Original Research Article

Learning From Consumers of Mandated Sex-Offending Programs: "It's Not Treatment, I Wish It Was."

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Abstract

The purpose of this qualitative study was to explore clients' perceptions of sex-offending treatment. The sample included 291 people required to register as sex offenders in the U.S. who answered an open-ended question in an online survey asking them to describe their positive and negative experiences in mandated treatment. Using qualitative analysis, three overarching themes (with several subthemes) were identified: (1) positive and (2) negative treatment experiences and (3) the affiliation between the criminal justice system and clinical services. Experiences in sex offending treatment were viewed as positive when clients had opportunities to learn about themselves, experience group cohesion, build a positive alliance with a caring therapist, learn tools and skills for emotional health, explore the roots of offense behavior, and create healthy life plans to reduce risk for re-offending. Negative themes emerged when treatments were viewed as coercive, confrontational, or demeaning; when therapists seemed inexperienced or unqualified; and when seemingly outdated or unscientific methods were emphasized without explanation or dialogue. The entanglement between court-mandated treatment providers and the criminal justice system led to concerns about confidentiality, conflicts of interest, and role ambiguity. Drawing upon literature related to therapeutic alliance, trauma-informed care, and Risk-Need-

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Responsivity models, we offer suggestions for integrating client feedback to improve treatment responsivity and prevent re-offending.

Keywords
Sexual offender treatment, qualitative, consumer perceptions, treatment effectiveness, risk, need, Responsivity

Introduction

There are few crimes that inspire as much public fear and anger as sexual offenses. Prevention of recidivism is an important public safety goal. Often neglected in policy debates is the role of therapeutic rehabilitation, due in part to widespread but erroneous beliefs that recidivism rates are alarmingly high, that people who perpetrate these crimes are destined to reoffend, and that they cannot be helped (Ellman & Ellman, 2015). Despite these assumptions, sex-offending treatment programs are almost always mandated in all 50 U.S. states for people convicted of sexual crimes, and a body of literature has amassed to guide clinical practice in this area (Association for the Treatment & Prevention of Sexual Abuse, 2022). Quantitative treatment outcome studies have been useful in determining recidivism rates and trends, conducting group comparisons, exploring associations between risk factors and reoffending, and using predictive modeling to devise actuarial tools and evaluate their utility. Big data, however, are less helpful in understanding how to improve therapeutic interventions to prevent future victimization.

Qualitative research captures the narratives of those who perpetrate harm so we can improve our understanding of why they offend and gain insights into which treatment strategies are perceived as relevant and helpful (Grady & Brodersen, 2008; Waldram, 2007). Yet, only about 11% of articles published in criminology journals between 2010 and 2019 used qualitative methods (Copes et al., 2020). Neglecting the voices and stories of service users overlooks the complexities of criminal behavior and over-simplifies the psychological and social interventions used to address it (Waldram, 2007). The current study offers a qualitative analysis of the treatment experiences of consumers of mandatory sex-offending treatment services after a conviction for a sexual crime in the U.S.

Treatment Effectiveness

Answers to questions about which treatment strategies work best for whom (and why) remain obscure (Levenson & Prescott, 2014). Empirical studies have demonstrated mixed results and small effect sizes (Gannon et al., 2019; Grady et al., 2015; Hanson et al., 2002, 2009; Långström et al., 2013; Marques et al., 2005; Schmucker & Lösel, 2015). Risk-Need-Responsivity (RNR) models aim to improve treatment delivery by

focusing on individualized assessment of risk level, dynamic variables, treatment needs, and protective factors (Bonta & Andrews, 2017; de Vries Robbé et al., 2015; Hanson et al., 2009; Jung, 2017; Stinson & Clark, 2017). The primary objective of treatment is, of course, to prevent future victimization. Recidivism rates are typically used as the primary (or only) measure of successful outcomes in criminal rehabilitation, while other indicators of client improvement and well-being have been ignored (Levenson et al., 2020; National Academies of Sciences & Medicine, 2022). Empirically-supported interventions are often narrowly defined as conforming to the "gold standard" of randomized controlled trials, but such studies may offer little insight and nuance about what contributes to positive results and desistance from offending (Harris, 2017; Levenson & Prescott, 2014).

Evidence-based practice requires empirical evidence, theoretical knowledge, clinical expertise, and consideration of client characteristics (APA Presidential Task Force on Evidence-Based Practice, 2006; Drisko & Grady, 2019). Person-centered interventions require us to assess client needs, risks, and strengths, apply research knowledge, and incorporate all of it into a delivery style that is relevant for each individual (Grady et al., 2017). Skillful clinicians minimize engagement barriers by utilizing positive, strengths-based, collaborative, and motivational approaches that integrate the wishes, perspectives, and goals of their clients (Drisko & Grady, 2019; Prescott & Wilson, 2013; Seligman & Csikszentmihalyi, 2000; Seligman et al., 2006; Ward & Brown, 2004).

The benefits of quantitative methods in criminology and psychology include scientific rigor, efficiency, statistical power, and their appeal to grant funders (Copes et al., 2020). Quantitative data, however, do not tell the stories of human complexity. Empirical inquiry can be bolstered by the powerful narratives of real people who share the substance and meaning of their real-life experiences (Ahmed et al., 2021; Reid et al., 2005; Van Manen, 2016). Qualitative methods (e.g. interviews, focus groups, and immersive fieldwork) are increasingly recognized as valuable to the application of theories and the refinement of interventions in criminal justice (Copes et al., 2020). Personal narratives get beyond stigma and stereotypes to elucidate pathways for meaningful clinical change and successful re-entry in correctional programs (Copes et al., 2020; Grady & Brodersen, 2008; LeBel & Richie, 2018; Waldram, 2007; Western et al., 2015).

