 minutes (Gegenfurtner & Ebner, 2019). Thus, the allotted time for this webinar is approximately 1 hour. It is important to note that a confidentiality statement about sharing information at one's discretion is included at the beginning of the webinar training to discourage attendees from sharing identifying information or sensitive information because privacy cannot be maintained on YouTube. YouTube Live provides options for attendees to write comments or ask questions during the training by utilizing the chat feature. This supports the inclusion of a Q&A module at the end of the webinar. Once the live broadcast of the webinar

is complete, the recorded webinar can be downloaded as an mp4 file to be shared on other platforms and/or remain as a YouTube video that can be viewed at any time thereafter. This allows the webinar training to be utilized later and be disseminated to a larger audience. One recommendation for ongoing interaction is for viewers to leave questions and comments on the YouTube page that webinar moderators can continue answering.

### **Contribution from Mental Health Professionals**

A needs assessment survey was conducted with MHPs pertaining to their training experiences and future needs for working with CSA and PCSA. The survey was approved and conducted in 2018 in conjunction with the other researchers in the three webinar series. The survey included items related to all three topics from the original research team. The results of this survey specific to PCSA, in combination with the reviewed literature, informed the structure and content of the webinar.

### ***Sample***

A sample of 21 MHPs were recruited to complete a survey regarding specific CSA training needs with respect to PCSA. For the purpose of collecting sample data in this study, MHPs included Master's and Doctoral level practitioners licensed in the United States. Master's and Doctoral level MHPs are licensed at the state level with respect to each state's own requirements.

### ***Recruitment Strategies and Procedures***

MHPs were recruited in accordance with IRB approval and in collaboration with the research team for the originally planned three-part webinar series. A convenience sampling method was used to recruit MHPs through email which invited them to complete an online survey. Initially the researchers' affiliated university was contacted to circulate the survey among

faculty and students. Additional recruitment efforts were made by emailing clinical training sites that are contracted with the researchers' university to distribute the survey. The Director of Clinical Training at the researchers' university provided the list of clinical training sites. Furthermore, recruitment strategies included emailing APA-accredited universities, professional school training programs, and other personal and professional contacts that met the inclusion criteria. Lastly, snowball sampling was used to further recruit survey participants by kindly asking existing participants to distribute the recruitment email to other mental health professionals. The use of snowball sampling was used during a secondary wave of recruitment to generate additional survey responses in order to reach the goal of 20 completed surveys. Survey responses were collected and reviewed until the minimum target of 20 responses was met.

The recruitment email included the intent of the survey and informed participants that the survey should take an estimated completion time of 10 minutes. A link in the body of the recruitment email directed participants to the informed consent page (Appendix A: Recruitment for Mental Health Professionals). The informed consent form informed potential participants that their participation was voluntary with the right to withdraw at any time during the survey and that their participation and survey responses will remain confidential should they choose to participate (Appendix B: Informed Consent for Survey Participants). The informed consent form detailed the nature and purpose of the study, the investigator's affiliation, potential risks and benefits of participating, confidentiality with no identifying information, and provided participants with an email contact (a Gmail account was created for the purpose of this dissertation project) for questions or concerns. Following the informed consent page was the survey through the platform Qualtrics. Qualtrics offers anonymous responding with IP address tracking inactivated to further protect the privacy of survey participants.

### ***Mental Health Professional Training Needs Survey***

An online survey comprised of 16 items that consisted of both Likert-scale and open-ended questions was created to assess the training needs of MHPs working with CSA and PCSA (Appendix C: Training Needs Survey). The survey included questions pertaining to the MHPs' credentials and general clinical experience. In addition, the survey gathered information about specific training and work experience with PCSA. Participants were asked questions pertaining to the quality of their training with PCSA, including any sociocultural factors relevant to working with PCSA. At the end of the survey there was an opportunity for the MHP to share specific information they think is necessary and valuable in future training or continuing education in relation to perpetrators of child sexual abuse.

### ***Data Collection and Analysis***

Descriptive analysis included analyzing data related to PCSA that was previously collected. The statistical summary of data was reviewed, and the feedback was incorporated in the content of the training webinar for MHPs that is strengths-based and culturally congruent with the needs, presentations, and contextual treatment factors faced by PCSA. The data from this survey was not intended to reflect a representative or random sample nor was it meant to be a comprehensive reflection of the training needs of all mental health professionals. All participant's private information and data was deidentified and stored separately to protect confidentiality.

### ***Development of the Webinar Training Resource***

Following the completion of an extensive review of the literature, review of existing resources, and analysis of MHPs training needs from the survey, the content for the webinar training resource was created. Although the webinar was initially designed as part of a larger

three-part webinar training resource, this specific webinar training focuses solely on the development of the webinar curriculum related to working with PCSA. The webinar training was designed to be approximately 1 hour. The webinar curriculum included an overview of PCSA, identified sociocultural considerations, reviewed strengths-based treatment including the GLM for PCSA, discussed treatment barriers, and highlighted the lack of training of MHPs with this population.

The webinar is organized into several sections. Introductory slides describe PCSA, terms, definitions, and statistics. Pertinent information related to PCSA such as perpetrator typologies, characteristics of PCSA, etiology and theories of sexual offending, and several obstacles of rehabilitation are also covered. The sociocultural considerations segment of the webinar includes a review of negative stereotypes that perpetuate stigma of PCSA and various systemic issues that impact this population. Next, a brief review of current therapy treatments for PCSA is discussed with emphasis on the GLM. The GLM is described with a case vignette utilized to apply the model to a PCSA. The webinar then includes discussion of treatment barriers and considerations, including the issue of mandated treatment with limited confidentiality, challenges of establishing and maintaining rapport, mental health professional biases, and secondary trauma and burnout. The webinar concludes by discussing the gap in MHPs' training on PCSA and calls attention to the need for additional training with this population.

### **Evaluation of the Webinar Training Resource**

After the development of the webinar content, the webinar was evaluated to gather some preliminary data about the usefulness and relevance of the training as a resource for MHPs. The evaluators included one general MHP who has interest in learning more about working with PCSA and a MHP with expertise in providing clinical services to PCSA. Selecting a general

MHP with an interest in working with PCSA to evaluate the webinar provided helpful information from the perspective of the intended population for the webinar. The expert MHP utilized their expertise in PCSA to provide helpful feedback about the webinar's ability to prepare MHPs to work with PCSA. The feedback and recommendations from the evaluators were essential to identifying the strengths and shortcomings of the webinar and informed areas of improvement and future directions of the webinar training for MHPs working with PCSA. Recruitment efforts were initiated by identifying and contacting MHPs with an interest in PCSA and experts in PCSA to review the webinar training content and complete an evaluation survey.

### *Sample*

Purposeful sampling was utilized to recruit one general MHP and one MHP with expertise pertaining to PCSA to review the webinar training curriculum and complete an evaluation survey of the webinar training. A general MHP was eligible to complete the evaluation of the webinar if they met all inclusion criteria: (a) licensed MHP, (b) minimum of 5 years post-licensure experience providing clinical services, (c) interested in learning more about working with PCSA, and (d) has not had specific training or focused experience that targeted working with PCSA. The expert MHP was eligible to complete the evaluation of the webinar if they met one or more of the following criteria: (a) licensed MHP with at least 5 years of specialized experience working in a program specializing in the treatment of PCSA, (b) licensed MHP with over 10 years of experience providing treatment to PCSA that has attended at least five trainings specific to PCSA and has provided treatment to at least 20 PCSA clients during the past 10 years, (c) director or previous director of a program specializing in treatment of PCSA, or (d) licensed MHP who has published on topics pertaining to PCSA over the past 10 years. MHPs that met the criteria to be an evaluator were identified and contacted until one general MHP and

one expert MHP agreed to review the webinar training curriculum and complete the evaluation survey.

### ***Evaluator Recruitment Strategies and Procedures***

Prior to contacting potential participants to evaluate the webinar training resource, approval from the Institutional Review Board (IRB) was obtained (Appendix D: IRB Approval Letter). The recruitment of the general MHP evaluator included the use of the researcher's social networks including the researcher's affiliated university's Facebook group for therapists and the researcher's professional LinkedIn account. The recruitment strategy included making a public post to the Facebook group and on LinkedIn announcing the researcher's search for an evaluator for a doctoral research project (Appendix E: Social Media Announcement for General MHP Evaluator). Three MHPs responded to the social media announcement and were sent a more detailed letter with all recruitment information along with a pre-screening questionnaire to determine eligibility (Appendix F: Recruitment for General MHP Evaluator).

The recruitment of the expert MHP evaluator included contacting two local sex offender treatment programs. An internet search included the keywords sex offender treatment program; approved sexual offender treatment programs; sex offender management board treatment programs; and adult sex offender management programs. The researcher utilized the administrative contact email provided on the company's website to send an email briefly describing the study and invitation to participate (Appendix G: Email Announcement for Expert MHP Evaluator). The researcher asked that the email be circulated among their colleagues and clinical staff who might be interested in participating in the evaluation of the webinar curriculum. One expert MHP responded to the email announcement and was sent a more detailed letter with all recruitment information along with a pre-screening questionnaire to determine

eligibility (Appendix H: Recruitment for Expert MHP Evaluator). Additional recruitment efforts that were initially proposed including compiling a list and contacting three authors who have published in relation to PCSA within the past 10 years was not utilized as the expert MHP evaluator was identified through the initial contact of the local sex offender treatment programs.

The recruitment invitation to participate detailed the nature and purpose of the webinar training resource. The four potential evaluators (three general MHPs and one expert MHP) were invited to evaluate the webinar training curriculum on its information, usefulness, specialization, practical implication, and readiness to work with PCSA from a strengths-based and sociocultural perspective. The pre-screening questionnaire included questions to determine their eligibility in the study. It included the inclusion criteria in the form of yes or no questions (Appendix I: Pre-Screening Questionnaire for General MHP Evaluator and Appendix J: Pre-Screening Questionnaire for Expert MHP Evaluator). One general MHP met the inclusion criteria, confirmed by the pre-screening questionnaire, and proceeded as an evaluator for the webinar training. The expert MHP evaluator met the inclusion criteria to be an expert evaluator, confirmed by the pre-screening questionnaire prior to reviewing the webinar and completing the evaluation.

Once eligibility was determined by the pre-screening questionnaire, the researcher sent the participants the informed consent along with the webinar curriculum and evaluation survey. The evaluators were informed that their participation to review the webinar content and complete the survey was voluntary with the right to withdraw at any time (Appendix K: Informed Consent for Evaluators). It also noted that their participation, including personal information will remain confidential should they choose to participate. It stated that the approximate time to review the webinar content will not exceed one hour with an estimated 10–15 minutes to complete the



evaluation survey. For reviewing the webinar training curriculum and completing the webinar training evaluation survey in its entirety, the evaluators each received a \$30 gift certificate to Amazon as compensation. Recruitment efforts ceased once one general MHP and one expert MHP met the inclusion criteria and returned the informed consent and the evaluation questionnaire.

### ***Webinar Evaluation Survey***

The webinar evaluation survey comprised of 11 questions designed to elicit feedback regarding the webinar content's applicability, effectiveness, and usefulness as a training for MHPs (Appendix L: Webinar Evaluation Survey). The evaluation survey gathered information using both Likert-scale and open-ended questions. The evaluation survey gathered specific feedback regarding the content of PCSA. The evaluation survey asked evaluators to rate the degree in which the webinar is informative, focused and specialized for training MHPs to work with PCSA, and whether it is most useful for early-career, mid-career, or late-career MHPs. The survey gathered information about the evaluators' opinions and impressions on ways the webinar training contributed to their understanding and readiness to work with PCSA. Specific feedback was solicited in the webinar training's use of a strengths-based perspective in treating PCSA and asked to rate the applicability of the sociocultural components of the webinar training. At the end of the survey the evaluators were asked to provide any suggestions for modification to the introductory training resource.

### ***Evaluation Data Analysis***

Following the completion of the webinar evaluation survey, the responses were reviewed. Data analysis included a descriptive summary of the Likert-scale ratings and qualitative responses regarding the webinar content's applicability, effectiveness, and usefulness as a

training for MHPs. The feedback was considered for the discussion of the strengths and limitations of the training resource. Furthermore, the data informed the discussion of future directions for improving the webinar training resource.

## Chapter 4: Results

### Mental Health Professionals' Training Needs Survey

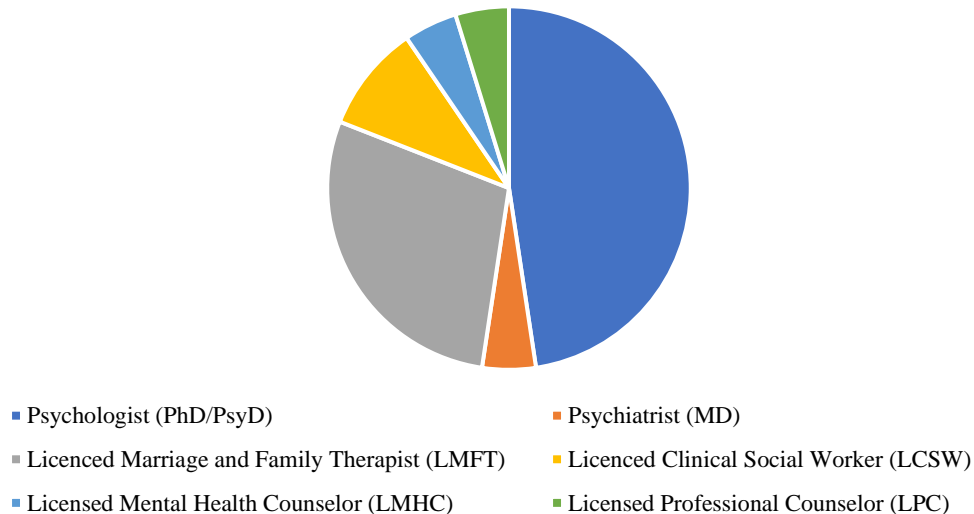
#### *Descriptive Analysis*

There were 21 participants that completed the MHPs' training needs survey ( $N = 21$ ). All 21 participants were licensed MHPs with various educational qualifications and job titles. As shown in Figure 1, the demographics among the participants included doctoral and master level mental health professionals. There were 11 doctoral level MHPs consisting of psychologists ( $n = 10$ , PhD/PsyD) and one psychiatrist ( $n = 1$ , MD), 10 were master's level MHPs consisting of licensed marriage and family therapists ( $n = 6$ , LMFT), licensed clinical social workers ( $n = 2$ , LCSW), licensed mental health counselor ( $n = 1$ , LMHC), and licensed professional counselor ( $n = 1$ , LPC). The MHPs reported varying experience in the mental health field spanning from 5–20 years.

#### **Figure 1**

#### *Educational Qualifications of MHP Needs Survey Participants*

#### Educational Qualifications of Mental Health Professionals



### *Experience and Training with Perpetrators of Child Sexual Abuse*

As shown in Table 1, less than one third of MHPs endorsed currently or previously working with PCSA ( $n = 6, 28.6\%$ ). The years of experience working with PCSA ranged from 1–9 years. Of the six participants with experience with PCSA, three had 1 year of experience, one had 3 years of experience, one had 6 years of experience, and one had 9 years of experience. Half of the MHPs with experience with PCSA indicated that they received specialized training ( $n = 3$ ) and two of the three with specialized training reported that the training inadequately prepared them to work with PCSA. Participants were asked about any gaps in their training related to working with PCSA. Among the 17 responses, eight participants endorsed a gap in their training on PCSA. Many reported that they received no training at all, no formal training, or limited training but could use more specific training. Among 20 responses, 19 participants reported that they could benefit from additional training in working with PCSA ( $n = 19, 95\%$ ).

**Table 1**

#### *Mental Health Professional Training with Perpetrators of Child Sexual Abuse*

MHPs Experience with PCSA	$N = 21$	%
Yes	6	28.6%
No	15	71.4%
PCSA Specialized Training	$N = 6$	%
Yes	3	50%
No	3	50%
Adequate PCSA Training	$N = 3$	%
Yes	1	33.3%
No	2	66.7%
Gaps in Training	$N = 17$	%
Yes	8	47.1%
No	9	52.9%
Benefit from Additional Training on PCSA	$N = 20$	%
Yes	19	95%
No	1	5%

The survey solicited information related to helpful skills for working with PCSA. The MHPs identified helpful therapist factors. The responses presented a theme of empathy with phrases that included the terms: compassion, honesty, empathetic listening, attunement, validation, unconditional positive regard, and nonjudgmental approach. Other helpful skills reported by the participants included firm limit-setting and boundaries. Lastly, the responses suggested treatment frameworks and certain interventions such as humanistic theory, motivational interviewing, assessment, and identifying and challenging cognitive distortions.

The MHPs identified several sociocultural factors to consider when working with PCSA. Responses from the participants included consideration of age, gender, race/ethnicity, sexual orientation, gender roles, socioeconomic status, education, occupation, family of origin, language, culture, religion/spirituality, drug and alcohol use, stigma, shame/guilt, mental health, and the abuse history of the perpetrator. Some responses specifically included the intersection between gender and power and the degree to which sexual abuse is actively policed. Many of these responses were incorporated in the webinar training. See Table 2 for a summary of the results related to key sociocultural factors to consider with PCSA.

**Table 2**

*Key Sociocultural Factors to Consider with Perpetrators of Child Sexual Abuse*

Sociocultural Factors	
Age, Race, Ethnicity	Religion and Spirituality
Power, Gender, and Sexuality	Trauma History
Education and Occupation	Drug and Alcohol Use
Family of Origin, Language, and Culture	Degree Sexual Abuse is Policed
Emotional and Mental Health	Stigma, Shame, and Guilt

The survey gathered specific information the MHPs would like to see in future trainings with PCSA. As shown in Table 3, the responses included a need for basic foundational training that includes a basic overview of helpful interventions and best practices to use when working with PCSA in a non-forensic setting. They also indicated a desire to learn about cultural factors that contribute to underreporting, building empathy for perpetrators, stigma, trauma-informed training, and training that is not blaming or shaming but attempts to understand underlying causes of sexual offending behavior. Additional responses indicated a need to learn how to assess for dangerousness, risk and protective factors, rehabilitation, risk of recidivism, legal implications, and interacting with the judicial system. The gaps in training along with the suggestions for future trainings for MHPs working with PCSA gathered by the participants were taken into consideration for the development of the webinar training. Certain content may have been limited or excluded as a result of the introductory nature of the training or due to the overall length of training.

**Table 3**

*Suggestions for Future Trainings*

Suggestions for Future Trainings
Basic foundational training including treatment and interventions
Best practices and EBP
Trauma-informed training
Training that is not blaming or shaming
Causes of sexual offending behavior
Building empathy for perpetrators
Assessment of dangerousness
Risk and protective factors
Risk of recidivism
Cultural factors that contribute to underreporting
Rehabilitation and Stigma
Legal implications and interacting with the judicial system

## **Webinar Development**

The literature review and MHP training needs survey informed the content for the webinar training. A suggested script was composed to be used as the audio commentary for the webinar (Appendix M: Suggested Script for Webinar Training). A total of 39 slides were developed (Appendix N: Webinar Training Slides). The webinar was constructed using PowerPoint slides and a corresponding suggested script accompanied each slide.

### ***Structure of the Webinar***

An outline of the webinar training was created to display the content of the webinar that is covered in the webinar training. See Figure 2 for a summary of the structure and outline of the webinar content. The webinar is structured to start with a confidentiality statement followed by the agenda and learning objectives of the training. The introduction to PCSA provides an overview of terminology, definitions, and relevant statistics (incidence, prevalence, and recidivism rates). Disclosure of CSA is also included in the webinar content. Attention is given to perpetrator typologies and characteristics, etiology and theories of sex offending, and the impact of CSA on the perpetrator. Treatment considerations are included in the training consisting of sociocultural and sociopolitical considerations, current therapy treatments for PCSA, risk assessments, the containment model, and shortcomings of current treatments. The emphasis of the training centers around strengths-based treatment including a strengths-based therapist approach, corresponding treatment themes and topics, and an introduction to the GLM. A case vignette is included to further illustrate the implementation of the GLM. The webinar summarizes treatment barriers to working with PCSA and training of MHPs. The webinar concludes with a brief overview that summarizes the main points of the training, an opportunity for questions, and resources and references for further reading.

