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Factors That May Predict a Counselor's Willingness Towards Working with Sex Offenders

Shirin Khosravi
Joy Teles Oliveira
LaVelle Hendricks
Dimitra Smith
and
Zaidy MohdZain

Counseling Department
Texas A&M University-Commerce
Commerce, TX.
United State

Abstract

The purpose of this study was to determine which factors contribute to counseling students' willingness towards working with persons who have committed sexual offenses. Using an online survey consisting of demographic questions, Attitudes Towards Sexual Offenders (ATTSO) scale, and Competency Assessment Inventory (CAI) scale. The research covered in this study addressed the following research question: Is there a specific combination of factors that predict counseling students' future willingness towards working with clients who have committed sexual offenses? Results from this study show that counselors who are willing to counsel sexual offenders find that treatment is effective.

Keywords: counseling, counseling practice, sexual offenders, correlational design

Introduction

The seriousness of the situation for survivors of sexual abuse has being more often come to light after being ignored by the majority of the mainstream population for years (Stemple & Meyer, 2014). As more attention has been place into sexual abuse and how society can respond to it, sexual abuse offenders have often found difficulties into getting specialized help from counselors (Fedoroff & Moran, 1997; Levenson et al., 2017; Piché, et al., 2016). Sexual offenders often struggle with finding a job, securing affordable housing, and maintaining themselves financially (Durling, 2006). Additionally, because of the stigma that behavioral and mental health disorders carry with them, sexual offenders often avoid seeking out professional help (Levenson et al., 2017). Myths and misconceptions about the people who commit sexual crimes continue to be a problem not only with the public, but also with counselors as well (Fedoroff & Moran, 1997).

Much research has been done on the perceptions that counselors have on sexual offenders (Carone & LaFleur, 2000; Cartwright, et al., 2018; Dreier & Wright, 2011; Fedoroff & Moran, 1997; Hanson & Bussière, 1998; Nelson et al., 2002; Polson & McCullom, 1995; Rudisill, 1997; Scaletta, 1995). However, little is known about what factors

contribute to future counselors' willingness of working with persons who have committed sexual offenses. For that reason, the purpose of this study was to determine which factors and/or personal characteristics, if any, contribute to counseling students' future willingness of working with persons who have committed sexual offenses.

Sexual Offenders

Society's views towards sexual offenders have often been one of punishment and not rehabilitation (Thomas et al., 2015). Historically, society has looked upon sexual offenders as hopeless and inexcusable lawbreakers (Garland et al., 2016; Quinn et al., 2004). It is estimated that less than 15% of convicted sex offenders will be rearrested within the first year of their release due to a new sex crime (Bureau of Justice Statistics, 2003; Hanson & Bussière, 1998; Hanson & Morton-Bouurgon, 2005; Levenson, et al., 2010), and one fourth will recidivate within the next 15 years (Harris & Hason, 2004; Levenson, et al., 2010). When released from the incarceration system, convicted sex offenders go through challenges of a more restricted world, which dictates where they can live, work, and eat (Thomas et al., 2015).

Upon being placed in the sex offender registry, individuals automatically have their names, addresses and pictures placed on a public website. The sex offender registry was put in place as an attempt to keep the community safe. However, these registries also in many ways put those whose name appear on it and their families in danger (Markman, 2008; Salerno et al., 2010). Out of all the participants of the study by Levenson and Tewksbury (2009), 44% reported being threatened or harassed by neighbors, 7% injured or psychically harmed, 27% reported property damage, and 30% reported someone they lived with being injured, harassed, or threatened because a registered sex offender lived in their home. These negative views that people have towards a person who is listed on sexual offender registries or who has ever been arrested for sexual misconduct prevent them from living fulfilling lives (Charles, 2010; Markman, 2008)

Consequently, stressors faced by sexual offenders can have a direct impact on their mental health (Thomas et al., 2015), and the consequences around the abuse, the disclosure, and the treatment that the offender goes through has a huge impact on their family dynamics (Chamarette et al., 2008). Charles (2010) found that sexual offenders needed more family involvement in order to see a successful future. Additional literature also points out that those who have had strong family support, both in and after prison, are more likely to succeed in society and less likely to sexually abuse again (Thomas et al., 2015). This is especially true for those who have a place to call home after they are released from prison (Harris & Hason, 2004; Levenson et al., 2010; Connor and Tewksbury, 2012).