**Figure 2***Structure and Outline of Webinar Content*

<b>Structure and Outline of Webinar Content</b>
Confidentiality statement
Agenda
Learning objectives
Introduction to PCSA
Terminology and definitions
Incidence and prevalence rates
Recidivism rates
Disclosure of CSA
Perpetrator typologies and characteristics
Etiology and theories of sex offending
Impact of CSA on the perpetrator
Treatment considerations
Sociocultural and sociopolitical considerations
Current therapy treatments for PCSA
Risk assessments
The containment model
Shortcoming of current therapy treatments
Strengths-based treatment
Therapist approach
Treatment themes
Therapeutic topics
Good Lives Model (GLM)
Treatment Barriers
Mandated treatment and confidentiality
Establishing and maintaining rapport
Mental health professional biases
Secondary/vicarious trauma and burnout
Case Vignette
Reflection questions
Training of mental health professionals
Child abuse reporter training
Perpetrator of child sexual abuse training
Overview
Q&A
Resources
References



### *Webinar Content*

The start of the webinar training provides a confidentiality statement regarding the participation and questions asked throughout the training. This statement reminds MHPs to use clinical judgment and discretion if sharing client-sensitive information since confidentiality cannot be provided. The agenda discusses the order in which the training will be presented. The learning objectives are targets that define what the MHP should learn from the training. These objectives help to stay focused on the learned outcomes throughout the training. The purpose of this webinar training is to broaden the knowledge of MHPs who are providing services in a diversity of settings where they may encounter PCSA. Specifically, introduce MHPs to understanding the complexities of working with PCSA while taking into consideration sociocultural factors and providing treatment from a strengths-based framework.

When introducing the topic of PCSA, attention is given to the terminology and definitions. This discusses the need to move away from negatively charged terminology when talking about PCSA and incorporate more neutral descriptions. The definition of PCSA is discussed and an important note is made regarding the exclusion of pedophiles in the training as it is an intricate population beyond the scope of this introductory training. The incidence and prevalence rates are provided to attempt to capture the extent of the problem. Additionally, recidivism rates are discussed, including the challenges of capturing an accurate account of sexual offending and reoffending. A segment related to barriers of sexual abuse disclosure is provided to better understand the challenge of gathering accurate statistical data related to sexual offending. An overview of perpetrator typologies and perpetrator characteristics are explored to provide some common patterns and traits of PCSA. A brief analysis of the etiology and theories of sex offending is presented to better understand why people engage in sexual offending

behavior. A way to highlight the need for treatment is to unpack the impact of CSA on the perpetrator. This helps to illustrate the many challenges PCSA face as they transition back into the community.

There are various treatment considerations to be aware of when working with PCSA. The webinar presents sociocultural and sociopolitical considerations including exploring negative stereotypes about perpetrators, the issue between punishment and treatment, and challenges to providing treatment to PCSA. Current therapy treatments for PCSA are briefly discussed along with the utilization of risk assessments in treatment. The framework of the containment model, which is the standard treatment model used in state mandated treatment programs is included in the training curriculum. Following the various components to treatment, shortcomings of current therapy treatments are explored to further highlight the need for strengths-based treatment.

A strengths-based treatment is introduced as an alternative approach to working with PCSA that emphasizes a collaboration and trusting therapeutic relationship that empowers and motivates clients to build on their existing strengths to make positive changes. The content includes therapist characteristics that align with a strengths-based approach such as empathy, warmth, trust, respect, support, genuineness, directiveness, flexibility, emotional responsiveness, and attentiveness. The strengths-based approach offers themes and topics that revolve around resiliency, well-being, post-traumatic growth, and overall quality of life. The GLM is a strengths-based treatment approach that is explored and a core component to the webinar training. The training discusses major components of the GLM including primary goods, the good lives plan, and flaws in good lives plan. To better grasp the concept of the GLM and implement the material, the webinar incorporates a case vignette with reflection questions that utilize the GLM near the end of the training.

Given that PCSA are unlike most clients who start therapy, it is important to discuss the various treatment barriers and considerations when working with this population. Since most PCSA are mandated to treatment and under parole supervision, it presents several barriers to treatment. Establishing and maintaining rapport is essential to making progress with PCSA. The training discusses the importance of MHPs exploring their own biases with this population. This may contribute to the difficulty of treating PCSA and have important implications for treatment. Another consideration when working with PCSA is the susceptibility to secondary traumatic stress and burnout. MHPs working with PCSA have the potential to be negatively impacted from repeated exposure to difficult content which can undermine the benefits of treatment. As such, it is imperative for MHPs working with PCSA to take steps to be actively involved in their self-care and seek help if symptoms arise.

The webinar training focuses attention on the lack of education and training MHPs receive on PCSA. It is unlikely that educational programs provide any education or training on PCSA and at most may provide an elective class or topic in lecture that briefly discusses PCSA. Most, if not all, training on PCSA is completed upon hire at a sex offender treatment center. The webinar emphasizes the need for more training for MHPs to use when working with PCSA in a non-forensic setting. This need for more training is also reflected in the MHPs training needs survey in which 95% of MHPs stated they could benefit from additional training on PCSA.

As the end of training approaches, there is an overview of the training which summarizes the main take away points from the topics covered in the training. These take away points should correspond to the learning objectives that were presented in the beginning of the training. The training concludes with a Q&A session that provides an opportunity for MHPs to ask questions pertaining to PCSA and the training. Available resources for further information pertaining to

PCSA are presented. After a list of selected references is displayed, the attendees are thanked for their time and participation in the webinar training. An email address is also provided for additional questions or comments regarding the training.

## **Evaluation of the Webinar**

### ***Evaluators Demographics***

One general MHP and one expert MHP reviewed the webinar training curriculum and completed an evaluation survey of the webinar training. The general MHP evaluator indicated that they are a licensed marriage and family therapist with 7 years working in the mental health field and 5 years of post-licensure clinical experience working in community mental health. The general MHP evaluator reported not having had previous training on PCSA and expressed an interest in learning more about working with PCSA, given the diversity of clients the general MHP works with. The expert MHP evaluator reported that they are a licensed clinical social worker with over 8 years of specialized experience working in a program specializing in the treatment of PCSA.

### ***Evaluation Feedback***

The evaluators reviewed the webinar curriculum and completed the webinar evaluation survey. The 11 questions on the survey comprised of item responses using a 5-point Likert scale with responses ranging from *strongly agree* to *strongly disagree* and open-ended questions. The evaluators rated the degree in which the webinar was informative, focused and specialized for working with PCSA, contributed to their readiness to work with PCSA, and whether it was most useful for early-career, mid-career, or late-career MHPs. Additionally, the evaluators reported their opinions and impressions of the webinar's use of a strengths-based perspective in treating PCSA and attention to sociocultural issues. Lastly, the evaluators provided their overall

impressions of the webinar training with what they found to be most effective and suggestions for modifications.

The general MHP evaluator reported *strongly agree* to the webinar training being informative and a specialized training necessary for preparing MHPs to work with PCSA. The general MHP recognized that the webinar is useful for MHPs at any point in their careers but found the training most useful for early career MHPs. Additionally, the general MHP evaluator indicated that they *strongly agree* that the webinar communicated a strengths-based perspective and reported that they *agree* the presentation effectively discussed sociocultural issues. They acknowledged that the training increases MHPs appreciation of the complex nature of PCSA and contributes to the readiness to treat PCSA.

The expert MHP evaluator *strongly agreed* that the webinar is useful for early to late-career MHPs. When asked about the content of the webinar training, the expert MHP reported that they *strongly agree* that the webinar was informative, specialized, and has practical implications for MHPs to work with PCSA. In response to evaluation survey questions inquiring about the application of a strengths-based perspective and attention to sociocultural issues in the webinar, the expert MHP indicated *strongly agree* and *agree* respectively. They *strongly agree* that the training increases MHPs appreciation of the complex nature of PCSA and *agree* that the webinar contributes to the readiness to treat PCSA. See Table 4 for a summary of the Likert scale responses from the general MHP evaluator and the expert MHP evaluator.

**Table 4***Webinar Evaluation Likert-Scale Results*

Evaluation Item	General MHP Evaluator	Expert MHP Evaluator
useful for early career MHPs	strongly agree	strongly agree
useful for mid-career MHPs	agree	strongly agree
useful for late-career MHPs	agree	strongly agree
informative	strongly agree	strongly agree
focused and specialized	strongly agree	strongly agree
practical implications for MHPs	agree	strongly agree
strengths-based perspective	strongly agree	strongly agree
sociocultural issues	agree	agree
appreciation of complex nature of PCSA	strongly agree	strongly agree
contribute to readiness to treat PCSA	strongly agree	agree

When asked to provide an open response to their overall impressions of the webinar training, the general MHP evaluator reported, “I found the presentation to be informative and serve its purpose to prepare a new or experienced clinician with valuable information about PCSA.” In response to the inquiry regarding what the evaluator finds most effective about the training resource, the general MHP indicated, “I found the knowledge on terminology, statistics regarding recidivism, and implementation of the GLM most effective about this training resource.” The general MHP evaluator noted, “it challenged me to think in ways in which we too quickly dismiss offenders as irredeemable ... and the dual role of working with an offender on his reintegration while at the same time considering public safety.”

When asked about the overall impressions about the training resource, the expert MHP reported, “The webinar provides a nuanced look at a difficult subject with professionalism and academic rigor.” The expert evaluator noted, “It is imperative that we familiarize ourselves with this subject and its broad impact. This is important and necessary work that should be included in training for MHPs.” The expert evaluator was asked to provide an open response about what they found most effective from the webinar training, and they responded, “The training proficiently

identifies the gaps in treatment and makes a strong case for utilizing a strength-based approach when working with PCSA.” See Table 5 for a summary of the Webinar Content Feedback from the general MHP evaluator and the expert MHP evaluator.

**Table 5**

*Webinar Content Feedback*

General MHP Evaluator Feedback
Informative and prepares MHP to work with PCSA
Most effective in providing knowledge on terminology, recidivism, and the GLM
Challenged me to think in ways in which we too quickly dismiss offenders as irredeemable
Treatment can place MHPs in the dual role of reintegration while considering public safety
Expert MHP Evaluator Feedback
Provides a nuanced look at a difficult subject with professionalism and academic rigor
Most effective at identifying the gaps in treatment
Makes a strong case for utilizing a strength-based approach when working with PCSA
Imperative that we familiarize ourselves with this subject and its broad impact
Important training that should be included in MHP training

Finally, the general MHP evaluator and expert MHP evaluator provided a suggestions for modification to the webinar as shown in Table 6. The general MHP evaluator suggested the utilization of the good life plan in the case vignette with an opportunity for breakout groups prior to having a formal group discussion. The expert MHP evaluator suggested inclusion of “cultural factors that may provide space for making PCSA acceptable or how families ignore or fail to address sexual offending behaviors.” Additionally, the expert MHP evaluator suggested highlighting the rates for suicide, addiction, and homelessness among PCSA and discuss how it may show up in therapy. Lastly, the expert MHP evaluator stated elaborating on how the GLM addresses the various systemic issues that impact PCSA and if the model places the responsibility on the PCSA to fit into a society that makes little room for them.

**Table 6***Webinar Modification Suggestions*

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General MHP Evaluator Suggestions
Incorporate the Good Life Plan in the case vignette
Include breakout groups for the vignette prior to formal group discussion
Expert MHP Evaluator Suggestions
Discuss cultural factors that make it difficult for families to address sexual offending behavior
Includes rates for suicide, addiction, and homelessness among PCSA
Elaborate on how the GLM addresses the various systemic issues that impact PCSA

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## **Chapter 5: Discussion**

The purpose of this dissertation project was to develop an introductory webinar training for MHPs to work with PCSA. The training emphasized sociocultural considerations and presented a strengths-based approach to working with PCSA. The literature on MHPs' training highlighted a need for more education and training on PCSA. Additionally, among the therapy treatments widely utilized with PCSA, there is little attention to strengths-based treatment. As opposed to most mental health treatment, treatment for PCSA is implicitly or explicitly punitive. PCSA are typically managed through programs that traditionally utilize a great deal of restrictions, external controls, and sanctions. The strengths-based treatment discussed in the training focused on the GLM for PCSA. The webinar was evaluated by one general MHP evaluator and one expert MHP evaluator. A webinar platform was selected due to its ability to be disseminated easily, its flexibility, convenience to users, and given the increased popularity among students and professionals.

### **Overview of Results**

The project included an initial MHP training needs survey to assess any gaps in training. There were 21 licensed master's and doctoral level MHPs that participated. Most MHPs endorsed little to no training on PCSA. Almost all MHPs reported that they could benefit from additional training on PCSA. Participants identified skills they found as helpful when working with PCSA including empathy, compassion, validation, unconditional positive regard, non-judgmental approach, and firm boundaries. They also suggested utilizing motivational interviewing, assessment, and cognitive restructuring. Participants identified sociocultural factors that may be relevant when working with PCSA such as the intersection between gender and power and the degree to which sexual abuse is actively policed. Additional responses included

race/ethnicity, sexual orientation, gender roles, socioeconomic status, education, occupation, family of origin, language, culture, religion/spirituality, drug and alcohol use, stigma, shame/guilt, mental health, and the abuse history of the perpetrator. Lastly, the survey gathered information the MHPs would find helpful in future trainings on PCSA. The responses reported basic foundational training for MHPs that work in a non-forensic setting, cultural factors that contribute to underreporting, empathy for perpetrators, stigma, and understanding underlying causes of sexual offending behavior. The responses from the MHPs training needs survey and the literature review were used to create the content of the webinar training.

The webinar slides were created using PowerPoint and included an accompanying script that narrated each slide. The introductory training was designed to be 1 hour in duration. Learning objectives for the training consisted of gaining a better understanding of the complex and dynamic issues related to PCSA, be able to identify sociocultural and sociopolitical factors related to PCSA, increase knowledge of current treatments including treatment barriers and considerations, be familiar with utilizing a strengths-based treatment approach and integrating the GLM into current treatments for PCSA. Relevant information was covered including terminology, recidivism statistics, barriers to disclosure, perpetrator typologies and characteristics, theories of sexual offending, and treatment. The webinar training discussed the various stereotypes about PCSA and the pervasive difficulties they experience with reintegration. Another important element of the training included treatment considerations, with an acknowledgement of MHPs' biases and the implications for treatment. A vignette with corresponding reflection questions was utilized to demonstrate the application of the GLM when working with PCSA.

Following the development of the webinar training, two evaluators reviewed the training resource and completed an evaluation survey. Purposeful sampling was utilized to obtain one general MHP evaluator and one expert MHP evaluator. Both evaluators reported that the webinar was informative, specialized, and emphasized a strengths-based perspective with attention to sociocultural issues. The evaluators agreed that the training contributed to MHPs readiness to treat PCSA. The evaluators found that the webinar training was useful for MHPs at any level in their career, while the general MHP evaluator found it most useful for early career MHPs. Additional feedback from the evaluators indicated the training was effective at increasing knowledge on PCSA, identifying gaps in treatment, and making a case for the utilization of a strengths-based approach with PCSA. Suggestions for webinar training modifications included incorporating the use of the Good Life Plan in the case vignette, discussing cultural factors and family dynamics of PCSA, including rates for suicide, addiction, and homelessness among PCSA, and elaborating on how the GLM addresses the systemic issues that impact PCSA.

### **Limitations and Future Directions**

There are potential limitations to this project including sample size, sample population, and webinar content. A limitation of this project involves the sample size for the MHP training needs survey and the sample size for the webinar evaluation. There were 21 MHPs that participated in the training needs survey that collected preliminary data about gaps in training for MHPs. Although the literature highlights the gap in training for MHPs in relation to working with PCSA, the data collected in this initial training needs survey is not broadly representative of the training gaps of MHPs with PCSA. Similarly, there were two MHPs that evaluated the webinar training resource. This sample size is too small to ensure a representative sample and

results cannot be generalized. It is recommended that future research utilize a larger sample for survey collection and webinar evaluation.

Another limitation of this project includes the sample population for the MHP training needs survey. A convenience sample was recruited through the researcher's affiliated doctoral program. The sample reflects selection bias as most participants were students or faculty of the researcher's university. Additionally, the sample of MHPs is limited to a specific geographic location. Given this narrow sample population, results from the MHP training needs survey cannot be generalized. Future research would benefit from recruiting participants from a broader population that is not limited to an affiliated university or geographic location.

Other limitations to this dissertation project consist of the webinar content. The evaluators provided some suggestions for content inclusion on the webinar training. The expert MHP evaluator suggested including the rates for suicide, addiction, and homelessness for PCSA in the training and discuss how these may present in therapy. This addition to the training can bring awareness to the challenges PCSA undergo and humanize PCSA by illustrating an array of problems they might be suffering from. Another suggestion from the expert evaluator included discussing cultural factors that make it difficult for families to address sexual offending behavior. This inclusion of greater cultural awareness is consistent with the sociocultural perspective of this project and would enhance the webinar training. Regarding the GLM, the expert MHP suggested elaborating on how the GLM addresses the various systemic issues that impact PCSA and if the model places the responsibility on the PCSA to fit into a society that makes little room for them. This recommendation would be an important inclusion as it is the premise of this strengths-based training on PCSA. The general MHP evaluator suggested incorporating the use of the Good Lives Plan in the case vignette. Additionally, should the training be offered in

person or if there should be an ability to group participants in webinars, the general MHP evaluator suggested breakout groups for the vignette prior to formal group discussion. Considering that this training is presented as a webinar format, a further addition to the content of the webinar to improve participants' understanding of treatment interventions presented in the GLM can include the use of multimedia sources such as videos imbedded in the webinar training to demonstrate interventions with a pseudo client (i.e., roleplay).

Additionally, another limitation regarding the webinar development is the time and attention given to sociocultural considerations. Although some sociocultural factors related to PCSA were included in the webinar training, several sociocultural topics suggested by MHPs in the training needs survey were not included in the training. Given the 60-minute time restraint for the webinar training, all topics could not be attended to. It is recommended that the webinar duration be extended by 15 minutes with the intention of integrating more sociocultural elements into the webinar. Future projects can explicitly discuss further sociocultural considerations while considering the introductory level of the webinar training.

Future directions for development of the webinar include: (a) publicly presenting or publishing the webinar, (b) expanding the ways MHP's attitudes and biases are addressed, (c) examining systemic factors pertaining to criminal behavior as it relates to recidivism, (d) incorporating the subpopulation of pedophiles into the curriculum, and (e) engaging a larger target audience.

The next step for this study is implementing the webinar training with MHPs. Future projects can publicly present or publish the webinar online through an online platform such as YouTube Live. Using this online platform would allow for a large audience. A feature of the live webinar could include the use of a chat feature for participants to ask questions throughout or

during the designated Q&A section of the training. The recorded webinar can be shared or remain as a YouTube video that can be viewed at any time thereafter.

An important area for future directions includes more thoroughly addressing aspects of MHPs' attitudes and biases related to PCSA. This might include highlighting the different levels of biases. Individual biases include the MHP's attitudes, beliefs, and stereotypes endorsed about PCSA. Professional biases include the influence of attitudes on the range of treatments available for PCSA that are intended to manage or control the PCSA. Societal biases include society's attitudes, beliefs, and endorsement of stereotypes that play a role in the systemic issues that hinder rehabilitation for PCSA.

Another way to address attitudes and biases related to PCSA is to integrate personal experiences into the training. Future projects would benefit from using the voices and faces of PCSA to tell their stories. Utilizing real people who are living these experiences not only humanizes the PCSA, but also helps to challenge the attitudes and biases towards PCSA. The simple visual of what a PCSA looks like can dismantle the stereotype of what society typically imagines a PCSA to resemble.

An additional valuable feature that could be incorporated into future projects is the ability to track and measure attitudes towards PCSA before and after viewing the webinar. Previous research suggests that training was effective at encouraging more positive attitudes towards PCSA (Craig, 2005; Hogue, 1993). A pre and post survey can be utilized to measure changes in attitudes following the webinar training. Attitudes towards PCSA can be tracked and measured using the Attitudes Towards Sex Offenders Scale (Hogue, 1993). The Attitudes Towards Sex Offenders Scale is a 36-item questionnaire using a 5-point Likert scale, with responses ranging from *strongly disagree* to *strongly agree*. About half of the items are worded as negative

statements (e.g., child sexual offenders never change), and the rest are worded positively (e.g., only a few child sexual offenders are really dangerous). On scoring, the negative items are reversed, and the total score is summed. High scores indicate more positive attitudes towards child sexual offenders (Nelson et al., 2002).