The effects on a sex offenders' growth after incarceration depended on whether their families were a positive, negative or any influence in their lives (Connor & Tewksbury, 2012). Sex offenders that had positive expectations from their families, believed that they would treat them as a person and not a sex offender, and that no matter the roadblocks and challenges ahead, their family would help provide for them and give them a job, a home, and a safe place (Connor & Tewksbury, 2012). On the other hand, negative expectations were also considered, and often came from the negative experiences that they had with their families. Those negative expectations included the believed that although there were family members who would look past their crime, certain family members might never be able to see past it and would not forgive them due to the sexual nature of their crime (Connor & Tewksbury, 2012), evidencing the impact that family dynamics has on the mental health of this population. Further, family dynamics and social communication are big factors in causes for children to become sex offenders, as family backgrounds and familial interactions could prove detrimental to children, causing them to become sex offenders (Baker et al., 2003). Additionally, family can also impact offenders' future behaviors, as adolescents who are exposed to domestic violence are at a higher risk of recidivism (Latzman et al., 2011), reinforcing the importance of including family members in treatment.

Working with Sexual Offenders

Providing care for those who have committed a sexual crime can influence their future in a positive manner (Charles, 2010; Latzman et al., 2011). Providers who work with this specific population have reported both positive and negative aspects of their work (Cartwright et al., 2018). How sex offenders are treated when receiving help can significantly impact their functioning, and may also influence their future behaviors, including the possibility of recidivism (Levenson et al., 2010). Counselors can more frequently be the first in line in providing care that will help sex offenders from recidivism and reducing the potential of creating more victims (Hanson & Bussière, 1998; Dreier & Wright, 2011).

Within factors around working with sexual offenders, it has been reported that counselors who have experience with sex abuse, either personally or because of a family member, report having fewer negative perceptions of sex offenders (Farrenkopf, 1992; Harnett, 1997; Nelson et al., 2002). Other characteristics such as being a parent, their gender, and their culture may also be a factor in a counselor's perceptions (Carone & LeFleur, 2000; Polson & McCullom, 1995; Nelson et al., 2002). Within counselor's demographic factors, when working with sex offenders, male counselors had increased guilt, and female counselors have reported increased vulnerability, hypervigilance regarding the safety their safety and their families, and increased paranoia (Farrenkopf, 1992; Nelson, et al., 2002). On the other hand, predictive factors demonstrated that counselors who had a background of training, personal experiences, and specific victim statuses, often had a more positive attitude towards sex offenders. This factor might seem counterintuitive, specifically within personal experiences, but counselors who had that experience may also have a better understanding of the different personality characteristics that sex offenders may have (Nelson, et al., 2002).

Although counselors have reported that they have positive aspects form their work in the field of providing care for sex offenders, they could experience burnout if they do not address the negative ones (Dreier & Wright, 2011; Scheela, 2001). The disadvantages to working with sex offenders can be taxing on a counselor specially one that does not engage in the appropriate amount of self-care that is needed, as this particular type of therapy requires a counselor to listen to traumatic events as well as graphic material all the while remaining impartial and empathic towards the client (Cartwright et al., 2018; Dreier & Wright, 2011; Moulden & Firestone, 2007; Moulden & Firestone, 2010). Keeping in mind that treatment can be the first line in defense against sexual crimes and recidivism (Charles, 2010; Nelson et al., 2002). Burnout could cause a client to withdraw from friends and family so as to not to project any traumatic material on to them, experience secondary trauma, and increased hypervigilance (Dreier & Wright, 2011). An additional disadvantage of working with sex offenders includes society's scrutiny of sex offenders. Many people may not understand how those in the mental health field could want or would be willing to work with sex offenders (Dreier & Wright, 2011). In fact, many may think that this type of therapy with this population could be a lost cause (Dreier & Wright, 2011). This causes difficulties in the personal lives of counselors who counsel sex offenders (Nelson et al., 2002).

Most importantly, counselors have reported that they have a sense of pride while working with sex offenders because they believe that their work can help the community be safe (Scheela, 2001; Dreier & Wright, 2011). In fact, many counselors have reported that they have felt not only professional satisfaction, but satisfaction in their personal lives as well (Cartwright et al., 2018; Dreier & Wright, 2011). They have reported that not only do they get gratification from seeing their clients grow, but they noticed that they are closer to their colleagues and supervisors due to the consultations and support they provide (Dreier & Wright, 2011; Scheela, 2001).

Within those factors in mind, the purpose of this study was to determine which factors and/or personal characteristics, if any, contribute to counseling students' future willingness of working with persons who have committed sexual offenses. The corresponding hypotheses were: $H1_o$ = There is statistically nonsignificant association apparent between predictor variables of interest (sex offenders scale, attitudes towards sex offenders survey, the competency assessment instrument, and demographic questions) and the binary criterion. $H1_1$ = There is statistically significant association apparent between predictors variables of interest (sex offenders scale, attitudes towards sex offenders survey, the competency assessment instrument, and demographic questions) and the binary criterion.

Methodology

Participants and Sample

The type of sampling that was used in this quantitative research was a non-probability sample of convenience. The desire sample size was 120 participants (Field, 2013). In the 7 months of data collection, a total of 142 surveys had been submitted. However, responses from 67 participants (47.18%) were not included in the data analyses for various reasons. In any case, this number follows the requirements of 10 participants per factor used to determine significance in a counselor's willingness (Field, 2013). Consequently, the sample population in this study was 75 (n=75) master's level counseling students who were currently towards the end of their education and enrolled either in practicum or internship classes. Of the sample of participants 88% (n = 66) were women and 12% (n = 9) were men. Of the sample of participants, 62.67% (n = 47) were between the ages of 21-29, 17.33% (n = 13) were between

the ages of 30-31, 9.33% (n = 7) were between the ages of 40-49, 4.00% (n = 3) were between the ages of 50-59, 4.00% (n = 3) were between the ages of 60-69, and 2.67% (n = 2) did not respond. Participants were asked to identify their sexual orientation, 81.3% (n = 61) of participants identified as heterosexual; 6.7% (n = 5) of participants identified as bisexual; 1.3% (n = 1) participant identified as lesbian; 3 (4.0%) participants identified as queer; 3 (4.0%) participants identified as questioning; 1 (1.3%) identified as other sexual orientation not listed above; and 1 (1.3%) participant chose not to answer. Table 1 demonstrations the frequency and percentages of the demographics listed above.

Within race and ethnicity, 69.3% (n =52) participants identified as white; 8% (n = 5) identified as Black/African American; 1.3% (n = 1); identified as American Indian/Aleut; 2.7% (n = 2) identified as Asian/Native Hawaiian or Pacific Islander; 2.7% (n = 2) identified as biracial, 1.3% (n = 1) identified as Middle Eastern/North African; 12.0% (n = 9) identified as Hispanic/Latino/Latina, and 2.7% (n = 2) identified as being Multiracial/Multiple Heritage. Participants were also asked to identify their religion, 56.0% (n = 42) participants identified as Christian; 1.3% (n = 1) identified as Jewish, 6.7% (n = 5) identified as Roman Catholic, 4.0% (n = 3) identified as Latter Day Saints or Mormon, 2.7% (n = 2) identified as Buddhist;, 1.3% (n = 1) identified as Hindu, 10.7 % (n = 8) identified as Agnostic, 4.0% (n = 3) identified as Atheist; 9 (12.0%) identified as Spiritual, but not committed to a specific faith; and 1 (1.3%) identified as other religion or spirituality not listed above. Table 2 demonstrations the frequency and percentages of the demographics listed above. Table 2 demonstrations the frequency and percentages of the demographics listed above.