Another area for future directions includes an examination of the systemic factors relating to general recidivism for PCSA. It is undeniable that PCSA experience significant systemic challenges. In relation to housing, many PCSA may be denied housing even among the housing resources available for homeless population. In relation to employment, many PCSA may be denied employment opportunities even among the organizations that typically hire individuals with previous felony charges. Given these challenges, PCSA may resort to criminal behavior to get their basic needs met. In essence, if we do not give PCSA a path to a sustaining life, then prison becomes a viable option for basic human needs to be met. Examining general recidivism for PCSA and the relationship of systemic factors that surround PCSA might provide further insight for PCSA treatment and rehabilitation.

Lastly, future projects can expand PCSA training to incorporate content on pedophiles and/or expand the target audience. This webinar training was intended as an introductory training for MHPs on PCSA. As such, the training excluded the subpopulation of PCSA classified as pedophiles. This subpopulation was deemed beyond the scope of this introductory training. Future research would benefit from expanding on this webinar training by including the topic of pedophiles. Additionally, this training can be modified for a target audience beyond MHPs. Training people in other professions that work with PCSA or come in contact with PCSA such as probation and parole agents, correctional officers, and healthcare workers to work with PCSA from a strengths-based and sociocultural approach can be invaluable.

## **Implications for Theory and Practice**

The role of MHPs working with PCSA is essential to the overall rehabilitation of PCSA. MHPs that work with PCSA have a difficult undertaking that involves the interplay of multiple roles including therapist, case manager, advocate, and public safety. Working with PCSA requires (a) MHPs to be adequately trained to work with all the challenges that surround PCSA, (b) an in-depth exploration of attitudes and biases towards PCSA, and (c) MHPs to aid in facilitating change in the rehabilitation of PCSA.

As MHPs, we are called upon to provide services to PCSA. At the time of reintegrating into society, the criminal justice system mandates PCSA to receive treatment in the community. Also, given the rate at which CSA occurs and is unreported, it is likely that even in non-forensic settings MHPs will encounter clients who are PCSA despite the MHP's knowledge. A client may be in therapy for an unrelated reason who eventually discloses that they have sexually offended. Despite the controversy surrounding effectiveness of treatment for PCSA, the literature supports that treatment can be effective with consideration to the MHP's training, treatment approach, and individual perpetrator traits (Hanson et al., 2003; Lösel & Schmucker, 2005).

It behooves MHPs to become familiarized and adequately trained to work with PCSA. To prepare MHPs to work with PCSA and ensure the most effective treatment is provided, the following needs are identified: (a) in-service training specific to working with this population, (b) peer support, supervision, and consultation to avoid burnout, and (c) opportunities to examine their personal attitudes toward PCSA. Training can increase general knowledge base related to perpetrators, help build clinical skills in working with PCSA, overcome biases, and lessen burnout. However, programs do not provide education and training to prepare MHPs to work with PCSA and instead, MHPs are faced with the challenge of pursuing training on their own. As



a profession, this is important and necessary work that should be included in educational and training programs.

In treating PCSA, MHPs may experience a great amount of stress. PCSA typically present for treatment under court ordered mandates rather than on their own volition which can lead to MHPs experiencing greater stress than working with voluntary clients. MHPs may experience additional stress as a result of working with a complex and challenging population. Additionally, MHPs working with PCSA are exposed to intense, traumatic material. Furthermore, MHPs who work with PCSA can become increasingly isolated from those that do not work with offenders (Ennis & Horne, 2003). This means MHPs are susceptible to secondary trauma and burnout. Ways to buffer against the negative, potentially traumatizing effects of conducting treatment to PCSA includes peer support, supervision, and consultation. Literature argues the importance of having supportive colleagues in one's work environment including opportunities to vent and receive clinical guidance and direction (Ennis & Horne, 2003).

Attitudes of the general public towards PCSA appear to be highly negative. Specifically, they are viewed as dangerous, harmful, violent, bad, unpredictable, unchangeable, aggressive, irrational, mentally ill, and morally wrong (Craig, 2005; Nelson et. al, 2002). This perpetual bias may contribute to the difficulty of treating PCSA who are identified with the nature of their crime on a negative, emotionally charged level. MHPs working with PCSA are confronted with the task of exploring their own attitudes and biases with this population as it can have implications for treatment. The attitudes of professionals toward their clients undoubtedly affects their work with them. It affects the MHP's belief that their client can change, the degree to which MHPs are present and engaged with their client, the effort made to utilize interventions and gather resources for the client, the therapy approach and therapist's characteristics, and overall

therapeutic alliance. If MHPs hold a negative attitude toward PCSA, an effective therapeutic relationship will be difficult to achieve (Nelson et al., 2002). Positive attitudes towards PCSA are related to a lack of stereotype endorsement and are critical to successful community rehabilitation (Craig, 2005). Training can improve attitudes towards PCSA by addressing and rectifying the stereotypes that the public holds about PCSA, increasing confidence in their knowledge, and increasing belief in treatment effectiveness (Sanghara & Wilson, 2006). MHPs who have training and experience with perpetrators of sexual abuse tend to endorse fewer negative stereotypes and have more positive attitudes towards perpetrators (Nelson et al., 2002).

In addition to the negative attitudes and biases the public has towards PCSA, there is often a similar disapproval of MHPs that work with PCSA. MHPs that work with PCSA may experience criticism from the public and even other MHPs, especially from MHPs that work with victims (Polson & McCullom, 1995). It is important to recognize that MHPs that work therapeutically with PCSA are also serving wider community interests through the reduction and/or prevention of future reoffending. As a profession, we need to abandon the ostracism and disapproval of MHPs who provide treatment to PCSA.

There is a professional bias in the treatment provided to PCSA. The range of treatments available reflects a negative view of perpetrators. The focus of these treatments typically includes the management or control of these individuals. The boundaries between therapy and punishment for PCSA are not very clear. Some researchers argue that sex offender treatment is an aspect of punishment since the aim of treatment is to protect the public, and not to restore or enhance the functional capacity and well-being of offenders (Glaser, 2010). Other researchers argue that there are aspects of sex offender treatment that seek to improve the well-being of PCSA; therefore, stating that treatment is not entirely a punishment (Prescott & Levenson, 2010).

There are two models to treatment for PCSA. The first model is concerned with risk management, where the primary aim of rehabilitating PCSA is to avoid harm to the community rather than to improve the quality of life for the PCSA. This risk management model implies that sexual offending behavior cannot be solved or overcome, but only managed. This pessimistic model of change is consistent with the current treatment for PCSA. This treatment approach uses negative labels for PCSA and negative treatment strategies. There is an emphasis on avoidance goals, consisting of people, places, and things to avoid. MHPs may have an aggressive or confrontational style and there is very little collaboration between the MHP and the client.

The second model is concerned with the enhancement of the perpetrator's capabilities to improve the quality of their life. The primary goal is not the reduction of crime, but rather the perpetrator's well-being. This model suggests that the process of the PCSA improving their life, reduces their chances of committing further crimes. This model is consistent with a strengths-based approach that emphasizes the importance of developing a therapeutic alliance and utilizing a collaborative approach in treatment (Craig, 2005). A strengths-based approach focuses on approach goals that are positive aims for PCSA to achieve (Marshall et al., 2005). The MHPs operating from this model typically embody features of warmth, trust, empathy, respect, and genuineness (Marshall, 2015).

There is a call for change in our current practice of providing treatment to PCSA. Although the management of risk is a necessary feature of treatment, it needs to occur in conjunction with a strengths-based approach (Marshall et al., 2005). The model that is most highly recognized as a strengths-based approach for perpetrators of sexual abuse is the GLM. The GLM assists PCSA to develop and implement meaningful life plans that are incompatible with future offending. The unique feature of the GLM is the ability to tailor treatment to the

individual and meet the client where they are. The GLM believes that the way to reduce offending is to give individuals the necessary conditions to lead better lives (i.e., finding meaning, purpose, reason, and desire to live a prosocial life) rather than simply to teach them how to minimize their chances of being incarcerated (Ward & Stewart, 2003a).

This project was created with a strengths-based perspective with attention to sociocultural issues. The components of this training offers a different lens for working with this highly stigmatized and marginalized population. Understanding the considerable obstacles to reintegration and the sociocultural factors that perpetuate negative stereotypes helps to humanize PCSA. An evaluator of the webinar training reported that the training “challenged [them] to think in ways in which we too quickly dismiss offenders as irredeemable, while our very systems, with their restrictions and implications, do not allow for rehabilitation.” This speaks to society’s view on criminality and if society provides the opportunity for rehabilitation and second chances or does it inherently accept the consequences of criminal behavior as the sole responsibility of the offender?

In relation to PCSA, when exploring the opportunities or lack thereof for rehabilitation in society, the question becomes what are we doing as MHPs to create shifts and changes that challenge the status quo of how PCSA are treated in both treatment and society? One of the ways to challenge the reliance on risk management treatment that emphasizes control and negative treatment strategies is to operate from a strengths-based approach. By changing the way treatment is provided to PCSA, we can begin restoring the dignity of the client and their pursuit for a better life, while simultaneously reducing sexual offending. We can provide training to MHPs to operate through this lens.

Similarly, training can challenge negative attitudes and biases towards PCSA by humanizing PCSA and demystifying stereotypes. Since MHPs are human beings first, and therapists second, it is understandable that compassion towards PCSA may be difficult. Ways to build empathy for PCSA includes getting to know them as a person, their likes and dislikes, and understanding that everyone has something good to offer, rather than perceiving them solely as PCSA. There are various cognitive frames that we can utilize to foster caring attitudes and behaviors towards PCSA such as (a) viewing the perpetrator as someone vulnerable with problems, (b) viewing the perpetrator as an individual with personal worth with a right to treatment, and (c) realizing that their families still love them and want to reunify (Polson & McCullom, 1995).

Additionally, MHPs can get involved in education, policy, and program funding. MHPs can serve as educators in the community by demystifying public misconceptions of PCSA and exploring ways to reduce sexual offending (Slater & Lambie, 2011). Moreover, MHPs can advocate for changes in policy to promote better opportunities for rehabilitation. Lastly, MHPs can work alongside agencies to support program funding for resources designated for PCSA to aid in successful reintegration into society.

In conclusion, the key takeaway from this study is the need to shift from a risk management focus to a strengths-based approach for treatment of PCSA. This project emphasizes the importance of MHPs being adequately trained to work with PCSA and exploring their own attitudes and biases towards PCSA. This includes being familiarized with sociocultural and sociopolitical factors that influence PCSA with attention to stigma and systemic issues. MHPs may contribute to the successful community rehabilitation of PCSA by working collaboratively, endorsing positive attitudes towards PCSA, exemplifying characteristics

consistent with warmth, respect, empathy, and genuineness, and utilizing a strengths-based sociocultural approach that focuses on developing strong therapeutic alliances. This study contributes to the literature of treatment for PCSA and offers an effective treatment that helps improve the quality of life of PCSA while addressing the universal goal of reducing and preventing sexual reoffending.

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APPENDIX A

Recruitment for Mental Health Professionals

Hello [insert name of mental health professional],

You are invited to participate in a research study conducted by Angie Reyes, M.A., and supervised by Shelly Harrell, Ph.D. at Pepperdine University. My dissertation project, titled, **“Development and Evaluation of an Introductory Webinar Training for Mental Health Professionals Working with Perpetrators of Child Sexual Abuse: A Strengths-Based Perspective”** needs your assistance.

I am currently conducting an online study to assess the level of exposure and specific training related to treating perpetrators of child sexual abuse. I am interested in developing an introductory webinar training for mental health professionals treating this specific sub-population related to child sexual abuse and would greatly appreciate your input.

In order to participate in this survey, you must be:

- 1) a **Master’s or Doctoral level** mental health professional
- 2) a mental health professional in the **United States**, and
- 3) a **licensed** mental health professional

The survey will take no more than 10 minutes and participation is completely voluntary and your responses will be de-identified. Additionally, the researcher kindly request that you distribute this email, with survey link, to other mental health professionals and networks. Your assistance is greatly appreciated.

If you would like to participate, please answer the questions in the survey linked below [insert link to survey]. If you have any questions about this study, please send an email to [insert email here].

Thank you,

Angie Reyes, M.A.

APPENDIX B

Informed Consent for Survey Participants

**Pepperdine University  
Graduate School of Education and Psychology**

**Informed Consent for Participation in Research Activities**

Development and Evaluation of an Introductory Webinar Training for Mental Health Professionals Working with Perpetrators of Child Sexual Abuse: A Strengths-Based Sociocultural Perspective.

You are invited to participate in a dissertation research study conducted by Angie Reyes, M.A., under the supervision of Shelly Harrell, Ph.D. at Pepperdine University because you are a mental health professional working in the United States. Please read the information about the study that is outlined below and decide whether you would like to participate. Your participation in the study is voluntary. If you have any questions prior to consenting to participate, please send an email to Angie.Reyes@Pepperdine.edu. If you decide to participate, please check yes on the following question and proceed to the survey.

**PURPOSE OF THE STUDY**

The overall purpose of this study is to develop an introductory webinar training for mental health professionals that focuses on the introductory mental health treatment of perpetrators of child sexual abuse in the United States.

**STUDY PROCEDURES**

If you agree to participate in this study, you will be asked to complete a confidential online survey that will take approximately 10 minutes to complete. The survey questions include a series of questions about your credentials and/or licensure, experience working with perpetrators of child sexual abuse, and quality of training you have received with this population. In addition, you will also be asked to provide open-ended feedback on areas or topics you deem useful for training mental health professionals who work with perpetrators of child sexual abuse.

After completion of the survey, the researcher will review data for content and suggestions will be considered for inclusion in the creation of the webinar. Following the completion of a comprehensive literature search, review of existing resources and review of mental health professionals training needs survey results, the webinar training resource will be created.

**POTENTIAL RISKS AND DISCOMFORTS**

The potential and foreseeable risks associated with participation in this study include feelings of fatigue, boredom, and discomfort as a result of the nature of the questions asked pertaining to clinical experiences with perpetrators of child sexual abuse. It should be noted that the risks are not considered to be greater than those encountered by a mental health professional in their regular work activities. Your involvement in the study and completion of the study is strictly voluntary. You may choose to leave responses blank or discontinue the survey at any point in time with no adverse consequences.

### **POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY**

While there are no direct benefits to the study participants, there are several anticipated benefits to society and the mental health field, which include: acknowledgement of contribution to the mental health field and improved mental health training/education of perpetrators of child sexual abuse for mental health professionals. More generally, the study may also benefit psychological literature and society because it may contribute to greater understanding of perpetrators of child sexual abuse, strengths-based conceptualization, and sociocultural diversity factors. Additionally, by outlining a webinar training curriculum, the researcher hopes that there may be greater interest in specialized mental health training for professionals and greater mental health care provided to perpetrators of child sexual abuse.

### **PAYMENT/COMPENSATION FOR PARTICIPATION**

There will be no payment/compensation for participation in the 10-minute survey.

### **CONFIDENTIALITY**

The records collected for this study will be confidential as far as permitted by law. However, if required to do so by law, it may be necessary to disclose information collected from you. Please keep confidentiality in mind when providing open-ended feedback within the survey. Please avoid using names or revealing any identifying patient information. If you choose to reveal information regarding clinical work with a patient, please use a pseudonym and change any identifying information (e.g., treatment facility, geographic location, etc.). Examples of the types of issues that would require researchers to break confidentiality are any instances of child abuse, elder adult abuse, and dependent adult abuse. Pepperdine University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

The identity of participants completing the survey will not be obtained, as the survey will not ask any identifying information. Your mental health employment history and clinical experience may be included as part of your response to survey questions. Data gathered from the survey will be coded and de-identified so that private information will be kept separate from information collected. The data will be stored for a minimum of three years. After that time, all information will be confidentially shredded and disposed.

### **SUSPECTED NEGLECT OR ABUSE OF CHILDREN**

Under California law, the researcher who may also be a mandated reporter will not maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect of a child, including child pornography, dependent adult or elder, including, but not limited to, physical, sexual, emotional, and financial abuse or neglect. If the researcher has or is given such information, he or she is required to report this abuse to the proper authorities.

### **PARTICIPATION AND WITHDRAWAL**

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights, or remedies because of your participation in this research study.

**ALTERNATIVES TO FULL PARTICIPATION**

The alternative to participation in the study is not participating or only completing the survey items you feel comfortable responding to.

**INVESTIGATOR'S CONTACT INFORMATION**

You understand that the investigator is willing to answer any inquiries you may have concerning the research herein described. You understand that you may contact Angie Reyes, M.A. and Shelly Harrell, Ph.D. at Angie.Reyes@Pepperdine.edu and Shelly.Harrell@Pepperdine.edu should you have any additional questions or concerns about this research study.

**RIGHTS OF RESEARCH PARTICIPANT**

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive, Suite 500, Los Angeles, CA 90045, (310) 568-5753 or at gpsirb@Pepperdine.edu.

By checking the box below, you acknowledge that you have read the information provided above, you have been given the opportunity to ask questions or address concerns, and you agree to participate in this study.



APPENDIX C

Training Needs Survey

1. I have read the information related to the present study and agree to participate in this voluntary questionnaire. I understand that I may elect to discontinue the survey with no penalty.
  - a. *Yes*
  - b. *No*
2. What is your current job title?  
*[Open text response field]*
3. Are you currently licensed?
  - a. *Yes*
  - b. *No*
4. What mental health license do you have? (e.g., LMFT, LCSW, Psychologist, etc.)  
*[Open text response field]*
5. How many years of experience do you have in the mental health field?  
*[Open text response field]*
6. Are you currently working or have you previously worked with perpetrators of child sexual abuse?
  - a. *Yes*
  - b. *No*
7. How many years of clinical experience do you have working with perpetrators of child sexual abuse?  
*[Open text response field]*
8. What skills have you found most helpful in working with perpetrators of child sexual abuse?  
*[Open text response field]*
9. Have you received any specialized training working with perpetrators of child sexual abuse?  
*[Open text response field]*
10. Was the training you received adequate in preparing you to work with perpetrators of child sexual abuse?
  - a. *Yes*
  - b. *No*

11. Have you noticed any gaps in your training versus the actual skills needed in working with perpetrators of child sexual abuse?

- a. *Yes*
- b. *No*

12. What are some of the key sociocultural factors to address or consider in working with perpetrators of child sexual abuse?

*[Open text response field]*

13. Do you believe you would benefit from additional training in working with perpetrators of child sexual abuse?

- a. *Yes*
- b. *No*

14. What specific information would you like to see in your future training or continuing education in relation to perpetrators of child sexual abuse?

*[Open text response field]*

15. Have you received training in any of the following areas in relation to working with perpetrators of child sexual abuse? Please specify what topics were discussed.

- a. Thriving in the face of adversity
- b. Post-Traumatic Growth
- c. Resiliency
- d. Sociocultural context
- e. Well-Being
- f. Empowerment
- g. Positive Psychology
- h. Other (please specify)

16. What other recommendations do you have for trainings on child sexual abuse?

*[Open text response field]*

APPENDIX D

IRB Approval Letter

**Pepperdine University**  
**24255 Pacific Coast Highway**  
**Malibu, CA 90263**  
**TEL: 310-506-4000**

## **NOTICE OF APPROVAL FOR HUMAN RESEARCH**

Date: November 07, 2022

Protocol Investigator Name: Angie Reyes

Protocol #: 22-01-1754

Project Title: Development and Evaluation of an Introductory Webinar Training for Mental Health Professionals Working with Perpetrators of Child Sexual Abuse: A Strengths-Based Sociocultural Perspective

School: Graduate School of Education and Psychology

Psychology Dear Angie Reyes:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at [community.pepperdine.edu/irb](http://community.pepperdine.edu/irb).

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

Cc: Mrs. Katy Carr, Assistant Provost for Research

APPENDIX E

Social Media Announcement for General MHP Evaluator

Seeking a licensed mental health professional that is interested in learning more about working with perpetrators of child sexual abuse to participate in a dissertation study. I am recruiting a mental health professional to evaluate an introductory webinar training on treating perpetrators of child sexual abuse that I developed for my doctoral dissertation research at Pepperdine University. Mental health professionals who are licensed, have a minimum of 5 years post-licensure experience providing clinical services, who are interested in learning more about working with perpetrators of child sexual abuse and have not had specific training or focused experience that targeted working with perpetrators of child sexual abuse are eligible. Participant will receive a \$30 gift card to Amazon for their time. If you are interested in participating or want additional information, please contact the researcher at [insert email address].

APPENDIX F

Recruitment for General MHP Evaluator



Hello [insert name of mental health professional],

Thank you for expressing interest in participating as an evaluator of an introductory webinar training on treating perpetrators of child sexual abuse that I developed for my doctoral dissertation research. The study is supervised by Shelly Harrell, Ph.D. at Pepperdine University and is titled “**Development and Evaluation of an Introductory Webinar Training for Mental Health Professionals Working with Perpetrators of Child Sexual Abuse: A Strengths-Based Perspective.**”

The project is seeking one mental health professional who has interest in working with perpetrators of child sexual abuse to evaluate the webinar training curriculum for the usefulness, effectiveness, and relevance of its content. Participation involves viewing the one-hour webinar and completing a 10–15-minute evaluation survey. The evaluation survey uses a 5-point Likert scale to rate how strongly you disagree or strongly agree with the quality and content of the proposed curriculum and will also include open-ended questions. Participation is completely voluntary, and your responses will be de-identified. The evaluator will receive a \$30 electronic gift certificate to Amazon as compensation for their time.

In order to qualify to evaluate the webinar training you must meet **all** of the following:

- 1) licensed mental health professional
- 2) minimum of 5 years post-licensure experience providing clinical services
- 3) interested in learning more about working with perpetrators of child sexual abuse
- 4) has **not** had specific training or focused experience that targeted working with perpetrators of child sexual abuse.

If you would like to participate, please complete the provided Pre-Screening Questionnaire. Upon meeting eligibility as confirmed by the pre-screen, the informed consent form will be provided along with the webinar training curriculum and the evaluation survey. If you have any questions about this study, please send an email to [insert email address].

If you are unable or unwilling to participate, please consider forwarding and distributing this invitation to other licensed mental health professionals that may meet the criteria listed above.

Thank you,

Angie Reyes, M.A.

APPENDIX G

Email Announcement for Expert MHP Evaluator

Hello [insert name of treatment program],

My name is Angie Reyes, M.A. and I am seeking a mental health professional that has an expertise in perpetrators of child sexual abuse to evaluate a webinar training curriculum for my dissertation project titled “Development and Evaluation of an Introductory Webinar Training for Mental Health Professionals Working with Perpetrators of Child Sexual Abuse: A Strengths-Based Perspective.” Participation involves viewing the one-hour webinar and completing a 10–15-minute evaluation survey. The participant will receive a \$30 gift card to Amazon for their time.

I would appreciate it if you would please circulate this email to your colleagues and clinical staff who might be interested in participating as an evaluator of a webinar training on perpetrators of child sexual abuse as part of my dissertation project.

To be eligible you must meet any one of the following:

- 1) licensed mental health professional with at least 5 years of specialized experience working in a program specializing in treatment of perpetrators of child sexual abuse
- 2) licensed mental health professional with over 10 years of experience providing treatment to perpetrators of child sexual abuse that has attended at least five trainings specific to perpetrators of child sexual abuse and has provided treatment to at least 20 perpetrators of child sexual abuse clients during the past 10 years
- 3) director or previous director of a program specializing in treatment of perpetrators of child sexual abuse
- 4) licensed mental health professional who has published on topics pertaining to perpetrators of child sexual abuse over the past 10 years

If you are interested in participating or want additional information, please contact the researcher at [insert email address].

Thank you,

Angie Reyes, M.A.

APPENDIX H

Recruitment for Expert MHP Evaluator

Hello [insert name of expert mental health professional],

My name is Angie Reyes, M.A. and I am currently seeking evaluators of an introductory webinar training on treating perpetrators of child sexual abuse that I developed for my doctoral dissertation research. The study is supervised by Shelly Harrell, Ph.D. at Pepperdine University and is titled “**Development and Evaluation of an Introductory Webinar Training for Mental Health Professionals Working with Perpetrators of Child Sexual Abuse: A Strengths-Based Perspective.**”

The project is seeking one mental health professional that has an expertise in perpetrators of child sexual abuse to evaluate the webinar training curriculum for the usefulness, effectiveness, and relevance of its content. Participation involves viewing the one-hour webinar and completing a 10–15-minute evaluation survey. The evaluation survey uses a 5-point Likert scale to rate how strongly you disagree or strongly agree with the quality and content of the proposed curriculum and will also include open-ended questions. Participation is completely voluntary, and your responses will be de-identified. The evaluator will receive a \$30 electronic gift certificate to Amazon as compensation for their time.

In order to qualify to evaluate the curriculum for the training as an expert mental health professional you must meet any **one** of the following:

- 1) licensed mental health professional with **at least 5 years of specialized experience** working in a program specializing in treatment of perpetrators of child sexual abuse
- 2) licensed mental health professional with over **10 years of experience** providing treatment to perpetrators of child sexual abuse that has attended **at least five trainings** specific to perpetrators of child sexual abuse and has provided treatment to **at least 20 perpetrators of child sexual abuse clients** during the past 10 years
- 3) **director or previous director of a program** specializing in treatment of perpetrators of child sexual abuse
- 4) a licensed mental health professional who has **published** on topics pertaining to perpetrators of child sexual abuse **over the past 10 years**

If you would like to participate, please complete the provided Pre-Screening Questionnaire. Upon meeting eligibility as confirmed by the pre-screen, the informed consent form will be provided along with the webinar training curriculum and the evaluation survey. If you have any questions about this study, please send an email to [insert email address].

If you are unable or unwilling to participate, please consider forwarding and distributing this invitation to other mental health professionals that may hold such expertise in working with perpetrators of child sexual abuse.

Thank you,

Angie Reyes, M.A.

APPENDIX I

Pre-Screening Questionnaire for General MHP Evaluator

Thank you for your interest in participating as an evaluator in the doctoral dissertation research study titled “Development and Evaluation of an Introductory Webinar Training for Mental Health Professionals Working with Perpetrators of Child Sexual Abuse: A Strengths-Based Perspective.” Please answer the following questions to determine your eligibility to be an evaluator of the webinar training.

Are you currently a licensed mental health professional?	Yes	No
Do you have a minimum of 5 years post-licensure experience providing clinical services?	Yes	No
Are you interested in learning more about working with perpetrators of child sexual abuse?	Yes	No
Have you had specific training or focused experience that targeted working with perpetrators of child sexual abuse?	Yes	No

Please return this completed questionnaire to the researcher at [insert email address]. You will be notified by email if you are eligible. If you meet the evaluator criteria, you will be provided with the informed consent form along with the webinar training curriculum and evaluation survey.

Thank you for considering being an evaluator of the introductory webinar training for mental health professionals working with perpetrators of child sexual abuse. Your time and effort are greatly appreciated.

Thank you,

Angie Reyes, M.A.

APPENDIX J

Pre-Screening Questionnaire for Expert MHP Evaluator



Thank you for your interest in participating as an evaluator in the doctoral dissertation research study titled “Development and Evaluation of an Introductory Webinar Training for Mental Health Professionals Working with Perpetrators of Child Sexual Abuse: A Strengths-Based Perspective.” Please answer the following questions to determine your eligibility to be an evaluator of the webinar training.

Are you currently a licensed mental health professional with at least 5 years of specialized experience working in a program specializing in treatment of perpetrators of child sexual abuse?	Yes	No
Are you currently a licensed mental health professional with over 10 years of experience providing treatment to perpetrators of child sexual abuse that has attended at least five trainings specific to perpetrators of child sexual abuse and has provided treatment to at least 20 perpetrators of child sexual abuse clients during the past 10 years?	Yes	No
Are you currently a director or previous director of a program specializing in treatment of perpetrators of child sexual abuse?	Yes	No
Are you a licensed mental health professional who has published on topics pertaining to perpetrators of child sexual abuse over the past 10 years?	Yes	No

Please return this completed questionnaire to the researcher at [insert email address]. You will be notified by email if you are eligible. If you meet the evaluator criteria, you will be provided with the informed consent form along with the webinar training curriculum and evaluation survey.

Thank you for considering being an evaluator of the introductory webinar training for mental health professionals working with perpetrators of child sexual abuse. Your time and effort are greatly appreciated.

Thank you,

Angie Reyes, M.A.

APPENDIX K

Informed Consent for Evaluators

**Pepperdine University  
Graduate School of Education and Psychology**

**Informed Consent for Participation in Research Activities**

Development and Evaluation of an Introductory Webinar Training for Mental Health Professionals Working with Perpetrators of Child Sexual Abuse: A Strengths-Based Sociocultural Perspective.

You are invited to participate in a dissertation research study conducted by Angie Reyes, M.A., under the supervision of Shelly Harrell, Ph.D. at Pepperdine University because you are a mental health professional working in the United States. Please read the information about the study that is outlined below and decide whether you would like to participate. Your participation in the study is voluntary. If you have any questions prior to consenting to participate, please send an email to Angie.Reyes@Pepperdine.edu. If you decide to participate, please print, sign, and date the bottom of this consent form and proceed to the webinar curriculum and evaluation survey provided as additional attachments.

**PURPOSE OF THE STUDY**

The overall purpose of this study is to develop an introductory webinar training for mental health professionals that focuses on the introductory mental health treatment of perpetrators of child sexual abuse in the United States.

**STUDY PROCEDURES**

In order to gather preliminary data about the usefulness and relevance of the webinar training, two evaluators will be recruited to review the webinar training resource. One general mental health professional with an interest in working with perpetrators of child sexual abuse will be recruited and one mental health professional with an expertise pertaining to perpetrators of child sexual abuse will be recruited to evaluate the webinar. If you agree to participate, you will be asked to review the webinar training content and complete an evaluation survey. The duration of reviewing the webinar content will not exceed one hour and the completion of the evaluation survey will take 10-15 minutes to complete. The survey will solicit feedback regarding the webinar content's accuracy, applicability, effectiveness, and usefulness as a training for mental health professionals. Following the review of the webinar curriculum and completion of the webinar training survey, data will be collected and organized into a list of future directions for improving the webinar training resource.

**POTENTIAL RISKS AND DISCOMFORTS**

The potential and foreseeable risks associated with participation in this study include feelings of fatigue, boredom, and discomfort as a result of the nature of the questions asked pertaining to clinical experiences with perpetrators of child sexual abuse. It should be noted that the risks are not considered to be greater than those encountered by a mental health professional in their regular work activities. Your involvement in the study and completion of the study is strictly

voluntary. You may choose to leave responses blank or discontinue the survey at any point in time with no adverse consequences.

### **POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY**

While there are no direct benefits to the study participants, there are several anticipated benefits to society and the mental health field, which include: acknowledgement of contribution to the mental health field and improved mental health training/education of perpetrators of child sexual abuse for mental health professionals. More generally, the study may also benefit psychological literature and society because it may contribute to greater understanding of perpetrators of child sexual abuse, strengths-based conceptualization, and sociocultural diversity factors. Additionally, by outlining a webinar training curriculum, the researcher hopes that there may be greater interest in specialized mental health training for professionals and greater mental health care provided to perpetrators of child sexual abuse.

### **PAYMENT/COMPENSATION FOR PARTICIPATION**

Each mental health professional evaluator that reviews the webinar training curriculum and completes an evaluation survey of the webinar training curriculum will be compensated with a \$30 electronic gift card to Amazon.

### **CONFIDENTIALITY**

The records collected for this study will be confidential as far as permitted by law. However, if required to do so by law, it may be necessary to disclose information collected from you. Please keep confidentiality in mind when providing open-ended feedback within the survey. Please avoid using names or revealing any identifying patient information. If you choose to reveal information regarding clinical work with a patient, please use a pseudonym and change any identifying information (e.g., treatment facility, geographic location, etc.). Examples of the types of issues that would require researchers to break confidentiality are any instances of child abuse, elder adult abuse, and dependent adult abuse. Pepperdine University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

The identity of participants completing the surveys will not be obtained, as the survey will not ask any identifying information. Data gathered from the study will be de-identified to maintain confidentiality. The data will be stored for a minimum of three years. After that time, all information will be confidentially shredded and disposed.

### **SUSPECTED NEGLECT OR ABUSE OF CHILDREN**

Under California law, the researcher who may also be a mandated reporter will not maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect of a child, including child pornography, dependent adult or elder, including, but not limited to, physical, sexual, emotional, and financial abuse or neglect. If the researcher has or is given such information, he or she is required to report this abuse to the proper authorities.

### **PARTICIPATION AND WITHDRAWAL**

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and

discontinue participation without penalty. You are not waiving any legal claims, rights, or remedies because of your participation in this research study.

### **ALTERNATIVES TO FULL PARTICIPATION**

The alternative to participation in the study is not participating or only completing the survey items you feel comfortable responding to.

### **INVESTIGATOR'S CONTACT INFORMATION**

You understand that the investigator is willing to answer any inquiries you may have concerning the research herein described. You understand that you may contact Angie Reyes, M.A. and Shelly Harrell, Ph.D. at Angie.Reyes@Pepperdine.edu and Shelly.Harrell@Pepperdine.edu should you have any additional questions or concerns about this research study.

### **RIGHTS OF RESEARCH PARTICIPANT**

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive, Suite 500, Los Angeles, CA 90045, (310) 568-5753 or at gpsirb@Pepperdine.edu.

You are voluntarily making a decision whether or not to be in this research study. Signing this form means that you have read and understood this consent form, you have had your questions answered, and you have decided to be in the research study. You will be given a copy of this consent form to keep.

### **Participant Name:**

\_\_\_\_\_  
Name of Participant: Please Print

### **Participant Signature:**

\_\_\_\_\_  
Signature of Research Participant

\_\_\_\_\_  
Date

APPENDIX L

Webinar Evaluation Survey

1. This webinar is **useful** for:
  - a. early career mental health professionals  
*1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.*
  - b. mid-career mental health professionals  
*1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.*
  - c. late-career mental health professionals  
*1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.*
  
2. This webinar on perpetrators of child sexual abuse was **informative**.  
*1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree.*
  
3. This webinar includes **focused and specialized** training necessary for preparing mental health professionals to work with perpetrators of child sexual abuse.  
*1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree*
  
4. This webinar has **practical** implications for mental health professionals' current/future work with perpetrators of child sexual abuse.  
*1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree*
  
5. This webinar effectively communicated the application of a **strengths-based** perspective to the treatment of perpetrators of child sexual abuse.  
*1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree*
  
6. The presentation of **sociocultural issues** related to the treatment of perpetrators of child sexual abuse was effective.  
*1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree*
  
7. This training increases mental health professionals' appreciation of the **complex** nature of perpetrators of child sexual abuse.  
*1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree*

8. This training contributes to mental health professionals' **readiness** to treat perpetrators of child sexual abuse?

*1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree*

9. What did you find **most effective** about this training resource?

*[Open text response field]*

10. Please provide any **suggestions** for modification and/or inclusion that you think would improve this introductory training resource requires.

*[Open text response field]*

11. What are your **overall impressions** about this training resource for mental health professionals?

*[Open text response field]*



APPENDIX M

Suggested Script for Webinar Training

### Slide 1: Title

Welcome to the introductory training for mental health professionals on working with perpetrators of child sexual abuse. Thank you for joining me today as I review relevant information and discuss ways to work with this highly stigmatized and marginalized population. The purpose of this webinar training is to provide a strengths-based sociocultural perspective that will encourage you to work with PCSA in a manner that facilitates more adaptive functioning.

Before we begin, I want to make a note about confidentiality. I welcome and encourage participation and questions, but it is important to keep in mind that confidentiality cannot be provided. Please use clinical judgment and discretion if you are sharing client-sensitive information.

For any questions or comments throughout the training feel free to use the chat feature and I will address them near the end, during the designated questions and answer segment of the training. You can also hold your question until that time. Please note that once this live training is over it will be made available for viewing if you want to replay any of this again or for those who were not able to attend the live training.

### Slide 2: Agenda

The agenda for today's training includes a review of perpetrators of child sexual abuse including terminology, statistics, typologies, etiology and theories of sexual offending. I will discuss the impact of child sexual abuse on the perpetrator and sociocultural and sociopolitical considerations when working with this population. I will briefly summarize the current therapy treatments for PCSA and shortcomings of those treatments. I will introduce a strengths-based treatment approach and review the Good Lives Model (GLM). I will cover treatment barriers and considerations when working with perpetrators of child sexual abuse. We will then have an opportunity to review a case vignette together and answer some reflection questions to grasp and implement the material. Training of mental health professionals will be discussed. Lastly, I will summarize the main points from this training and answer any questions.

### Slide 3: Learning Objectives

Here are the learning objectives for today's training. After today's training you should:

- Have a better understanding of the complex and dynamic issues related to perpetrators of child sexual abuse including terminology, disclosure, recidivism, typologies, origin of sexual offending, and treatment effectiveness
- Be able to identify sociocultural and sociopolitical factors related to perpetrators of child sexual abuse
- Have increase knowledge of current treatments including treatment barriers and considerations
- Have greater familiarity with utilizing a strengths-based treatment approach with perpetrators of child sexual abuse
- Understand the utility of integrating the Good Lives Model (GLM) into current treatments for PCSA

#### Slide 4: Introduction

Child sexual abuse (CSA) is a widespread public health problem with significant psychosocial consequences. CSA has been studied at length over the years. Yet, research on PCSA is still in its infancy. There is a need for continued research of PCSA because what we know is still rudimentary. We know that perpetrators of child sexual abuse (PCSA) are among the most feared and hated in society. They are often the target of public rage, hostility, and ostracism. PCSA are often viewed as unsalvageable and not worthy of treatment. Public attitudes and responses to sexual offending have a profound impact on the range and quality of opportunities for successful reintegration amongst PCSA. This stigma is not only detrimental to the impact of community reintegration, but it is unhelpful in encouraging prosocial behavior. Treatment for PCSA remains a controversial and misunderstood subject even amongst mental health professionals. However, the reality is that the majority of PCSA will be released back into the community. If our goal is to protect the community, we need to focus on treatment. Specifically, treatment from a stance that respects the dignity of the client and their pursuit for a better life. Treatment that builds strengths and treats PCSA in a respectful, empathic, and rewarding manner is effective in reducing sexual reoffending (Marshall & Marshall, 2014).

#### Slide 5: Terminology and Definitions

We have come a long way from “sticks and stones will break my bones, but words will never hurt me.” We know that the words have impact. There are plenty of labels used in society to describe PCSA that are very stigmatizing. The label we use to discuss perpetrators of child sexual abuse matters. Much of the literature uses the label “sex offender,” however, this label has become negatively charged. In attempt to avoid negatively charged terminology and maintain a strengths-based perspective, this training uses PCSA. This neutral behavioral description is used to describe individuals who have committed sex offenses with a child. Alternative phrases such as “individuals who have committed sex offenses on children” or “persons who have engaged in sexual activity with a child” would also be acceptable. This terminology describes the behavior rather than attribute the behavior to their identity. Using terminology that labels individual’s offense as part of their identity perpetuates the notion that the behavior in which they have engaged in defines the individual as a whole. In other words, these are whole human beings who engaged in a behavior, they are not the behavior—they are more than the behavior.

Although this training is on PCSA, it is important to note that this training is not on the specific population classified as pedophiles. Not all persons who have committed sexual offenses on children are pedophiles. Pedophiles refers to a narrow group of individuals diagnosed with pedophilia, which is a disorder defined in the DSM 5th Edition, by the extended presence of intense, recurring sexual urges, fantasies, or behaviors involving sexual activity with prepubescent children (American Psychiatric Association, 2013). This specific population is beyond the scope of this introductory training.

#### Slide 6: Incidence and Prevalence Rates

It is important to recognize that it is challenging to capture an accurate account of sexual offending. There are numerous definitions of CSA in the literature. There is no single streamline consensus of what is considered CSA. Some studies include contact only offenses, others include contact and non-contact offenses, and others have an entirely different definition. Additionally, it is challenging to capture the full extent of the problem, when the data is based off reported

sexual offenses, whether self-reported or based on convictions, and we know that most sexual offenses are not reported. According to the Centers for Disease and Control, about “1 in 4 girls and 1 in 13 boys in the United States experience child sexual abuse” (CDC, 2022). Research estimates that only 10–15% of cases are reported which suggests that CSA may be much larger than current research documents. Research states that children are most likely to be abused by adults. Perpetrators are typically male, and victims are typically female. Some research has shown that approximately half of CSA victims lived with the perpetrators at the time of the abuse. Acquaintances, family members, extended family members, neighbors, friends, or those in positions of care of children, have been found to account for around 75–84% of child sexual abuse. Given this information, we know that the “stranger danger” narrative is a misrepresentation of the majority of child sexual abuse cases since the perpetrator is most likely to be someone known to the victim.