Table 1

Gender, Age, and Sexual Orientation

Demographic Variables	Frequency (*n*)	Percent
Gender		
Male	9	12%
Female	66	88%
Age		
20-29	47	62.67%
30-39	13	17.33%
40-49	7	9.33%
50-59	3	4.00%
60-69	3	4.00%
No response	2	2.67%
Sexual Orientation		
Heterosexual	61	81.3%
Bisexual	5	6.7%
Lesbian	1	1.3%
Queer	3	4.0%
Questioning	3	4.0%
Other sexual orientation not listed above	1	1.3%

Table 2

Ethnicity/Race and Religion

Demographic Variables	Frequency (*n*)	Percent
Ethnicity/Race		
White	52	69.3%
Black or African American	6	8.0%
American Indian or Aleut	1	1.3%
Asian/Native Hawaiian/Pacific Islander	2	2.7%
Biracial	2	2.7%
Middle Eastern or North African	1	1.3%
Hispanic/Latino/Latina	9	12.0%
Multiple Heritage/Multiracial	2	2.7%

Religion		
Christian	42	56.0%
Jewish	1	1.3%
Roman Catholic	5	6.7%
Latter Day Saints or Mormon	3	4.0%
Buddhist	2	2.7%
Hindu	1	1.3%
Agnostic	8	10.7%
Atheist	3	4.0%
Spiritual, but not to specific faith	9	12.0%
Other religion or spiritual not listed	1	1.3%

Research Design

This research study was part of a dissertation completed by the first author. This study consists of a quantitative, correlational design. A structured survey questionnaire was created in Qualtrics. The survey questionnaire comprised of the demographic questions, the Attitudes Towards the Treatment of Sex Offenders survey (ATTSO) Scale (Wnuk et al., 2006) and the Competency Assessment Instrument CAI (Chinman et al., 2003). Each question on the survey provided an analysis from the predicators in this study for the quantitative outcome of (a) likely to work with sex offenders or, (b) not likely to work with sex offenders. A binary logistical regression analysis was utilized for data analysis.

Instruments

Attitudes toward the Treatment of Sex Offenders Scale

The ATTSO scale was developed by Wnuk et al. (2006) as a way to measure people's attitudes toward the treatment of sex offenders. Originally a 35-item instrument, it was refined into a 15-item scale with more suitable psychometric items (Church et al., 2008; Wnuk et al., 2006). A 5-point Likert-type rating scale (1-strongly disagree to 5-strongly agree) is used in the ATTSO scale. The three subscales in the ATTSO are as follows: (a) treatment ineffectiveness, (b) mandated treatment, and (c) incapacitation. One hundred seventy eight undergraduate students provided a Cronbach's coefficient alpha for the 15 items retained in the final factor solution and separately for each of the three factors, yielding estimates of 0.86, 0.88, 0.81 and 0.78, respectively (Wnuk et al., 2006).. In the ATTSO scale, a higher score implies a positive attitude towards the treatment of sex offenders with no cut off scores. When scoring the ATTSO scale, the researcher must remember that a negatively worded item should be reversely scored (Wnuk et al., 2006).

Competency Assessment Instrument

The CAI is an instrument is an instrument developed by Chinman et al. (2003). It contains 15 scales equaling a total of 55 items. The first 11 items have been removed for this research due to being demographic questions. Since the questions were addressed in the demographic section created by the researcher there was no need to include the CAI's demographic questions. Therefore, there was a total of 44 items from the CAI used in the survey. Each of the scales assess the clinical competency of a mental health provider in the services that they provide. The 15 scales measured the following areas of clinical competency: goal setting, skills coping with stress, client preferences, intensive care management, holistic approach, family education, rehabilitation, skill advocacy, natural supports, stigma, community resources, medication management, family involvement, team value, and evidenced-based practice. The CAI is scored on a 5-point Likert rating scale. The responses range from 1-strongly agree to 5-strongly disagree, 1-all clients to 5-few or no clients, 1-several times a day to 5-never, 1-always a problem to 5-never a problem, 1-all to 5-none, 1-completetly confident to 5- little or no confidence, 1-all the time to 5-rarley or never, and 1-extremely effective to 5-little or no effect (Chiman et al., 2003). These scale responses are used in the majority of the CAI with the exception of three items in the rehabilitation scale asking participants what percentage of their clients they believe would benefit from different rehabilitation services (Chinman et al., 2003). Two hundred and sixty-nine participants provided Cronbach alpha scores ranging from .41 (medication management) to .72 (rehabilitation). The test retest reliability score was .79 and the RAQ-7 and optimism scales had a total score of .66 and .73 respectively (Chinman et al., 2003).