### Slide 7: Recidivism Rates

The literature reflects various recidivism rates for perpetrators. This is largely due to the different ways recidivism is defined and collected. Recidivism refers to a person’s relapse into criminal behavior. Some studies define recidivism as a violation of condition of release, a new arrest, a reconviction, or a return to prison. Several studies collect recidivism data based on general recidivism which accounts for any new offense committed, that is not limited to sexual offenses. Other studies that measure recidivism only account for sexual recidivism referring to any new sexual offenses committed. There are also studies that measure both general and sexual recidivism.

Studies also vary in the length of time they track participants to calculate recidivism. This can alter the findings regarding recidivism rates. Some studies gather data over a follow-up period of 3 years, 4-5 years, 7 years, and some even longer than 10 years. The literature suggests that the longer the length of follow-up period the higher the general recidivism, but typically sexual recidivism decreases over the years.

In 2019, the Bureau of Justice Statistics (BJS) studied 412,731 prisoners that were released from state prisons across 30 states over nine years. They measured recidivism as a return to prison. The study revealed a **7.7% sexual recidivism rate** among those with prior sex offense convictions during the nine-year follow-up. Additionally, the study reported a **67% general recidivism rate** among those with prior sex offense convictions over the course of nine years, compared to 84% general recidivism for other released prisoners not previously convicted of sexual offenses (Alper & Durose, 2019).

In other words, of those released prisoners with prior sexual offenses, 7.7% were incarcerated for another sexual offense within nine years, and 67% were incarcerated for any crime within nine years. In addition, released prisoners without a previous sexual offense were convicted for a new crime at a higher rate than those with previous sexual offenses. This suggests that perpetrators of sexual abuse are more likely to be convicted of a non-sexual offense, rather than sexually reoffend but less likely to commit a new crime compared to released prisoners without a previous sexual offense.

It is important to note that this Bureau of Justice (BOJ) report is not based on samples of offender populations, as is the case in most of the academic research in this area. Rather, the report relies on data from the entire population of the prisoners released in 30 states. This means that when the report says there is a 7.7% sex offense recidivism rate among those with prior sex offense convictions, it is not an estimate of the recidivism rate based on statistical sampling, it is the actual rate of recidivism for the population (in this case, as measured by arrests for a new sex offense). Additionally, the arrest-based sex offense recidivism rate reported (7.7% over 9 years) is lower than the estimated rates obtained by most meta-analytic studies. The literature reports recidivism rates ranging from 5-15% over 5 years (Alper & Durose, 2019).

Another significant variable is that most recidivism rates reflect all sexual offense perpetrators and are not specific to PCSA, which presents another challenge of capturing recidivism rates. Most studies group perpetrators of different sexual offenses together in their sample population when different subgroups of perpetrators have been shown to reoffend at different rates. Studies suggest that recidivism rates are different for different types of sexual offenses. This inclusion of all subgroups in studies alters the statistical outcome of recidivism.

However, the research on re-offense rates by type of sexual offense shows inconsistent findings. Some research suggests that child offenders recidivate less than rapists, and exhibitionists recidivate more than other types of sexual offenders. Other research states that the highest observed recidivism rates were found among child offenders who offend against boys and that comparatively lower recidivism rates were found for rapists, child offenders who victimize girls, and incest offenders. Nonetheless, it is not clear if these findings are based on general recidivism or sexual recidivism, but the general consensus among the literature is that perpetrators of sexual abuse, regardless of type, have higher rates of general recidivism than sexual recidivism. Therefore, when critiquing the literature, it is frequently misleading to refer to recidivism without specifically identifying if it is referring to general or sexual recidivism.

Lastly, it is important to keep in mind that recidivism rates are typically based on arrests, convictions, or incarceration which indicate they are reported or known sexual offenses, and sexual offenses are one of the most underreported crimes.

#### Slide 8: Disclosure of CSA

Given that sexual offenses are one of the most underreported crimes and that underreporting of sexual abuse contributes to the challenges of fully capturing statistical data, it is important to understand factors that compound this issue and to humanize the problem. There are many barriers that contribute to silencing victims, making it more challenging for them to disclose and/or report the abuse.

Young children might not disclose because they lack the language abilities. They might be unable to articulate the offense, not understand the extent of the behavior, and may confuse it with love or affection. Adults are generally perceived as authority figures and out of obedience, children might be more inclined to keep a secret when an adult tells them to. Age may play a role in how the offender manipulates the child. Perpetrators of child sexual abuse use grooming to gradually build trust and an emotional connection with the child in order to sexually offend. Some grooming behaviors include undivided attention, special privileges, gifts, and keeping

secrets (Faller, 2020). Once an emotional connection has been established, the perpetrator might start to sexualize the relationship and engage in behaviors that desensitize the child and normalize the behavior. After sexual abuse has taken place, the grooming process ends with manipulating the child to keep the abuse a secret, sometimes even through threats or blackmail.

Gender may be a barrier to disclosure. The literature suggests that boys are less likely to report CSA. Since most perpetrators of child sexual abuse are men, research suggests that boys may be less likely to disclose in childhood or adolescence for fear of being seen as homosexual (Brennan & McElvaney, 2020).

The nature and quality of the victim's relationship to the perpetrator are also important factors to nondisclosure. Children abused by relatives and individuals known to them are less likely to disclose than children abused by non-relatives or strangers, particularly when the perpetrator is a parent, sibling, or another person the victim relies on for emotional, social, financial, and other support. This is especially a barrier when the perpetrator lives with the victim (Kellogga et al., 2020).

Psychological and emotional barriers such as shame, and self-blame also hinder self-disclosure. Many victims of CSA report feeling responsible for the abuse; feeling shame and stigma associated with the abuse; fear of being blamed or judged negatively; and fear of not being believed (Brennan & McElvaney, 2020). Studies also suggest that the longer duration and greater severity of the abuse inhibits disclosure of CSA (Kellogga et al., 2020).

Victims may be inhibited from disclosure due to fear of retaliation for reporting (i.e., fear for safety of self, family, pets, etc.), fear of divorce or professional intervention, such as placement in foster care, or fear of the unknown. As mentioned earlier perpetrators may make threats in the grooming process to keep the abuse a secret, stating they will harm a parent or pet if they were to disclose (Alaggia et al., 2019).

Lastly, families with a patriarchal structure, power imbalances, rigidly fixed gender roles, dysfunctional communication, other forms of abuse (i.e., domestic violence), and isolation have been found to suppress disclosure. Children of families and cultures that express passive acceptance that unwanted sexual experiences are inevitable; not wanting to bring shame to the family by admitting sexual abuse; lack of involvement from neighbors, school personnel; and stigma perpetuated by societal perceptions are less likely to disclose CSA (Alaggia et al., 2019).

### Slide 9: Perpetrator Typologies

So, who are these perpetrators who commit child sexual abuse? Many times, people believe if we can identify who they are we know who to avoid. This mentality is perpetuated by the stereotype of the man wearing a trench coat in the alley or the man driving the white van. But here is the thing, there is no "sex offender profile" or "typical sex offender." Statistically we know that perpetrators of child sexual abuse can be any age, gender, race, religion, marital status, education level, socioeconomic status, with or without a previous criminal record (Simons, 2017). We also know statistically that most PCSA are people known to the victim.

Although there is no sex offender profile, we have what they call typologies. Typologies are a classification system that provides information regarding patterns among categories of offenders. The literature has identified common typologies including what they term child sexual abusers, rapists, female offenders, and internet sexual offenders. For the purpose of this training, we will focus on the ‘child sexual abuser’ typology.

The first thing to consider when looking at patterns within the ‘child abuser typology’ is to rule out whether this person is a pedophile or not. There is misconception that all perpetrators of child sexual abuse are pedophiles. A person can be a perpetrator of child sexual abuse without being a pedophile. In fact, most perpetrators of child sexual abuse are considered situational offenders and do not have a genuine interest in children but may sexually offend for a number of complex reasons. A pedophile is considered a preferential offender who has a sexual preference for children. Pedophilia consists of a sexual preference for children that may or may not lead to child sexual abuse, whereas a perpetrator of child sexual abuse engages in sexual activity with a child that may or may not be due to pedophilia.

A pattern found when examining the relationship between the perpetrator of child sexual abuse and their victims is differentiating between intrafamilial and extrafamilial perpetrators. Intrafamilial perpetrators are those who exclusively select victims within their family, typically their own children or stepchildren. Intrafamilial perpetrators tend to be less psychopathic, have fewer victims, and less likely to be pedophiles. Researchers suggest that they are more likely to have female victims, cause less injury, and have lower recidivism (Rice & Harris, 2002). They often maintain their adult sexual relationships. Extrafamilial perpetrators are those who select their victims from outside their family members. Extrafamilial perpetrators are more likely to be pedophilic and have more child victims. They likely have few or no adult relationships.

Another pattern to examine among perpetrators of child sexual abuse is whether they are considered fixed or regressed perpetrators of child sexual abuse. Fixed PCSA are described as having a persistent, continual, and compulsive attraction to children. The fixated offender prefers interaction and identifies with children socially and sexually. These individuals often develop and maintain relationships with children to satisfy their sexual needs. In contrast, regressed perpetrators of child sexual abuse prefer social and sexual interaction with adults. Their sexual involvement with children is situational and occurs as a result of life stresses (Terry & Tallon, 2004). These stressors can include unemployment, marital problems, or can be related to negative affective states such as loneliness, stress, isolation, or anxiety. Regressed PCSA tend to victimize children they have easy access, and as such, they often victimize their own children.

#### Slide 10: Characteristics of Perpetrators

There are some shared characteristics that perpetrators of child sexual abuse exhibit. PCSA often have poor social skills, feelings of inadequacy or loneliness, low self-esteem, a sense of worthlessness, and/or depression. They may be passive in relationships and have previously frustrating adult relationships (Maniglio, 2012). PCSA often believe that there is a mutual relationship with the victims. Lastly, most PCSA tend to “groom” their victims. Grooming refers to the premeditated behavior intended to manipulate potential victims into complying with the sexual abuse (John Jay College, 2004). Types of grooming behavior include verbal and/or physical coercion, emotional manipulation, seduction, games, and enticements (Pryor, 1999).

### Slide 11: Etiology and Theories of Sex Offending

The etiology of sexual offending refers to the origins or cause of sexually abusive behavior. It is understandable that we want to know why people sexually offend; however, understanding the causes and origins of sexual offending is still developing. There are numerous theories that have formulated their beliefs of what causes someone to sexually offend. Some of these theories have helped us better understand sexual offending behavior. There are single-factor theories that have provided insight into offending behavior. These include biological theories which focus on brain abnormalities; evolutionary theories which focus on sexual selection and sexual strategies to explain sexual aggression; personality theories which focus on principles of attachment theory to explain relationships between children and their primary caretaker, and how this early relationship affects later adjustment; feminist theories which focus on gender and the imbalance of power between men and women; cognitive theories which focus on how one's thoughts affect their behavior; behavioral theories which focus on the occurrence of continued deviant sexual behavior depending on reinforcement and punishment; and social learning theories which focus on the notion of environmental influences playing a role in sexual offending, suggest that children who are sexually abused grow into sexually abusive adults, and that sexually explicit material contributes to sexual offending behavior. The literature suggests that no single-factor theory fully captures the cause of sexual offending. As such, several multifactor theories emerged which integrated multiple theories and factors to explain offending behavior. Ultimately, there is no simple answer to the question of why people engage in sexual offending behavior. The problem of sexual offending is too complex to attribute solely to a single theory and even though multifactor theories provide greater insight into the causes of sexual offending, the field has yet to find a clear explanation or cause for sexual offending behavior. People who sexually abuse vary in the reasons they offend, who they offend against and the various sexual behaviors and crimes they commit. Despite not have a definite cause, the research shows that there are some contributing factors to sexual offending including sexual offending being a learned behavior, negative or adverse conditions in early development leading to poor attachment to others, cognitive distortions or thinking errors to rationalize their sexually abusive behavior, and problems with self-regulation and impulse control (SMART, 2022; Faupel & Przybylski, 2017).

### Slide 12: Impact of CSA on the Perpetrator

When examining the impact of CSA on the perpetrator, one of the first consequences includes a criminal proceeding which often leads to a jail or prison sentence. In prison there is a hierarchy based on criminal offense and at the bottom of the hierarchy are those who commit sexual offenses, specifically sexual offenses against children. Although society may not make distinctions between perpetrators, the offenders themselves have their own hierarchy. Due to personal feelings or prison politics, perpetrators of child sexual abuse are often a target of violence in the prison system. This often forces them to go into protective custody for safety. While some prisons house perpetrators of sexual abuse in a different housing unit away from general population, other prisons integrate populations. Perpetrators frequently attempt to conceal their sex offense and create a cover story for their safety when they are integrated with general population.

A small percentage of perpetrators known as sexually violent predators (SVP) are placed under an indefinite civil psychiatric commitment due to a threat to public safety if they were released



from custody. However, most perpetrators do not meet the criteria for sexually violent predator and are released from prison after completing their sentence. It is estimated that 90% of all convicted sex offenders who serve time in prison are ultimately released back into the community (Phillips, 2003).

Upon reentry into society, perpetrators are required to register as convicted sex offenders. Sex offender registration laws require offenders to provide their addresses, and other identifying information, to a state agency or law enforcement agency for tracking purposes with the intent of increasing community protection (CASOMB, 2022). States have also passed laws that allow for the community to be notified or have access to sex offender registration information.

A key issue with registration and community notification laws is finding a balance between the public's right to know about sex offenders in the community and the need to successfully integrate perpetrators of sexual abuse back into the community. In addition to sex offender registration, some PCSA are required to be electronically monitored through a GPS tracking device. Lastly, while on probation or parole, they are supervised by an assigned probation officer or parole agent that monitors the offender to ensure they are abiding their condition of release. The condition of release is a list of requirements that the parolee must follow to prevent parole violations that could result in reincarceration. It usually includes things such as a curfew, indicating a time they need to be home every day, and a detailed list of people they cannot be around, and places that must be avoided.

Once a PCSA is released back into society there is often a threat to their safety. PCSA are part of a highly stigmatized group where hostility and aggression are routinely directed. Many communities are not fond of having registered sex offenders returning to their community. There is a sense of vigilantism where community members are punishing sex offenders in their neighborhoods. A study that surveyed 137 registered sex offenders found that 48% of the sample reported having been physically threatened or harassed (Mercado et al., 2008).

#### Slide 13: Impact of CSA on the Perpetrator

Having a criminal record can present challenges to finding employment, but even more so when the criminal record reflects a sex offense. PCSA often experience difficulties securing employment since many employers who may hire people with criminal records are less willing to hire someone with a sex offense. Several jobs are also eliminated as possibilities for employment if they violate any condition of release (e.g., working with or around minors). Some PCSA who obtain employment may be terminated once their conviction is discovered either through a background check, sex offender registration, or community notification. A study found that 52% of the sample they surveyed reported having lost their job as a result of notification (Mercado et al., 2008). Similarly, another study found that of the 121 registered sex offenders surveyed 43% of the sample reported job loss (Tewksbury, 2005). The challenge of securing employment is stressful for PCSA returning to the community and often is a source contributing to financial hardship.

In addition to the employment struggles, many communities have passed residency restrictions for perpetrators of sexual abuse. Most states have enacted housing restriction statutes which prohibit PCSA from residing in close proximity to children. Specifically, these state laws may

forbid PCSA from living in close proximity to schools, daycare centers, parks, and school bus stops. The challenge to find a place of residency is compounded when many landlords or rental properties deny the applicant housing as a result of their background check. A study found that 45.3% of perpetrators of sexual abuse reported loss or denial of a place to live (Tewksbury, 2005). A consequence of the barriers to finding housing is that many perpetrators end up homeless. A study found that 39% of perpetrators of sexual abuse were homeless and 22% were forced to relocate at least twice (Schwartz, 2011).

#### Slide 14: Impact of CSA on the Perpetrator

Many perpetrators report losing relationships including family members, friendships, and marriages or romantic relationships as a result of their sex conviction. Often there is a separation in the family because the victim is a child or member in the family. As such, the perpetrator's condition of release typically states that they must remain an identified distance away from the victim and not have any communication with them.

Researchers found that 80% of perpetrators of sexual abuse report a loss of their marriage or romantic relationship they had pre-conviction as a result of their conviction (Harris, 2014). Many PCSA express a desire to date or have a romantic relationship but fear having to explain their situation to their potential partners.

PCSA frequently experience a loss in their friendships and acquaintances once they return to their community and their conviction is discovered. A study found that half of the perpetrators reported they lost a friend as a result of registration (Tewksbury, 2005). Due to the residency restrictions, most perpetrators are displaced and have to move away from their family and friends who may be their only supportive contacts (Levenson & Cotter, 2005b).

Perpetrators of child sexual abuse experience significant impact to their psychological and emotional well-being, often a result of the stigmatization, isolation, and alienation they experience. PCSA who have been ostracized by angry community members have been found to experience significant stress, depression, and hopelessness (Tewksbury & Lees, 2006). The majority of the perpetrators surveyed in a study report experiencing hopelessness (72%), shame and embarrassment (67%), and stress that interfered with their recovery (71%) (Levenson & Cotter, 2005a). Some studies even report a risk for suicide among perpetrators of child sexual abuse. Perpetrators of child sexual abuse lack a sense of belonging and might see themselves as a burden to society, having nothing to contribute. They may have concerns about their future as it relates to their reputation, sexual offending, or prison sentence. Perpetrators of child sexual abuse face numerous judgments, rejections, and emotional obstacles. They may internalize the negative labels and messages they receive in society, such as, they are "bad," "evil," "monsters," or "perverts" and begin to view themselves as such. PCSA may use cognitive distortions, such as denial, rationalization, and minimization, in order to maintain a positive sense of self and to relieve their underlying shame and anxiety. All of these factors affect a perpetrator's ability to function as a successful member of society.

#### Slide 15: Sociocultural and Sociopolitical Considerations

There are several sociocultural and sociopolitical considerations when working with perpetrators of child sexual abuse. By its very nature, child sexual abuse includes a power differential

between adult and child. Adults are viewed as authority figures with power and children are powerless and meant to obey them. Although most perpetrators of child sexual abuse do not use physical force, they groom and manipulate vulnerable children to comply through the use of gifts, money, and undivided attention (Faller, 2020). Additionally, since most PCSA are men, sexual offenses are a gendered issue. In a patriarchal system men dominate, and women are considered subordinate to men. In this way, sexual abuse of girls by men is more than an act; it is a systematic way to oppress and dehumanize girls. Specifically, women and girls are viewed as property and objects for sexual use rather than equal human beings (Morris, 2009).

Social stigma includes the attribution of negative stereotypes, as well as endorsements of prejudice and intended discriminatory behavior toward negatively labeled persons (DeLuca et al., 2018). The label “sex offender” appears to be particularly associated with stigma and routinely conjures up feelings of anger, disgust, and fear. There are several other negatively charged words frequently used in society to describe a person who engages in sexual activity with a minor. These labels perpetuate the marginalization of perpetrators of child sexual abuse.

Society endorses a host of negative stereotypes and myths about perpetrators of sexual abuse. There is a belief that *all perpetrators of child sexual abuse are dangerous and are pedophiles*. In reality, only a small group of PCSA known as sexually violent predators (SVP) are considered “dangerous.” SVPs are housed indefinitely at a psychiatric hospital. When a layperson thinks of a sex offender, they often view that offender with the same lens associated with a pedophile. In reality, pedophiles make up a small subset of PCSA who are exclusively attracted to children—which is far from the majority. The most common PCSA is opportunistic, has one victim and is known to the victim.

Another stereotype includes the belief that *most perpetrators of child sexual abuse are strangers*. There is often an image associated with this idea of “stranger danger” and it usually includes some version of an older disheveled man wearing a trench coat in the alley or a man driving around a van handing out candy. The truth is that acquaintances, including family members, extended family members, neighbors, friends, or those in positions of care of children, have been found to account for around 75–84% of child sexual abuse (Sanghara & Wilson, 2006).

Additionally, there is the myth that *all perpetrators are unmarried and sexually frustrated men* who turn to children because they are unable to achieve intimacy with adults. However, research has shown that an equal numbers of PCSA were married as those who were not, and the sexual encounters with children co-existed with sexual encounters with adults rather than occurring as a substitute for them (Sanghara & Wilson, 2006).

Lastly, there is the myth that *perpetrators are untreatable and have high rates of recidivism*. In reality, research supports that sexual offender treatment can be effective. The effectiveness of treatment depends on a number of factors, including the type of offender, the type of treatment and how much management, supervision and support the offender has. Most offenders can and will lead productive and offense-free lives after treatment. Additionally, numerous studies reveal that sex offender recidivism rates are quite low, especially sexual recidivism. In fact, their general recidivism rates are much lower than that of general criminals. Literature suggests that

most perpetrators of sexual abuse are considered “situational offenders,” which refers to opportunists who engage in sexual offending under a certain set of circumstances. This includes adults who turn to children as sexual substitutes under various stressful conditions and adults who are relatively normal in other behavioral areas but may be socially inadequate. Such offenders usually do not have a genuine interest in children but may sexually offend for a number of complex reasons. This offending is often impulsive and opportunistic as compared to a “preferential offender” who have a particular sexual preference for children and may be identified as a pedophile (Davis, 2013).

#### Slide 16: Sociocultural and Sociopolitical Considerations

Another sociocultural/sociopolitical consideration to working with PCSA is this notion of punishment vs treatment. Treatment for perpetrators of child sexual abuse is often viewed as controversial. Many people have negative feelings towards PCSA and believe they are criminals needing punishment and should be locked away, warehoused, or exiled instead of receive treatment. Sex offender treatment programs have characteristics and values that are implicitly or explicitly similar to those of punishment than traditional treatment in mental health. Historically, perpetrators of sexual abuse are managed through the use of restrictions, external controls, and punitive sanctions.

When PCSA complete their prison sentences and are released they are left to navigate a society that marginalizes them. They are faced with numerous obstacles that continue to have negative consequences on their quality of life including sex offender registration and notification, condition of release, residency restrictions, employment challenges, GPS electronic monitoring, polygraph exams, and mandated sex offender treatment. Although treatment at face value does not appear punitive, it can be when treatment is framed as a requirement to avoid repercussions of returning to prison. Additionally, while understandable that sex offender treatment’s primary directive is risk mitigation, it typically operates using a confrontational style with a focus on what the client should not do (including things and places to avoid) rather than facilitating growth and a better life.

Much of the punishments we inflict on perpetrators of sexual abuse is due to the widely held belief that they are more likely to re-offend than the perpetrators of other classes of crimes, although the research continues to show that perpetrators of sexual abuse have a low recidivism rate, even lower than that for the general criminal population. For more than two decades, research has strongly indicated that punishment-and-sanctions-based approaches are not effective in reducing recidivism (Bonta & Andrews, 2017; Latessa et al., 2014). Punitive barriers such as limited jobs, housing restrictions and sex offender registration raise significant risk factors for recidivism. These barriers often negate the efforts of those who work with perpetrators and those perpetrators who desire to recover and return as productive members of society. Casting them off and marginalizing them after they have returned to the community, regardless of the nature of their crimes, is not just cruel, it does not make society any safer. It is possible that removing support networks, making it more difficult to solicit help, limiting what they can do to earn a living and even limiting where they can live makes recidivism more likely, not less. Research indicates that if we want to discourage perpetrators from reoffending, we need to encourage positive support systems, employment, and property ownership (Schwartz, 2011).

Mental health professionals who treat people who commit sexual offenses face a variety of difficulties. It is mandated that perpetrators of sexual abuse receive treatment, meaning that more perpetrators of sexual abuse are receiving treatment in community agencies and other outpatient facilities. It is also likely that many mental health professionals will work with perpetrators of sexual abuse without being aware. Given the underreporting of sexual crimes, it is not unthinkable that a client may be in therapy for an unrelated reason who eventually discloses that they have sexually offended. Therefore, it is imperative that mental health professionals receive specialized training to provide treatment to PCSA. However, education and training programs do not prepare mental health professionals to work with PCSA.

The primary goal of traditional mental health treatment is generally to reduce suffering by the client and almost always promotes the best interests of the patient; however, in the instance of sex offender treatment there is priority of public safety over the interests of the client (Mela & Ahmed, 2014). It may seem challenging for mental health professionals to provide treatment to PCSA that respects an offender's autonomy, and at the same time protects the public. Additionally, mental health professionals that provide treatment to PCSA are not immune from their own biases. It is imperative that mental health professionals explore their own biases about working with this population. The approach to treatment will be negatively affected should MHPs hold on to the same misconceptions and biases that are so prevalent in society.

Mental health professionals that provide treatment to PCSA are also susceptible to negative opinions and treatment by the public and other mental health professionals. Researchers stated that therapists treating offenders may experience ostracism or criticism from members of their community. They may also experience some degree of disapproval from other mental health professionals, especially those promoting victim treatment. Some MHPs even view those that work with perpetrators as "offender defenders," even if most MHPs that work with perpetrators have treated, and continue to treat, victims of sexual and other abuse.

#### Slide 17: Current Therapy Treatments for PCSA

Now I want to briefly discuss the current therapy treatment for perpetrators of child sexual abuse. **Relapse prevention (RP)** is almost universally used in one form or another in sex offender treatment. It was originally developed as a treatment for alcoholism. This approach stresses how to avoid staying out of high-risk situations. RP is aimed at helping individuals to improve their management of situations in which they are at increased risk of sexual offending. RP work is based on the notion that the identification of the thoughts and actions that lead from a lapse to a relapse helps an individual intervene before a relapse occurs. It teaches perpetrators of sexual abuse new, more effective specific strategies to cope with identified future risks (Serran et al., 2007). Present day RP is commonly integrated with other treatment modalities.

Another treatment is the **Risk-Need-Responsivity (RNR)** model which outlines the basic principles of risk, need, and responsivity to generate effective interventions for perpetrators of child sexual abuse with the goal to reduce recidivism. *The Risk principle* has two important components: (a) use of a reliable and validated risk assessment to predict criminal behavior and (b) appropriately matching level of service to the assessed level of risk. In other words, perpetrators of sexual abuse differ in their risk for recidivism, therefore different kinds of interventions are appropriate. When the risk is low, complex interventions may not be necessary

and for high-risk offenders, intensive interventions are likely necessary for change. *The Need principle* suggests that every perpetrator of sexual abuse naturally has their own set of dynamic risk factors or criminogenic needs, therefore, treatment programs should focus on criminogenic needs, or those factors directly relating to offending behavior that are amenable to change for that individual. Criminogenic risk factors such as pro-criminal associates, anti-social attitudes, substance abuse, limited work opportunities, and dysfunctional relationships have all been associated with reoffending and are the most frequently targeted risk factors (Andrews & Bonta, 2010b). *The Responsivity principle* provides guidance on how to maximize the offender's ability to learn from a rehabilitative intervention by providing cognitive behavioral treatment and tailoring the intervention to the learning style, motivation, abilities, and strengths of the offender (Andrews & Bonta, 2007).

#### Slide 18: Current Therapy Treatments for PCSA

Most of us are probably familiar with Cognitive-Behavioral Therapy (CBT). CBT has dominated treatment programs for PCSA and is considered an evidence-based therapy for perpetrators of sexual abuse. Treatment programs adopting a cognitive-behavioral approach were deemed most effective in reducing both general and sexual recidivism (Serran et al., 2007). CBT is based on the premise that cognition, affect, and behavior are closely linked, with each influencing the other. It is often implemented within the framework of relapse prevention and can include elements of motivational interviewing. The focus of treatment is on altering patterns of behavioral, cognitive, and affective responding associated with sexual offending, such that problematic, deviant, and/or criminal behavioral patterns and responses are replaced with adaptive, non-deviant, pro-social responding. CBT addresses cognitive distortions including denial or minimization of guilt, problematic sexual interests, harm to victims, responsibility for the offenses, and need for treatment. Many sex offender treatment programs that utilize CBT focus more on cognitive interventions with very little implementation of behavioral interventions.

The Self-Regulation Model (SRM) of sexual offending is an alternative approach to the traditional relapse prevention model and based off the self-regulation theory that is specific to the sexual offending process (Yates et al., 2010). The self-regulation model is a nine-stage process of offending that addresses both the individual's goals with respect to the offending behavior (approach versus avoidance) and the manner in which the individual attempts to achieve these goals (passive versus active), resulting in four hypothesized pathways that lead to sexual offending. The SRM describes the offense progression or the chain of events that occurs during a specific sexual offense or series of offenses, in order to identify the cognitive, behavioral, emotional, and situational factors that culminate in offending (Yates et al., 2010). In brief, the SRM contains four pathways, representing different combinations of offence-related goals (i.e., is the aim to approach or avoid the sexual offense), and the use of distinct self-regulation styles in relation to sexually offensive contact (under-regulation, misregulation and effective regulation). The major clinical implication of this research has been a call to move away from a one-size-fits-all approach to an appreciation of the need to adopt interventions to match offenders' individual constellations of vulnerability factors (Ward, 2007).

### Slide 19: Risk Assessments

When talking about treatment, it is important to discuss risk assessments since risk assessments are an important element of sex offender treatment. Risk assessments estimate the likelihood that an offender will recidivate (Baldwin, 2017). Perpetrators of child sexual abuse encounter risk assessments frequently. Risk assessments are often used in the sentencing and adjudication process to determine appropriate levels and periods of confinement. In the case of civil commitment of the small group of PCSA that are sexually violent predators (SVP), risk assessments are used to argue for and against indefinite confinement. Risk assessments are also used to determine treatment needs, setting, and modality. There are a several type of risk assessments including those classified as: **(a) unguided (or unstructured) clinical judgment** that includes using personal experience to arrive at a risk estimate, **(b) guided (or structured) clinical judgment** that includes drawing from both personal experience and theory to estimate risk, **(c) research-guided clinical judgment** that includes a list of factors identified in professional literature as being related to risk, **(d), pure actuarial approach** that includes a standard of finite, weighted set of factors (generally static, or relatively unchanging and historical in nature) identified in the literature as being associated with risk, and **(e) adjusted actuarial approach** that administers an actuarial instrument and then employs a list of considerations that can be used to raise or lower the assessed risk level (Baldwin, 2017). Research has yet to identify a single “best” risk assessment instrument and is moving toward measures of risk that incorporate both static and dynamic risk factors, even though there is less agreement about dynamic factors. Static risk factors are factors that are relatively unchangeable such as age at first offense and number of previous convictions. Dynamic risk factors are more fluid and changeable such as employment status and cooperation with supervision. Most of the time, mental health professionals that work with PCSA are the administrators of these risk assessments at various intervals of treatment. As such, it is imperative that training is provided, and evaluators are frequently monitored to ensure that risk-assessment instruments and procedures including scoring are used appropriately and with integrity.

### Slide 20: The Containment Model

Several states that operate under state-specific sex offender management boards typically utilize a variation of the containment model to facilitate state approved sex offender treatment at specialized sex offender treatment centers. The containment model is a multidisciplinary approach to managing sex offenders in the community. The containment model incorporates assessment, monitoring, supervision, intervention and treatment into a comprehensive program that highlights a victim-centered, public safety model; uses multidisciplinary partnerships; external controls for sex offenders (polygraph); informs public policy; and employs quality control mechanisms (CASOMB, 2022). The collaboration that is at the center of treatment is between parole agent, treatment provider, polygraph examiner, and other relevant agencies. Regular meetings are held to discuss treatment progress, develop treatment strategies, and share resources.

Typically, PCSA are mandated by the state to complete a sex offender treatment program upon release from prison. While on parole they must attend weekly group sessions and monthly individual sessions to abide by their parole conditions. Throughout treatment, perpetrators are routinely assessed for risk using a variety of different risk assessment tools. PCSA will usually attend treatment with GPS monitors strapped to their ankles, per their condition of release. These

GPS trackers will remain strapped to their ankles until they complete their parole term. This tracking device allows parole officers the ability to monitor their movements within the community, identify risky behavior, and intervene appropriately, if necessary.

While the use of polygraph assessment is somewhat controversial, the containment model utilizes polygraph examinations to review the offender's compliance with supervision and treatment. Polygraph testing plays a role in enforcing the expectation of honesty and accountability, much like urine testing for drug offenders, and can be used as a tool to detect new offenses (Phillips, 2003). The information gathered from polygraph exams, in addition to other assessment tools, is used to develop or modify treatment and supervision in ways that are appropriate given the offender's risks and needs.

#### Slide 21: Shortcomings of Current Therapy Treatments

When evaluating current therapy treatments, the literature finds limitations and a need for improvement. Relapse Prevention (RP) has been criticized for using a "one-size-fits-all" approach without addressing multiple treatment needs. Relapse prevention also assumes that all perpetrators commit sex offenses as a maladaptive response to a negative emotional state. Essentially assumes that they are trying to avoid offending but do not have effective coping skills and interventions. The exclusive focus of avoiding relapse can produce resistance in some clients since treatment imposes a primary goal without regard for what the client finds important. RP plans emphasize things, places, and people to avoid in order to prevent relapse, but one can argue that all we have done is remove their only pathway to achieve their goal rather than providing an alternative prosocial pathway to meet their need.

Mental health professionals and researchers have challenged certain aspects of the Risk-Need-Responsivity (RNR) model by stating that concentrating on reducing dynamic risk factors (criminogenic needs) is necessary but not sufficient for effective correctional interventions. One of the major concerns is the perceived narrowness of the RNR model and its failure to adopt a more constructive or strengths-based approach to treatment. It has been argued that it is necessary to broaden the scope of correctional interventions to consider the promotion of overall quality of life.

Cognitive-behavioral therapy (CBT) for perpetrators of sexual abuse has been criticized for devaluing the human experience (i.e., emotions) and heavily relying on cognitive interventions. Because many CBT programs focus almost exclusively on cognitive interventions, they may not be suitable for clients who do not have high levels of education. Targeting cognitive distortions has historically been a common component of sex offender treatment. However, cognitive schemas represent individuals' underlying views and attitudes, while cognitive distortions are the products of these underlying schemas; therefore, treatment should focus more on identifying and altering schemas (e.g., sexual entitlement, a general view that the world is a hostile place, or the belief that children can consent to sexual activity), rather than focusing solely on cognitive distortions (Yates, 2013). Furthermore, manual-based CBT programs can become overly prescriptive and inflexible that do not allow for individual adjustments.

There are also concerns about current treatment approaches in general. These general concerns include (a) an excessive emphasis on negative issues in both the targets of treatment and the



language used by treatment providers, (b) a failure to explicitly encourage optimism in clients and encourage their belief in their capacity to change, (c) a general absence of an explicit attempt to work collaboratively with clients, and (d) few attempts to provide clients with goals that will result in them leading a more fulfilling and prosocial life (Marshall et al., 2005). Most programs outline their treatment strategies in rather negative terms. For example, the focus is often on the elimination of negative attitudes, the reduction of cognitive distortions, the extinction of deviant sexual interests, and the generation of a list of people, activities, and places to avoid. Negative labels for the components of treatment may draw us to focus on negative (or avoidance) goals. Renaming relapse prevention strategies as “self-management” or “respectful living” or renaming treatment that targets deviant sexual arousal as “healthy sexual functioning,” helps to focus on strengths and healthy goals. In addition, many mental health professionals appear to believe that it is necessary to be extremely confrontational when working with PCSA. There is evidence that confrontation reduces otherwise effective treatment with PCSA. It is suggested that a more positive approach be utilized among all aspects of treatment with PCSA to maximize treatment benefits.

#### Slide 22: Strengths-based Treatment Approaches

The premise of this training is to emphasize the utilization of strengths-based treatment when working with perpetrators of child sexual abuse. A strengths-based treatment approach requires collaboration and a trusting relationship that empowers and motivates clients to build on their existing strengths to make positive changes. Strengths-based treatment values the well-being of all human beings, including PCSA. There is a focus on human dignity and the ability to live a better life. Strengths-based sex offender treatment is not inconsistent with cognitive-behavioral therapy, risk-need-responsivity, or relapse prevention, but rather complementary. Strengths-based approaches help address both the needs of PCSA and those of the community (Ward, 2007). Mental health professionals that operate from a strengths-based treatment approach typically embody features that enhance treatment effectiveness such as: empathy, warmth, trust, respect, support, genuineness, directiveness, flexibility, emotional responsiveness, and attentiveness. They also encourage participation, are rewarding, and make use of humor in treatment. Studies have found that the therapist features that are related to significant treatment-induced changes are warmth, empathy, rewarding, and directive (Marshall, 2015).

#### Slide 23: Strengths-based Treatment Approaches

Strengths-based treatment incorporates themes of resiliency, well-being, thriving in the context of adversity, post-traumatic growth, wellness, and overall quality of life (Ward, 2007).

As mentioned previously, negative labels and treatment terminology can have detrimental affects in treatment and overall rehabilitation. Adopting more positive language in therapy can help PCSA identify their existing strengths and find ways to adapt these strengths to meet their needs more appropriately. One particularly valuable way to do this is to refrain from describing clients as “sexual offenders,” “rapists,” and “child molesters,” but rather distinguishing people from their behaviors (i.e., “person who committed a sexual offense”) to avoid shame and client’s seeing themselves as unchangeable (Fernandez, 2006).

#### Slide 24: Strengths-based Treatment Approaches

Some strengths-based topics include self-esteem, hope, guilt, empathy, coping, relationships, healthy sexuality, motivation, approach goals, knowledge, agency, autonomy, mastery, relatedness, creativity, mindfulness, and relaxation (Marshall, 2015).

Research on sex offender treatment tells us that simply targeting deviance, addressing non-criminogenic targets, only utilizing relapse prevention, and being aggressively confrontational is not effective (Marshall, 2016). The approach to treating PCSA should involve enhancing many skills, instilling prosocial attitudes, and increasing the client's sense of self-worth. The model that is most highly recognized as a strengths-based approach for perpetrators of sexual abuse is the Good Lives Model (GLM).

#### Slide 25: Good Lives Model (GLM)

The Good Lives Model (GLM) takes a positive psychology and humanistic approach to the treatment of perpetrators of child sexual abuse. It is a strengths-based rehabilitation approach that augments other treatment modalities with a focus on developing a healthy and satisfying lifestyle. GLM is based on the pursuit of better lives and the goals of treatment include the attainment of good lives, which is achieved by enhancing hope, increasing self-esteem, developing approach goals, and working collaboratively with clients. Approach goals are positive aims people strive to achieve, such as "eating healthy" rather than an avoidance goal of "not putting on weight." The GLM assists PCSA to develop and implement meaningful life plans that are incompatible with future offending. GLM does not ignore the need for community safety, but rather it helps to reduce recidivism through the means of helping clients find meaning, purpose, reason, and desire to live a prosocial life. The GLM believes that the way to reduce offending is to give individuals the necessary conditions to lead better lives (i.e., good lives) rather than simply to teach them how to minimize their chances of being incarcerated.

Treatment begins with an assessment and the development of a comprehensive case conceptualization that forms the basis of the treatment plan. A GLM treatment plan considers each person's strengths, goals, and personal circumstances, accepts the client as an autonomous individual, and respects his capacity to make certain decisions himself. A characteristic of the GLM is the ability to adapt to various cultures. The GLM can be implemented in a way that respects all individuals, in their communities, and with respect to their culture by allowing the client to identify areas of their life that is important and create a plan that honors those values. Overall, from a GLM perspective, the aim of treatment is to equip offenders with the knowledge, skills, and competencies to obtain their primary goods in socially acceptable ways and to reduce and/or manage their risk of future reoffending.

#### Slide 26: Good Lives Model (GLM)

The GLM states that human beings are goal-directed and seek certain experiences, outcomes, and states of being in their lives, which are termed primary goods. Primary goods are activities, experiences, and/or situations that are sought for their own sake and that benefit individuals and increase their sense of fulfillment and happiness (Barnao et al., 2015).