Data Analysis

In this study, the criterion variables were statistically nonsignificant association apparent between predictor variables of interest (attitudes towards sex offenders survey, the competency assessment instrument, and demographic questions) and the binary criterion, versus if there is statistically significant association apparent between predictor variables of interest (attitudes towards sex offenders survey, the competency assessment instrument, and demographic questions) and the binary criterion. Further, the predictor variables were the ATTSO instrument (Wnuk et al., 2006) and the CAI (Chinman et al., 2003), as well as the demographic information about the participants. These demographic questions included the participant's gender, religion/spirituality, ethnicity, age, sexual orientation, socioeconomic status, population of clients served, political party, willingness to work with sex offenders, personal past trauma, and knowing someone with a personal trauma.

The following steps were taken in order to analyze the data collected from the survey questionnaire. First, Statistical Program from the Social Sciences (SPSS) software was used to compartmentalize and analyze the data. Each instrument used (ATTSO and CAI) in the survey as well as the demographic questions were scored and then entered into the SPSS software for comparison, once the data was downloaded from the Qualtrics survey software and converted into a data format file for SPSS. Once converted into the SPSS format, responses were compared in order to see if there were specific factors that cause a counselor to be more willing to work with the sex offender population in their future career. Due to SPSS not being able to compute the data with missing data it was important to run a missing data analysis. With this analysis, it allowed a way to fill in the missing data using an algorithm that predicted answers the participant may have given (Field, 2013).

To determine whether or not certain factors impact if a counselor is willing to have a future in treating sex offenders, a binary logistic regression was performed (Fields, 2013). Using the binary logistic regression, this study used the predictor variables (i.e., ATTSO, CAI, and demographic information) to predict the criterion variable of working with or not working with clients who have committed sexual offense. Logistic binary regression was able to compare these factors between certain predictor variables and in turn see if there were factors that see if a counselor is more willing to have a career in working solely (or mostly) with sex offenders. There were three assumptions for a binary logistical regression model: (a) Making sure to have an adequate sample size. Not having enough participants in the study based on the number of predictors could be very bad for the research (Fields, 2013); (b) The absence of multicollinearity. Multicollinearity cause the mutual relationship between two (or more) predictors to be high; (c) Having no outliners in the results.

Results

The purpose of the study was to determine if there were specific factors that would predict a counselor's willingness to work with sexual offenders. In this study, the dependent variable, a counselor's willingness to work with sex offenders, was measured in eight different ways. The first three being the average scores comes the ATTSO (Wnuk et al., 2006) sub scales factor I (Incapacitation), factor II (Treatment Ineffectiveness), and factor III (Mandated Treatment). The last five come from the CAI (Chiman et al, 2003) sub scales: stress, client preferences, holistic approach, stigma, and family involvement. The average ATTSO factor I mean score is 1.86 (this is an average of an average) and SD = 0.539. The average ATTSO factor II mean score is 2.07 (this is an average of an average) and SD = 0.473. The average ATTSO factor 3 mean score is 1.67 (this is an average of an average) and SD = 0.728. The average CAI sub scale for stress mean score is 0.705 (this is an average of an average) and SD = 0.234. The average CAI sub scale for client preferences mean score is 0.075 (this is an average of an average) and SD = 0.104. The average CAI sub scale for holistic approach mean score is 0.459 (this is an average of an average) and SD = 0.132. The average CAI sub scale for stigma mean score is 0.754 (this is an average of an average) and SD = 0.152. The average CAI sub scale for family involvement mean score is 0.283 (this is an average of an average) and SD = 0.252.

Classification Table

The study participants were asked a yes or no question on if they were willing to counsel someone who has been committed of a sexual offense. Of the 75 participants, 89.33% (n = 67) said yes. While, 10.77% (n = 7) stated that they would not be willing. There also was 1.3% (n = 1) that declined to answer. Therefore, per this study most participants would be willing to counseling a client who had been committed of a sexual offense. Due to some missing data 4.00% (n =3) cases were not included in the data analysis in SPSS due to having missing information.

Shown in Table 3 is the classification table. The classification table shows that if variables were not included the "best guess" would be that 98.5% of participants would be willing to counsel clients who have committed a sexual offense.