The GLM outlines areas of functioning in which people attempt to maximize satisfaction across their lifespan. The primary goods include:

- **Life:** This primary good involves healthy living and functioning. This includes basic survival needs. Common means by which people ensure living and surviving are through healthy nutrition, exercising, health care, and acquiring income for food and shelter. It is important to remember that while this good may be in the background of consciousness for mental health professionals, it is often perceived as extremely important to clients in treatment, especially those who have recently re-entered the community following incarceration. Although mental health professionals may want to stay focused on more psychologically oriented goals in treatment, it may be necessary to help clients achieve more immediate goals in order to be truly helpful to clients.
- **Knowledge:** This primary good involves a desire for information and understanding about oneself and the world. People often work to achieve this primary good through various forms of education, self-study or therapy, and other self-help activities. Knowledge is also implicated in any number of problematic behaviors. For example, some clients have noted that knowledge played a role in their viewing child sexual exploitation materials (CSEM) simply because they wanted to know what sex with children would be like. Mental health professionals using the GLM are therefore encouraged to look beyond the more traditional means by which people acquire knowledge, such as in academic settings. One way to do this is to investigate how curiosity has appeared (or not appeared) in the functioning of the client across their lifespan.
- **Excellence in Play and/or Work:** This primary good includes hobbies and recreational pursuits and/or mastery in experiences. Being good at anything involves a sense of mastery. Although it may seem obvious, human beings commonly want to be good at something, and find the process of doing something well to be intrinsically rewarding. Treatment programs and mental health professionals often focus on this primary good by promoting sports, leisure hobbies, or other activities that align with client interests and strengths. Another place to focus on is on those more subtle, day-to-day activities where clients experience even minor success (e.g., waking up on time, submitting job applications, treating others respectfully).
- **Agency:** This primary good includes autonomy, independence, and self-directedness. In one way or another, all human beings want self-directedness and desire the ability to make decisions for themselves. In practical applications, this primary good can actually be difficult for mental health professionals and clients to grasp. Clients can often view autonomy in all-or-nothing terms (e.g., having freedom as an ultimate goal). It is also common for programs to focus on this primary good in terms of how it was implicated in offending; many sex crimes have occurred because the person wanted to have their way without regard or concern for the other(s) involved. Often, mental health professionals focus less on how passing moments of personal choice and independence may manifest throughout one's day or intersect with other primary goods (e.g., maintaining personal choice and independence within relationships).
- **Inner peace:** This primary good includes freedom from emotional turmoil and stress. Everyone needs some kind of emotional regulation. Like autonomy, it can be easy to focus on how clients have met this primary good via harmful means (e.g., substance abuse, sexual assault). There has been considerable focus on importing meditation,

mindfulness, and movement therapies such as yoga as adjunctive methods for helping clients to achieve a sense of inner peace. One advantage to using these methods and focusing on inner peace more broadly is that it enables clients to develop the self-observation skills needed to address other areas of their lives. All too often, clients who have sexually abused have had histories of trauma and adversity that have led them to spend their lives focusing on their environment and scanning it for evidence of threats. By explicitly focusing on methods for achieving a sense of inner peace, mental health professionals can better prepare their clients to engage in self-regulation.

- **Friendship:** This primary good includes intimate, romantic, and family relationships. It takes some effort to establish healthy bonds with others. While treatment programs typically focus on how clients misused or otherwise violated their relationships with others through abuse it may be helpful to focus on the basics of building relationships and practicing social skills. This allows mental health professionals to utilize skills-based interventions to help build empathy, compassion, and daily interactions with others.
- **Community:** This primary good involves connection to wider social groups. Reintegrating people who have sexually abused others into the community can be challenging. Mental health professionals may supplement their role as therapist with one in case management (for example, helping to research resources within the community).
- **Spirituality:** This primary good includes a broad sense of finding meaning and purpose in life. The idea is that all humans desire to have a sense of meaning and purpose in their lives. Indeed, having a sense of meaning and purpose is among the most important aspects of the GLM. Often, this is the sense that one is part of a larger whole. For many clients, spirituality and religion are intertwined.
- **Happiness:** This primary good includes feeling good in the here and now. All human beings need to have at least some moments of happiness from time to time. Many clients can actually become highly reluctant to seek anything resembling happiness or pleasure because, that is what led them to trouble. Clients may express that experiencing happiness and pleasure could pose an unacceptably high risk to others in that any experience of pleasure may serve as a gateway to offending. Treatment therefore requires a re-assessment of what happiness and pleasure could be for these clients. Finally, it is important to remember that many clients with backgrounds of trauma and adversity can have difficulty recalling any past states of happiness or pleasure.
- **Creativity:** This primary good includes the desire to have novelty or innovation in one's life. While it is a common experience among mental health professionals that clients can be surprisingly creative in the arts, this good also captures the need for people to find their own solutions, try new things, and have fresh, different experiences. This good, along with autonomy is among the first to be severely limited when one is arrested for a sex crime.

There is evidence that the attainment of primary human goods is associated with higher levels of well-being. According to GLM, sexual offending arises as a result of an attempt to obtain these goods in an inappropriate manner, out of frustration at being unable to achieve these goods, or out of an imbalance between the goods so that some goods are prioritized over others (e.g., sexual gratification over emotional intimacy). It has been suggested that they choose inappropriate pathways (i.e., sexual offending) to achieve these goals because they do not have the skills, attitudes, and self-confidence to achieve them by prosocial pathways. Treatment,

therefore, should provide sexual offenders with the attitudes and self-confidence necessary for them to meet their needs in appropriate ways.

#### Slide 27: Good Lives Plan

Here is a template of what a good lives plan consists of. The GLM views intervention as an activity that should build capabilities, strengths, opportunities, and resources in individuals. The starting point in helping individuals to achieve their primary goods in pro-social ways is to help them understand their conceptualization of what constitutes a good life. This is achieved through asking questions about the individual's core commitments in life and their valued day-to-day activities and experiences and identifying the goals and values underlying their offending. The next stage is to collaboratively formulate a good lives plan to identify secondary goods that can satisfy their primary goods in socially acceptable ways. Individualized intervention then focuses on building internal capacity and skills and building external resources and supports to successfully implement the good lives plan and address any dynamic risk factors that might block fulfilment of the plan. The primary goods would be discussed in depth. The client has an opportunity to identify which primary goods are important to them and what specifically they value within that primary good. Then they can formulate a goal they want for that domain. Moving along the columns, the client can identify ways to achieve this goal, how they will know they are achieving this goal, signs they may not be getting what they want, and what they will do if this happens. The good lives plan can incorporate elements of SMART goals, being specific, measurable, achievable, relevant, and time bound (Yates, et al., 2010).

#### Slide 28: Flaws in Good Lives Plan

The GLM argues that there are four difficulties or problems that clients may experience in their good lives plans when they attempt to obtain primary goods. Typically, it is not the client's goals that are problematic, but rather the *secondary goods*—which are activities or strategies clients use to obtain certain primary goods. These four obstacles, known as flaws in the good lives comprise of:

- **Means Used to Obtain Goods:** This problem occurs when the individual uses inappropriate or harmful strategies to obtain a particular good or goods. For example, an individual may socialize with children in order to achieve the primary good of relatedness.
- **Lack of Scope in Good Lives Plan:** This flaw occurs when an individual's good life plan is too narrow, with important goods left out. For example, the individual may be missing the good of autonomy and, as a result, may then feel disempowered and chronically inadequate, and may offend as a result of too great a focus on one good.
- **Conflict Among Primary Goods:** This problem occurs when a conflict exists between two primary goods and/or the ways the individual goes about obtaining them. The conflict results in psychological stress, unhappiness, and the attainment of neither good. For example, an individual who strongly desires both relatedness and autonomy may attempt to gain both by attempting to control or dominate a partner. In addition to creating conflict, this approach also has the ironic effect of making it less likely that either good will be acquired. In the GLM, this approach is also referred to as a *lack of coherence* among goods sought.

- **Lack of Internal or External Capabilities:** This flaw occurs when the individual lacks the skills or opportunities to obtain certain primary goods. For example, an individual who lacks the skills needed to plan and to solve problems in life and who responds to life events impulsively, demonstrates a problem with *internal capacity*. Furthermore, because he is impulsive, he may have alienated other people and, as a result, will not have access to social relationships (a problem with *external capacity*). In addition to not getting his needs met, this situation may increase his level of frustration (Yates, et al., 2010).

#### Slide 29: Treatment Barriers and Considerations

There are several treatment barriers and factors to consider when working with perpetrators of child sexual abuse. Unlike most clients who start therapy, PCSA typically do not seek out therapy on their own. PCSA are mandated to treatment as part of their parole conditions. As a result of mandated treatment, individuals may enter treatment with resistance, lack of interest, denial of offense, and/or lack of participation. When PCSA are mandated to seek treatment, they may enter at earlier stages of change (e.g., prior to recognizing that they have a serious problem). Many times, PCSA face serious repercussions that can include being sent back to prison should they not abide by treatment. Mental health professionals working with PCSA may have to spend time addressing motivation and encouraging clients to engage in the treatment process.

Another unique challenge of sex offender treatment is confidentiality. Individuals in sex offender treatment are not afforded complete confidentiality. Along with the usual limits of confidentiality, details of therapy sessions and progress updates are frequently shared with parole officers and other members of the treatment team to maximize community safety and help address challenges. This is often a barrier in treatment since PCSA are further reluctant to be open and discuss things in treatment for fear of what might be shared with their parole agent that could ultimately result in a parole violation.

As with all therapeutic relationships, establishing and maintaining rapport is a crucial component to therapy. Research has consistently found that positive therapeutic relationships with clients improves treatment outcome. However, the barriers of mandated treatment and confidentiality make it especially challenging to establish and maintain rapport. When working with PCSA, MHPs need to be able to express genuine regard for PCSA as human beings. Mental health professionals should express a concern for their clients' wellbeing, respect their dignity and agency, and express the need to understand their life goals. Rogerian attributes of genuineness, accurate empathetic understanding, and unconditional positive regard are important attributes for mental health professionals working with PCSA. Additionally, it is important to embody therapist characteristics that have been shown to maximize alliance and treatment gains including demonstrating empathy, respect, warmth, friendliness, sincerity, genuineness, support, emotional responsiveness, flexibility, directness, confidence, and interest in the client. Being able to communicate clearly, engage in active listening, be firm but fair, reinforce and encourage clients, create opportunities for success, deal appropriately with frustration and other client difficulties, be appropriately challenging without being aggressively confrontational, and create a secure treatment atmosphere, all contribute to treatment alliance and outcome.

Mental health professionals working with PCSA may have their own biases and negative stereotypes. It is imperative that mental health professionals providing services to PCSA to

explore their own biases with this population. This may contribute to the difficulty of treating PCSA and have important implications for treatment. Naturally, many mental health professionals may struggle with feeling empathetic towards PCSA, however, it is necessary to separate the offending behavior from the individual. Additionally, mental health professionals can strategically use cognitive frames to nurture a positive view of the perpetrators they treat. Mental health professionals may find it easier to treat PCSA if they focus on their strengths and their vulnerabilities, including those life experiences in which the PCSA was also a victim. It may be helpful to view a perpetrator as someone who is “vulnerable,” “impaired,” or “human,” a person who has a family that still loves them, and as someone with struggles with problems and has the right to treatment. Furthermore, the literature suggests training and learning more about PCSA helps to decrease negative biases along with dismantle myths and stereotypes that society believes about PCSA.

Lastly, another consideration when working with PCSA is secondary traumatic stress and burnout. Mental health professionals working with perpetrators of sexual abuse have the potential to be deeply affected by the stories and the images they are exposed to during their work. Over time, repeated exposure to difficult content can have a negative impact on functioning and overall mental health. Secondary traumatic stress and vicarious trauma are frequently used interchangeably to refer to the indirect trauma that can occur when we are exposed to difficult or disturbing images and stories second-hand. Compassion fatigue is another term which is also sometimes used interchangeable with secondary traumatization. Burnout is a state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations marked by depression, cynicism, boredom, loss of compassion, and discouragement (Office for Victims of Crime, 2022).

Mental health professionals working with perpetrators of child sexual abuse may develop anxiety or changes in their mood, characterized by feelings of depression, cynicism, mistrust, hopelessness, irritability, anger, and frustration. Some mental health professionals may become affected by case information that they experience sensitization to the details of a case and encounter intrusive images and thoughts about case material. This can result in an avoidance of disturbing material in sessions. Conversely, such disturbance in emotion regulation may lead to emotional hardening or desensitization.

Many mental health professionals describe a hypervigilance regarding their own and others' behavior, particularly toward children. Mental health professionals may become more fearful and protective of their children, extremely aware of how others interact with their children, and more fearful for their children's safety. There is often a shift in worldview where the mental health professional experiences a decrease sense of trust for others and perceive the world as less safe than before.

The negative consequences of secondary trauma and/or burnout, such as anger, fear, and the experience of emotional hardening, are likely to compromise the therapist's ability to genuinely engage with clients and undermines the benefits of treatment. Self-care is necessary for mental health professionals, especially when working with PCSA. It is imperative for mental health professionals working with perpetrators of sexual abuse to take care of themselves and some ways to do so include maintaining a light and humorous work environment, having healthy

relationships, taking time to enjoy activities, and avoiding negative coping skills such as alcohol consumption, risky behaviors, or isolation. Lastly, training and education on secondary traumatic stress and burnout should be provided to individuals working with PCSA to lower the risk and become familiarized with the warning signs in order to take proper action before symptoms become severe.

### Slide 30: Case Vignette

Now I would like for us to review a case vignette together about John, a fictional perpetrator of child sexual abuse. While reading or listening to the vignette, imagine that John is your client and try to keep in mind how you could implement the Good Lives Model (GLM) with this client. Make note of any sociocultural/sociopolitical factors to consider. What are some of John's strengths, and any possible treatment goals.

*John is a 40-year-old, single, Caucasian male mandated to sex offender treatment for lewd or lascivious acts with a 14-year-old female. John is determined to make necessary changes in his life. He indicates that he is disgusted with himself for what he did, especially since his stepfather molested him on numerous occasions when he was a child. He is adamant that he does not want to ever hurt anyone again. He reports that he is feeling stressed, irritable, and lonely lately. Since his sexual offense, John lost his job, reputation, and close friends. He has always been a hard worker and misses his employment at the car dealership where he worked for over 13 years. He explains that he is having a hard time finding employment due to his sexual offense. He is worried that he will not be able to pay his rent next month. He also misses hanging out with friends every weekend to watch football. His friends stopped inviting him places and when John reaches out to them, they always say they're busy. John said on a few occasions he left angry voicemails on his friends' phones after they ignored his calls. John says he wants a romantic relationship but does not think he has anything to offer and says, "besides, nobody wants to be with a child molester." Lately, he has been thinking about going back to church and says luckily, he finally got his license, so he no longer has to take the bus to church.*

### Slide 31: Case Vignette Reflection Questions

Here are the reflection questions we can answer together about our client John from the vignette. I will give you a few minutes to write down any notes before we review the questions together.

Okay, let's review the reflection questions together.

- *What goods are important to John (primary goods)?*
  - **Life:** Basic survival needs such as finding employment; being able to pay his rent
  - **Knowledge:** he is amenable to therapy and is determined to learn more about himself and make positive changes.
  - **Excellence in Play:** He misses his hobbies such as watching football and likely could benefit from more hobbies and recreational pursuits.
  - **Excellence in Work:** John reported that he is a hard worker and lost his car dealership job he had for 13 years that he was good at. He likely felt a level mastery at his work and since losing his job he is in search of new mastery experiences.



- **Agency:** John feels the weight of parole and the control his sexual offense has in his life (e.g., employment difficulties, loss of friends, difficulties in relationships); he likely values freedom and the ability to make personal choices.
  - **Inner Peace:** John describes feeling stressed, irritable, and lonely. He also reports feeling disgusted with himself over his sex offense; he even referred to himself as a “child molester.” John disclosed being molested on numerous occasions as a child and likely has trauma as a result.
  - **Friendship:** John misses his friends and has a desire to be in a romantic relationship
  - **Community:** He desires a sense of belonging within his friend group and is interested in going back to his church community.
  - **Spirituality:** John is in the process of seeking out religion by going back to church but likely struggles to find meaning and purpose in his life after all the losses he has experienced.
  - **Happiness:** John is not currently happy and does not seem to have many things going on presently that bring him much joy or pleasure.
  - **Creativity:** John appears to be struggling with starting over; although, he was able to find solutions to taking the bus to church by obtaining his license and getting a car. It may be helpful to encourage new prosocial experiences.
- *What flaws exist in John’s good life plan that blocks his attainment to those goods? In other words, what are the problematic behaviors (the secondary goods) in which John engages in to obtain his primary goods?*
    - John’s use of negative language when describing himself (e.g., disgusting, child molester) makes it challenging for him to reach his primary good of inner peace and agency. Negative labels can be internalized, and he may begin to view himself as those negative labels.
    - John struggles with his approach to attain his primary good of friendship and is unintentionally making it harder to accomplish his goal. John misses his friends and wants to reconnect with them. He reported that he left angry voicemails on his friends’ phones on a few occasions when they did not answer. This strategy (secondary good) to obtain friendships (primary good) is preventing him from getting his need met, and likely increasing his frustration and loneliness. In other words, he is inadvertently alienating himself with his angry outbursts which moves him further away from his goal.
  - *What are some sociocultural and/or sociopolitical factors to consider?*
    - Consider how social stigma and negative stereotypes affects John now that he is reintegrated in society
    - Consider how John is adjusting to his life on parole with the use of restrictions, external controls, and punitive sanctions.
    - Consider the language you use in treatment when referring to clients and avoiding any negatively charged terminology
    - Consider how your own biases about working with PCSA can negatively affect treatment

- Consider how you can provide treatment to PCSA that respects their autonomy, and at the same time protects the public rather than only prioritizing the public
- *What strengths and positive attributes did John bring to treatment on which he could build?*
  - John demonstrates accountability for his sex offense.
  - He expresses remorse and shows empathy by relating through his own molestation.
  - John presents as motivated in treatment and expresses a desire to make positive changes in his life.
  - He is a hard worker with the ability to maintain long-term employment. He desires to be a productive member in society and is attempting to find employment.
  - He wants to feel connected and desires to gather with friends.
  - John can utilize his religion as a means of coping and as a way of connecting to a larger community.
  - John is resourceful and determined. He recently obtained his driver's license.
- *What might be part of the treatment plan or some treatment goals?*
  - Basic survival needs such as securing employment and paying rent. Assisting in finding community resources such as job fairs, resume workshops, agencies that assist in finding employment for people on parole, and government assistance for food, housing, and cash aid.
  - Ways to cope and navigate the challenges of community reintegration and sex offender regulations/restrictions (condition of release, sex offender registration, community notification, GPS monitoring, mandated treatment)
  - Identify primary goods and create approach goals such as respectful living or healthy sexual functioning
  - Create good lives plan with identified primary goods and goals
  - Self-compassion skills to help build self-esteem and use more positive language when talking about self
  - Stress management and coping skills for stress, irritability, loneliness, and the numerous obstacles of reintegrating into society
  - Communication skills to build skills that foster ways to better express self and learn to respond and not react impulsively (e.g., angry voicemails)
  - Healthy relationship skills to help build relationships and practice social skills; encourage healthy relationships
  - Explore how trauma (his own child molestation) plays a role in his current relationships with others and his ability to obtain inner peace and happiness

### Slide 32: Training of Mental Health Professionals

Research stresses the importance of mental health professionals receiving education and training to work with perpetrators of child sexual abuse. Training related to PCSA is typically limited to child abuse mandated reporter training, which does not address the need for education and training on PCSA. Educational programs in mental health are unlikely to provide education or

training on how to work with PCSA. At most, there may be an elective class offered or a topic in a forensic class that briefly discusses perpetrators of child sexual abuse.

Training can increase general knowledge base related to perpetrators, help build clinical skills in working with PCSA, overcome biases, and lessen the risk of developing vicarious trauma or burnout. Studies suggest that attitudes and stereotypes toward perpetrators of sexual abuse differ depending on the degrees of experience and specialized training. Studies found that mental health professionals' attitudes are more positive and fewer negative stereotypes are endorsed following training on sex offenders (Nelson et al., 2002).

There is a need for educational and training programs to incorporate theoretical models and treatment strategies specific to providing treatment to people who commit sexual offenses (Nelson et al., 2002). Most, if not all, training on PCSA is completed upon hire at a sex offender treatment center. Normally, state operated sex offender treatment programs are overseen by the state-specific Sex Offender Management Board. Through the management board, general training, risk assessment training, and certification in working with perpetrators of sexual abuse is provided to mental health professionals; however, this training and certification is limited to mental health professionals that work at designated sex offender treatment centers. This webinar is offered to broaden the knowledge of therapists who are providing services in a diversity of settings where they may encounter perpetrators of child sexual abuse.

#### Slide 33: Overview

As the training comes to an end, here is a summary of the main take away points from the topics covered in this training:

- Literature on PCSA is still in its infancy
- There is no “sex offender profile” or a typical sex offender
- People sexually offend for different reasons but some of the factors include learned behavior, negative or adverse conditions in early development leading to poor attachment to others, cognitive distortions to rationalize sexually abusive behavior, and problems with self-regulation and impulse control
- It is important to take note of the sociocultural/sociopolitical issues and treatment barriers and considerations when working with PCSA
- Mental health professionals need to examine their own biases about PCSA
- There is little attention to strengths-based treatment approaches in the literature
- Strengths-based treatment, such as, Good Lives Model (GLM) that focuses on building strengths, and treats offenders in a respectful, empathic, and rewarding manner is an effective treatment for PCSA
- There is a need for more training on PCSA for mental health professionals

#### Slide 34: Q&A

Now I would like to take some time to answer any questions you may have pertaining to perpetrators of child sexual abuse and the training. Again, please be mindful and use clinical judgment and discretion if sharing client-sensitive information since confidentiality cannot be provided. If I am unable to get to your question due to time or if you prefer to ask individually, I will provide my email address where you can email me after the training.

Slide 35: Resources

Here are some available resources for further information pertaining to perpetrators of child sexual abuse. These are some useful national websites and state-specific website regarding sex offender management. For more information about the Good Lives Model, there are some websites along with some books written by the pioneers of the Good Lives Model.

Slide 36: Selected ReferencesSlide 37: Selected ReferencesSlide 38: Selected ReferencesSlide 39: Thank You

That concludes our training on perpetrators of child sexual abuse. Thank you for your time and participation. If you have any additional questions or comments about today's training, please feel free to email me at [enter email address] or leave a comment on this training once it's uploaded. Thank you.

APPENDIX N

Webinar Training Slides

# Working with Perpetrators of Child Sexual Abuse

An Introductory Strengths-based Sociocultural Training for Mental Health Professionals



Angie Reyes, M.A.

## Agenda

- Introduction to Perpetrators of Child Sexual Abuse (PCSA)
  - Terminology, Statistics, Typologies, Etiology and Theories of Sexual Offending
- Impact of Child Sexual Abuse (CSA) on the Perpetrator and Sociocultural/Sociopolitical Considerations
- Current Therapy Treatments for PCSA and Shortcomings of Treatments
- Strengths-based Treatment Approach and Overview of Good Lives Model (GLM)
- Case Vignette and Reflection Questions
- Training of Mental Health Professionals and Treatment Barriers/Considerations
- Summary, Q&A, and Resources



## Learning Objectives

- Gain a better understanding of complex and dynamic issues related to perpetrators of child sexual abuse including terminology, disclosure, recidivism, typologies, origin of sexual offending, and treatment effectiveness
- Identify sociocultural and sociopolitical factors related to perpetrators of child sexual abuse
- Increase knowledge of current treatments including treatment barriers and considerations
- Develop familiarity with utilizing a strengths-based treatment approach with perpetrators of child sexual abuse
- Understand the utility of integrating the Good Lives Model (GLM) into current treatments for PCSA



## Introduction



- Child sexual abuse (CSA) is a widespread public health problem
- Perpetrators of child sexual abuse (PCSA) are among the most feared and hated in society; often the target of public rage, hostility, and ostracism
- Research on PCSA is still in its infancy
- Majority of PCSA will be released back into the community
- Treatment that builds strengths and treats PCSA in a respectful, empathic, and rewarding manner is effective in reducing sexual reoffending

## Terminology and Definitions

- Perpetrators of child sexual abuse (PCSA) are adults who engage sexually with a minor, with or without physical contact
- Neutral behavioral description instead of using labels that impose identity
- Alternative phrases include “individuals who have committed sex offenses on children” or “persons who have engaged in sexual activity with a child”
- Pedophiles are not included in this training. It refers to a narrow group of individuals diagnosed with pedophilia (presence of intense, recurring sexual urges, fantasies, or behaviors involving sexual activity with prepubescent children), and is beyond the scope of this introductory training



American Psychiatric Association. (2013)

## Incidence and Prevalence Rates

- Challenge to capture an accurate account of sexual offending when there are numerous definitions of sexual offending and most sexual offenses are not reported
- About 1 in 4 girls and 1 in 13 boys in the United States experience child sexual abuse
- Research estimates that only 10–15% of cases are reported
- Acquaintances, family members, extended family members, neighbors, friends, or those in positions of care of children, have been found to account for around 75–84% of child sexual abuse



Centers for Disease Control and Prevention (2022); Rueda, P., Ferragut, M., Cerezo, M. V., & Ortiz-Tallo, M. (2021); Sanghara, K., & Wilson, C. (2006)



## Recidivism Rates



- Recidivism refers to a person's relapse into criminal behavior
- Challenge to capture accurate recidivism rates due to different definitions, length of follow-up period, and issues related to underreporting
- Recidivism rates can also differ based on type of sexual offense and treatment provided
- *Sexual Recidivism*: only new sexual offenses; *General Recidivism*: any new offense committed;
- **Sexual Recidivism**: 7.7% during a 9-year follow-up
- **General Recidivism**: 67% during a 9-year follow up
- Most perpetrators of sexual abuse do not sexually reoffend
- Perpetrators of sexual abuse, regardless of type, are more likely to be convicted of a non-sexual offense
- Recidivism rates are based on reported sexual offenses such as arrests, convictions, or incarcerations but sexual offenses are one of the most underreported crimes.

Alper, M., & Durose, M., (2019); NJ, (2022); SMART, (2017)

## Disclosure of CSA

Factors that inhibit or delay disclosure of child sexual abuse

- Age
- Gender
- Relationship to perpetrator
- Self-blame
- Shame
- Stigma
- Severity
- Fear of being blamed or not believed
- Fear of retaliation (self, family, pet, etc.)
- Fear of negative consequences for the family (divorce, foster care, etc.)
- Families with patriarchal structures, power imbalances, rigidly fixed gender roles, dysfunctional communication, and other forms of abuse



Alaggia et al., (2019); Brennan & McElvaney, (2020); Faller, (2020); Kellogga et al., (2020)

## Perpetrator Typologies

There is no "sex offender profile" or "typical" perpetrator of child sexual abuse. PCSA can be any age, gender, education level, marital status, socioeconomic status, with or without criminal history

- Typologies are a classification system that provides information regarding patterns
  - Pedophile vs Not pedophile
  - Intrafamilial vs Extrafamilial
  - Fixed vs Regressed
    - Fixed: compulsive attraction to children; identifies with children; occurs to satisfy their needs
    - Regressed: occurs situationally out of life stressors; incest offenders



Maniglio, R. (2012); Simons, D. (2017); Terry, K., & Tallon, J. (2004)

## Characteristics of Perpetrators

- Poor social skills
- Loneliness
- Feelings of inadequacy
- Low self-esteem
- Sense of worthlessness
- Depression
- Previously frustrating adult relationships
- Passive in adult relationships
- Believe they have a mutual relationship with the victim
- Groom their victims



John Jay College, (2004); Maniglio, (2012); Pryor, (1999)

## Etiology and Theories of Sex Offending



- There is no simple answer to the question of why people engage in sexual offending behavior
- Single-factor theories and multifactor/integrated theories of sexual offending are insufficient
- Understanding the causes and origins of sexually abusive behavior is still developing
- Adverse conditions in early development leading to poor attachment
- Learned behavior
- Cognitive distortions to rationalize their sexually abusive behavior
- Problems with self-regulation and impulse control

Faupel S., Przybylski R. (2017); SMART, (2017)

## Impact of CSA on the Perpetrator

- Legal
  - Incarceration
  - Condition of release
  - Sex offender registry
  - Community notification
  - GPS monitoring
  - Mandated treatment
- Safety
  - Hostility and aggression
  - Harassment and threats
  - Physical harm



CASOMB, (2022); Mercado et al., (2008); Phillips, (2003)

## Impact of CSA on the Perpetrator



Mercado et al., (2008), Schwartz, (2011), Tewksbury, (2005)

- Employment/Financial
  - Job loss
  - Difficulties finding a job
  - Financial hardship
- Housing
  - Residency housing restrictions
  - Denied housing
  - Homelessness

## Impact of CSA on the Perpetrator

- Relationships
  - Loss of relationships (family, romantic/marriage, friends, coworkers, etc.)
  - Challenge to develop romantic relationships
- Psychological and Emotional
  - Stigmatization
  - Isolation
  - Alienation
  - Ostracization
  - Stress
  - Hopelessness
  - Embarrassment
  - Shame and guilt
  - Depression
  - Cognitive distortions
  - Risk for suicide



Harris, (2014); Levenson & Cotter, (2005); Tewksbury, (2005); Tewksbury & Lees, (2006)

## Sociocultural and Sociopolitical Considerations

- Age and Gender
  - Patriarchal system with power differential
  - Grooming
- Social Stigma and Stereotypes
  - Negative labels
  - Beliefs about Perpetrators
    - All PCSA are "dangerous pedophiles"
    - Most PCSA are strangers
    - All PCSA are unmarried and sexually frustrated men
    - PCSA are untreatable and have high rates of recidivism



Davis, (2013); DeLuca et al., (2018); Faller, (2020); Sanghara & Wilson, (2006)

## Sociocultural and Sociopolitical Considerations

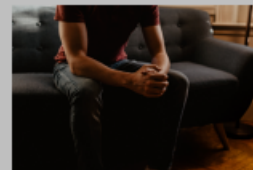
- Punishment and Treatment
  - Treatment for PCSA is often controversial; Many people believe they deserve punishment instead of treatment
  - Treatment is mandatory with repercussions of returning to prison for not cooperating
  - Reintegration is presented with "punishments" (restrictions, external controls, and punitive sanctions)
- Treatment Providers
  - Prioritize public safety over the interest of the client
  - Mental health professionals' biases towards PCSA
  - Negative opinions of mental health professionals (MHP) that work with PCSA by the public and other MHPs



Bonta & Andrews, (2017); Latessa et al., (2014); Mela & Ahmed, (2014); Schwartz, (2011)



## Current Therapy Treatments for PCSA



- Relapse Prevention (RP)
  - Identify thoughts and actions that lead to a relapse to help prevent the relapse
- Risk-Need-Responsivity (RNR)
  - *Risk*: (a) use of a reliable and validated risk assessment to predict criminal behavior and (b) appropriately matching level of service to the assessed level of risk
  - *Need*: treatment programs should focus on criminogenic needs, or those factors directly relating to offending behavior that are amenable to change
  - *Responsivity*: providing CBT and tailoring the intervention to the learning style, motivation, abilities, and strengths of the offender

Andrews & Bonta, (2007); Andrews & Bonta, (2010); Serran et al., (2007); Viglione, J. (2018)

## Current Therapy Treatments for PCSA



- Cognitive-Behavioral Therapy (CBT)
  - Altering patterns of behavioral, cognitive, and affective responding associated with sexual offending
  - Cognitive distortions including denial or minimization of guilt, problematic sexual interests, harm to victims, responsibility for the offenses, and need for treatment
- Self-Regulation Model (SRM)
  - Offense progression (chain of events) that occurs during sexual offense to identify the cognitive, behavioral, emotional, and situational factors that contributed to the sexual offense



Ly, T., Fedoroff, P., Briken, P. (2020); Ward, (2007); Yates, P. (2013); Yates, P., Prescott, D., and Ward, T. (2010)

## Risk Assessments

- Estimate the likelihood that an offender will recidivate
- Sentencing and criminal adjudications (appropriate levels and periods of confinement and/or community supervision)
- Civil commitment proceedings (argue for and against indefinite confinement)
- Determine treatment needs, settings, and modalities
- Shift to using measures of risk that incorporate both static and dynamic risk factors
- "Static" risk factors (e.g., age at first offense, number of previous convictions)
- There is less agreement at present regarding more fluid, changeable risk factors referred to as "dynamic" risk factors (e.g., employment status, cooperation with supervision)
- Training and monitoring of evaluators to ensure that risk-assessment procedures and instruments are always used appropriately and with integrity



Baldwin, K. (2017); Doren, D.M. (2002); Hanson, R.K. (2009)

## The Containment Model

- Victim-centered with an emphasis on public safety
- Collaboration between parole agent, treatment provider, polygraph examiner, and other relevant agencies
- Global Positioning Satellite Systems (GPS) monitoring
- The model incorporates assessment, monitoring, supervision, intervention, and treatment into a comprehensive program



CASOMB, (2022); Phillips, C. (2003)

# Shortcomings of Current Therapy Treatments



- Exclusive focus on avoiding relapse including people, places, and activities to be avoided
- Reducing dynamic risk factors (criminogenic needs) is necessary but not sufficient
- CBT almost exclusively focuses on cognitive interventions, specifically cognitive distortions
- Emphasis on negative issues including the language used by treatment providers
- Fails to encourage optimism and encourage their belief in their capacity to change
- Few attempts to provide clients with goals that will result in them leading a more fulfilling and prosocial life

Marshall et al., (2005); Yates, (2013)

# Strengths-based Treatment Approach

Collaboration and trusting relationship that empowers and motivates to build on strengths to make positive changes

## Therapist Qualities

- Empathy
- Warmth
- Trust
- Respect
- Support
- Genuineness
- Directiveness
- Flexibility
- Emotional Responsiveness
- Attentiveness



Marshall, (2015); Ward, (2007)



## Strengths-based Treatment Approach

### Themes



- Resiliency
- Well-being
- Thriving in the context of adversity
- Post-traumatic growth
- Wellness
- Quality of life



Fernandez, (2008); Ward, (2007)

## Strengths-based Treatment Approach

### Topics



- Self-esteem
- Hope
- Empathy
- Coping
- Relationships
- Healthy sexuality
- Motivation
- Approach goals
- Agency
- Autonomy
- Mastery
- Creativity
- Mindfulness

Marshall, (2015); Marshall, (2016)

## Good Lives Model (GLM)

- A positive, strengths-based, humanistic approach
- Adjunct to current therapy treatments (risk management model)
- The goals of treatment are on the attainment of good lives, which is achieved by enhancing hope, increasing self-esteem, developing approach goals, and working collaboratively with the offenders
- Focuses on “approach goals” to help client approach situations and life conditions that bring satisfaction and meet goals and needs
- Customizable to respect all individuals and their cultures
- Treatment begins with an assessment and the development of a comprehensive case conceptualization
- Treatment plan considers each person’s strengths, goals, and personal circumstances, accepts the client as an autonomous individual, and respects his capacity to make certain decisions himself
- The aim of treatment is to equip offenders with the knowledge, skills, and competencies to obtain their primary goods in socially acceptable ways and to reduce and/or manage their risk of future reoffending



Barnao, M., Ward, T., & Robertson, P. (2016); Yates, P., Prescott, D., and Ward, T. (2010)

## Good Lives Model (GLM)

- Human beings are goal-directed and seek “primary goods.” Primary goods are activities, experiences, and/or situations that benefit individuals and increase their sense of fulfilment and happiness
- Areas of functioning in attempt to maximize satisfaction across lifespan
  - **Life:** healthy living and functioning
  - **Knowledge:** desire for information and understanding about oneself and the world
  - **Excellence in play:** hobbies/recreational pursuits
  - **Excellence in work:** mastery experiences
  - **Agency:** autonomy, independence, and self-directedness
  - **Inner peace:** freedom from emotional turmoil and stress
  - **Friendship:** intimate, romantic, and family relationships
  - **Community:** connection to wider social groups
  - **Spirituality:** finding meaning and purpose in life
  - **Happiness:** feeling good in the here and now
  - **Creativity:** desire to have novelty or innovation in one’s life



Barnao, M., Ward, T., & Robertson, P. (2015); Purvis, M. (2010); Yates, P., Prescott, D., and Ward, T. (2010)

## Good Lives Plan

Primary Goods	What I Want (Goal)	Ways to Achieve This Goal	How I know I Am Achieving My Goals	Signs I May Not Be Getting What I Want	What I Will Do
Life					
Knowledge					
Excellence in Play					
Excellence in work					
Agency					
Inner peace					
Friendship					
Community					
Spirituality					
Happiness					
Creativity					

Yates, P., Prescott, D., and Ward, T. (2010)

## Flaws in Good Lives Plan



- **Means Used to Obtain Goods:** When individuals use inappropriate or harmful strategies to obtain a particular good
- **Lack of Scope in Good Lives Plan:** When an individual's good lives plan is too narrow, with important goods left out
- **Conflict Among Primary Goods:** When a conflict exists between two primary goods and/or the ways the individual goes about obtaining them
- **Lack of Internal or External Capabilities:** When the individual lacks the skills or opportunities to obtain certain primary goods

Yates, P., Prescott, D., and Ward, T. (2010)

## Treatment Barriers and Considerations

- Mandated Treatment and Confidentiality
  - PCSA may enter treatment with resistance, lack of interest, denial of offense, and/or lack of participation
- Establishing and Maintaining Rapport
  - Express concern for the offender's wellbeing, respect the dignity and agency of the offender, and express the need to understand the life goals of the offender
- Mental Health Professional Biases
  - Implications for service delivery, including impact on quality of care, choice of intervention, and quality of the therapeutic relationship
- Secondary/Vicarious Trauma and Burnout
  - Negative impact on functioning and overall mental health
  - Compromises therapist's ability to genuinely engage clients and undermines the benefits of treatment



Moulden, H. M., & Firestone, P. (2010); Nelson, M., Herlihy, B., & Oescher, J. (2002); Ward, T. (2007)

## Case Vignette

John is a 40-year-old, single, Caucasian male mandated to sex offender treatment for lewd or lascivious acts with a 14-year-old female. John is determined to make necessary changes in his life. He indicates that he is disgusted with himself for what he did, especially since his stepfather molested him on numerous occasions when he was a child. He is adamant that he does not want to ever hurt anyone again. He reports that he is feeling stressed, irritable, and lonely lately. Since his sexual offense, John lost his job, reputation, and close friends. He has always been a hard worker and misses his employment at the car dealership where he worked for over 13 years. He explains that he is having a hard time finding employment due to his sexual offense. He is worried that he will not be able to pay his rent next month. He also misses hanging out with friends every weekend to watch football. His friends stopped inviting him places and when John reaches out to them, they always say they're busy. John said on a few occasions he left angry voicemails on his friends' phones after they ignored his calls. John says he wants a romantic relationship but does not think he has anything to offer and says, "besides, nobody wants to be with a child molester." Lately, he has been thinking about going back to church and says luckily, he finally got his license, so he no longer has to take the bus to church.

## Case Vignette Reflection Questions

- What goods are important to John (primary goods)?
- What flaws exist in John's good life plan that blocks his attainment to those goods? In other words, what are the problematic behaviors (the secondary goods) in which John engages in to obtain his primary goods?
- What are some sociocultural and/or sociopolitical factors to consider?
- What strengths and positive attributes did John bring to treatment on which he could build?
- What might be part of the treatment plan or some treatment goals?

## Training of Mental Health Professionals

- Child Abuse Mandated Reporter Training
- Perpetrator of Child Sexual Abuse Training
  - Education and training programs have given little attention to preparing MHPs to provide services to PCSA
  - Elective course or topic in a forensic class
  - Training and certification in sex offender treatment is provided upon hire at a Sex Offender Treatment Center (overseen by state specific Sex Offender Management Board)



Mela M., & Ahmed A.G., (2014); Nelson et al., (2002)



## Overview

- Literature on PCSA is still in its infancy
- There is no “sex offender profile” or a typical sex offender
- People sexually offend for different reasons but some of the factors include learned behavior, negative or adverse conditions in early development leading to poor attachment to others, cognitive distortions to rationalize sexually abusive behavior, and problems with self-regulation and impulse control
- It is important to take note of the sociocultural/sociopolitical issues and overall treatment barriers and considerations when working with PCSA
- Mental health professionals need to examine their own biases about PCSA
- There is little attention to strengths-based treatment approaches in the literature
- Strengths-based treatment, such as, Good Lives Model (GLM) that focuses on building strengths, and treats offenders in a respectful, empathic, and rewarding manner is an effective treatment for PCSA
- There is a need for more training on PCSA for mental health professionals

Faupel, S. Przybylski, R. (2017); Marshall, W., Marshall, L., (2014); Przybylski, R. (2017)



## Q&A



## Resources

- Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART)
  - <https://smart.ojp.gov/>
- The United States Department of Justice Dru Sjodin National Sex Offender Public Website (NSOPW)
  - <https://www.nsopw.gov/>
- Association for the Treatment of Sexual Abusers (ATSA)
  - <https://www.atsa.com/>
- California Sex Offender Management Board (CASOMB)
  - <https://casomb.org/>
- Safer Society Press
  - <https://safer.society.press.org/the-good-lives-model/>
- Good Lives Model
  - <https://www.goodlivesmodel.com/>



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Thank You!