Table 3

Classification Table[a]

			Predicted		
			Are you willing to counsel clients who have committed a sexual offense?		Percentage
	Observed		Yes	No	Correct
Step 1	Are you willing to counsel clients who have committed a sexual offense?	Yes	64	1	98.5%
		No	4	3	42.9%
	Overall Percentage				93.1

a. The cut value is .500

Variables in the Equation

The Wald test has been used to determine if there is a statistical significance for each of the independent variables (Field, 2013). The results shown in table 4 are as follows, ATTSO factor I (p = 0.192), ATTSO factor II (p = .011), ATTSO factor III (p = .813), CAI sub scale stress (p = .442), CAI sub scale client preferences (p = .494), CAI sub scale holistic approach (p = .659), CAI sub scale stigma (p = .768), and CAI sub scale family involvement (p = .252). From these results, the variables in the equation table shows that a constant was included.

Table 4

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp (B)
Step 1[a]	ATTSOfactor1	2.063	1.582	1.700	1	.192	7.868
	ATTSOFactor2	4.814	1.882	6.544	1	.011	123.206
	ATTSOFactor3	-.235	.995	.056	1	.813	.791
	Stress	2.480	3.223	.583	1	.442	11.936
	Client Preferences	4.265	6.230	.469	1	.494	71.181
	Holistic Approach	-2.085	4.721	.195	1	.695	.124
	Stigma	-.998	3.382	.087	1	.768	.369
	Family Involvement	-5.033	4.394	1.312	1	.252	.007
	Constant	-20.047	11.515	3.031	1	.082	.000

a. Variable(s) entered on step 1: ATTSOFactor1, ATTSOFactor2, ATTSOFactor3, Stress, Client Preferences, Holistic Approach, Stigma, Family Involvement.

Variables not in the Equation

The results shown in table 5 are as follows, ATTSO factor I (p = .082), ATTSO factor II (p = .000), ATTSO factor III (p = .731), CAI sub scale stress (p = .190), CAI sub scale client preferences (p = .354), CAI sub scale holistic approach (p = .815), CAI sub scale stigma (p = .100), and CAI sub scale family involvement (p = .137). From these results, it can be seen that ATTSO factor II is the only variable that showed statistical significance. Although the results are not significant with the numbers 7.868 (ATTSOfactor1), 11.936 (CAI subscale stress), and 71.181 (subscale client preferences) it shows that with more participants it is possible that these can play a significant role as factors predicting a counselor's willingness to work with the sex offender population.

Table 5

Variables not in the Equation

			Score	df	Sig.
Step 0	Variables	ATTSOfactor1	3.016	1	.082
		ATTSOFactor2	13.275	1	.000
		ATTSOFactor3	.118	1	.731
		Stress	1.719	1	.190
		Client Preferences	.860	1	.354
		Holistic Approach	.055	1	.815
		Stigma	2.207	1	.100
		Family Involvement	2.207	1	.137
		Constant	16.188	8	.040

Model Summary

In the Omnibus tests of model coefficients, it shows that the model is not overall statistically significant due to the *p* value 0.008 being greater than 0.005 (see table 6). Furthermore, the Hosmer and Lemeshow Test also shows that the study has a poor fitting model due to the *p* value being 0.993 (see table 7). The Cox & Snell R^2 and Nagelkerke R^2 values were consulted in order to see how much variation there is in the dependent variable (counselor's willingness to counsel sexual offenders). Per the responses of the participants the study's model ranges from 25% to 53.1% (see table 8).

Table 6

Omnibus Tests of Model Coefficients

		Chi-square	df	Sig.
Step 1	Step	20.739	8	.008
	Block	20.739	8	.008
	Model	20.739	8	.008

Table 7

Hosmer and Lemeshow Test

Step	Chi-square	df	Sig.
1	1.456	8	.993

Table 8

Model Summary

Step	-2 Log likelihood	Cox & Snell R^2	Nagelkerke R^2
1	25.188[a]	.250	.531

a. Estimation terminated at iteration number 8 because parameter estimates changed by less than .001.

A binary logistical regression was performed in order to assess if ATTSO factor I, ATTSO factor II, ATTSO factor III, CAI sub scale stress, CAI sub scale client preferences, CAI sub scale holistic approach, CAI sub scale family involvement, and CAI sub scale stigma predicted a counselor's willingness to work with clients who have committed a sexual offense. The logistic regression model was not significantly significant, $x^2(8) = 20.739$, $p > .001$. The model explained 53.1% (Nagelkerke R^2) of the variance in willingness and correctly classified 93.1% of cases. Of the eight predictors, only one was statistically significant: ATTSO factor II (as shown in table 5).

Discussion

A binary logistical regression analysis was used to determine if the 75 counseling student participants who completed the online survey had factors that would predict their willingness to treat someone who has committed a sexual offense. Although there were going to be 12 factors that would be measured, 4 of those being demographic

questions, the analysis ended with looking at 8. Demographic questions were omitted from the analysis due to the number of possible participants that were omitted from the final analysis because they did not complete anything past the demographic questions. Although the demographic results were an indication of the variety of the participants, due to the small sample size (n = 75) it does not accurately reflect the population on those variables. For that reason, the demographics questions were not included as factors predicting a counselor's willingness to work with sex offenders. The majority of participants identified as female (n = 66), ages ranging from 20-29 (n = 47), heterosexual (n = 61), white (n = 52), and Christian (n = 42).

Before reviewing the results of the 8 factors covered in this study, it is important to review the results of the Classification Table (Table 3). This table shows whether the factors that are significant predict a counselor's willingness to counsel sex offenders or their unwillingness. Due to the cut value being .500, anything above that would be what the significant factors in the study would be predicting. In this study, counselors who would be willing to counsel a person who has committed a sexual offense with a percentage of 93.1% (n = 64).

The 8 factors that were measured came from the ATTSO scale and CAI scale. Each scale had their own sub scales, ATTSO having 3 and the CAI having a total of 16. All 3 subscales were used from the ATTSO scale: factor I (Incapacitation), factor II (Treatment Ineffectiveness), and factor III (Mandated Treatment). The CAI was narrowed down into 5; stress, holistic approach, client preferences, stigma, and family involvement.

The ATTSO subscale Factor I, Incapacitation, focuses on the belief that sex offenders should not be treated. The results of this survey showed that ATTSO subscale Factor I, Incapacitation, does not hold statistical significance p = .082. This means that this factor on whether sexual offenders should or should not be treated, does not predict a counselor's willingness to work with someone who has committed a sexual offense.

The ATTSO subscale Factor II, Treatment Ineffectiveness, measures if a counselor believes that treatment for sex offenders is effective or not. The results of this survey show that there is a statistical significance p = .000. In other words, participants of this study who are willing to counsel sexual offenders find that treatment is effective in helping them. Although, it was surprising to see that this factor was significant and Factor I, Incapacitation, was not because in the study for ATTSO scale it showed that those 2 factors had a significant correlation between them (Wnuk et al., 2006).

The ATTSO subscale Factor III, measures a counselor's attitude towards those who have committed sexual offense getting mandatory treatment. Per the results of the data collected in this study, this factor is not statistically significant (p = .731). This result did not come as a surprise due to the findings in the study completed by Wnuk et al. (2006). It was stated in their findings that there was no correlation with Factors II and III. Therefore, it was assumed, once that Factor II was proven statistically significant, Factor III would not be.

The next factor that was observed in the data collection was the CAI subscale for stress. This competency subscale was developed in order to see if providers had competency in aiding clients to identify and cope with different stressors that may cause them to begin to depreciate (Chinman et al., 2003). Research in previous chapters of this study have deemed this tool useful. Per the results of this data collected in this study, it is not a statistically significant factor (p = .190) to predict a counselor's willingness to counsel sex offenders. Therefore, it is concluded that whether or not a counselor has competency in a client's stressors it does not affect that counselor's willingness to work with the sex offender population.

The fifth factor that was observed in the data collection was the CAI subscale for client preferences. This competency scale measures how a counselor learns and respects their client's preferences towards treatment (Chinman et al., 2003). Per the results presented in chapter 4, the sub scale of counselor's competency in client preferences (p = .354) was not statistically significant. Therefore, it is concluded that whether or not a counselor has competency in a client's preference for treatment it does not affect that counselor's willingness to work with the sex offender population.

The sixth factor that was measured was a counselor's competency in the holistic approach. This competency scale measures if a counselor stimulates a client's life experiences while providing a safe environment (Chinman et al., 2003). Per the data collected, the sub scale of a counselor's competency in holistic approach (p = .815) was not statistically significant. Therefore, it is concluded that whether or not a counselor has competency in holistic approach it does not affect that counselor's willingness to work with the sex offender population.

The seventh factor that was measured was a counselor's competency in stigma. This competency scale measures if a counselor is working with the client in order to help them cope with the stigmas they may face (Chinman et al., 2003). Per the data collected, the sub scale of a counselor's competency in stigma ($p = .100$) was not statistically significant. Therefore, it is concluded that whether or not a counselor has competency in reviewing stigma and ways to cope with it, it does not affect that counselor's willingness to work with the sex offender population.

The eighth and final factor that was measured was a counselor's competency in the family involvement. This competency scale measures if a counselor involves the client's family members and helps them cope effectively (Chinman et al., 2003). Per the data collected, the sub scale of a counselor's competency in family involvement ($p = .137$) was not statistically significant. Therefore, it is concluded that whether or not a counselor has competency in involving the client's family into treatment does not affect that counselor's willingness to work with the sex offender population.

Limitations

There are a number of limitations that may have prevented the outcome of the results in the data presented in this study. Primarily, how many questions were on the survey. The demographics combined with the ATTSO scale and the CAI scale caused there to be over 100 questions. Many of the participants had to be removed from the final data collection because they did not complete the full survey. In fact, one participant (who was removed from the data collection because she did not meet criteria of being a Master's level student) left a message in the space for email stating that the survey was too long and should be shortened. Once data collection had stopped, it had come apparent that there were several questions that could have been removed from the ATTSO scale and the CAI scale due to not being in the final factors that were measured and therefore not needed to be asked.

Another limitation was the CAI scale itself. Many people who were given the survey in person stated that they had never worked for an agency and therefore did not know how to answer several of the questions. Again, the women who provided feedback in the survey stated that she had only ever worked in private practice and could not fill out the questions. Upon review of the questions in the CAI, it does appear to be focused on those who work for mental health centers; however, the practices mentioned should be followed by most as it asks about continuity of care and staying in communication with providers and family members if at wish of clients. Furthermore, on some of the other surveys, many participants skipped questions on the CAI due to seeing children and believing that the questions on the survey were focused mostly on adults. Especially those pertaining to alcohol and drug abuse/rehabilitation.

Distribution of the survey further proved to be a limitation in the study due to the lack of responses. Although there were those who responded back stating that they would pass the survey on to their students, there were many who did not reply and passed it on. Therefore, making it difficult to identify who received it and who to provide a 2nd call email to. The instructors who did reply only a select few responded with how many students it was passed on to and therefore it was not possible to track how many potential participants there could have been. Another limitation to distribution that was not considered prior to data collection was that some universities require researchers to submit a request to their universities IRB before they allow distribution to their students.

Recommendations

Since this research showed, even with less participants than was originally ideal, that there are statistically significant factors out there that can predict a counselor's willingness to work with sex offenders, it would be fruitful to continue to find more. Several of the results had to be discarded due to not having enough data filled out under the ATTSO and CAI scale. However, a majority of them did fill out the demographics. It might be beneficial to go back and complete another data run with that information to see if there are specific demographics that would predict a counselor's willingness to counsel sexual offenders.

This study researched counseling students new to the field, it may further be beneficial to conduct a study and measure the responses of counselors who have a full license and have been in the field for a while. Their factors may differ after being in the field for so many years. Where they may have once been opposed after years of service they have come to find out more about the field itself. This may also help if the opposite were true. Maybe factor's that predict a student counselor's willingness changes and makes it to where they may not be willing after a while, either due to experience or burnout.

This study was a quantitative binary logistical regression and future studies may also benefit from a study that combines quantitative and qualitative perspective. Future studies could also explore if a type of intervention or class changes counselor's willingness to work with such a population change with a type of intervention or class.

Conclusion

The literature review done in this study has shown, how for the sex offender population counseling can beneficial and a need. Although the American Counseling Association makes it clear that counselors cannot refuse to see a specific population based off of their own beliefs, it does not mean that a counselor cannot still chose to work in a setting where they will not work with that population (many advocacy centers have the requirement that no one with a sexual offense can be in the building at any time). This research has served to broaden the knowledge that there are factors that can predict if a counselor is willing to work with a population that others have strong opinions about (Thomas et al., 2015).

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