Perceptions of Consumers of Sex Offending Treatment Programs

People who commit sex crimes are a diverse group, and they yearn to have their voices heard (Waldram, 2007). It can be helpful to view them not simply through the lens of the worst thing they have ever done (Stevenson, 2014), but as "everyman" who is, in many ways, more similar than different from other citizens (Douglass et al., 2022; Marshall, 1996). As contemporary society evolves, interpretive science can shed light on social problems and cultural phenomena; the voices of marginalized populations can enhance social justice and public safety (Ahmed et al., 2021; Copes et al., 2020).

The consumer-driven services movement began in the 1990s in response to disempowering programs for people with physical disabilities and psychiatric illnesses (Charlton, 1998; Segal & Hayes, 2016; Substance Abuse and Mental Health Services Administration, 2011). The phrase "nothing about us without us" became a defining principle of service design, implementation, delivery, and evaluation, emphasizing the importance of self-determination, self-advocacy, personal agency, and mutual peer support (Segal & Hayes, 2016; Substance Abuse and Mental Health Services Administration, 2011). Including consumers in decisions about their own care empowers them as experts who can help guide social services to be more useful and relevant. When ownership and responsibility are shared between organizations and their clients, along with mutual respect and consensus about what is helpful, service users become active partners in shaping the outcomes of interventions (Segal & Hayes, 2016). Consumers of services within the criminal-legal system in the U.S. are rarely included in this type of dialogue, and if they are, research usually focuses on evaluating the treatment protocol itself rather than the client's experience of the legal system or service delivery process (McCartan et al., 2021).

Client-centered programs focus on each person's unique strengths, needs, and goals (Rogers, 1961) and seek feedback from consumers (Prescott et al., 2017). The "common factors" of psychotherapy are well-established in the psychology literature and explain most of the variance in client outcomes (Duncan et al., 2010; Wampold, 2010). These factors include warmth, positive regard, collaborative problem-solving, empathic engagement, and authentic interest in understanding the client's experiences without judgment (Rogers, 1961; Wampold, 2019).

Sex-offending treatment research has revealed that warm, empathic, encouraging, directive but non-confrontational therapist characteristics were associated with client improvement and helped to reduce defensive denial and cognitive distortions (Marshall, 2005; Marshall et al., 2002, 2003). Consumer surveys revealed that client-centered qualities were perceived as crucial to their engagement and progress in counseling (Levenson et al., 2009, 2010; Levenson & Prescott, 2009). Because these clients in the U.S. typically enter treatment under post-conviction mandates, therapists may be predisposed to expect resistance, denial, and lack of motivation, and therefore respond to clients in negative or confrontational ways (Jenkins-Hall, 1994; Jennings & Sawyer, 2003; Marshall et al., 2001; Serran et al., 2003; Wakeling et al., 2005; Winn, 1996). Therapeutic ruptures in psychotherapy can contribute to treatment failures in every clinical population (Binder & Strupp, 1997; Ward et al., 2012). Beech and Hamilton-Giachritsis (2005) found that therapists tended to overestimate their effectiveness, holding more positive evaluations of group therapy than the members themselves.

Links between therapeutic alliance and treatment outcomes are difficult to ascertain with quantitative measures alone (Blasko & Jeglic, 2016). Qualitative exploration has therefore been recommended to help improve program efficacy (Wakeling et al., 2005). Using qualitative interviewing methods, researchers have identified common themes related to treatment content and process, engagement, therapeutic alliance, and peer

support (much of the qualitative research about sex offending treatment appears to be conducted outside of the U.S.). Beneficial content areas include self-development, risk-awareness, accountability, changes in thinking, victim empathy, and coping skills (Grady & Brodersen, 2008; Levenson et al., 2010; Wakeling et al., 2005). Positive group process included sharing with and learning from groupmates, relating to others, and receiving support (Grady & Brodersen, 2008; Levenson et al., 2010; McCartan et al., 2021; Wakeling et al., 2005). Clients in different countries perceived therapeutic alliance and group atmosphere to be among the most important contributors to the effectiveness of sex-offending treatment (Blagden et al., 2016; Grady & Brodersen, 2008; Levenson et al., 2010; McCartan et al., 2021; Wakeling et al., 2005; Willemsen et al., 2016). Obstructions to change include professionals' negative assumptions and expectations (Blagden & Wilson, 2020; McCartan et al., 2021; Wakeling et al., 2005). Societal messages act as a mirror by which we see ourselves; the cognitive transformation to a non-criminal identity and desistance can be impeded when professional helpers reinforce stigmatizing and negative beliefs (Cooley, 1902; Maruna et al., 2004)

Purpose of This Study

The purpose of this study was to explore clients' perceptions of treatment for sex offense behavior. We provided an open-ended narrative prompt asking participants to describe their positive and negative experiences. Engaging services users when evaluating health and mental health care is desirable, but it rarely happens within the U.S. criminal legal system (McCartan et al., 2021). Qualitative research can inform our understanding of therapist qualities and program content that help consumers to prevent re-offending and enhance their well-being. The voices of clients can help us improve responsivity to service delivery, the often-neglected third principle within the RNR framework (Jung, 2017).

Method

This study was part of a larger project aimed at exploring the post-conviction experiences of individuals listed on sex offender registries. The full study used a mixed methodology to collect quantitative and qualitative data about post-traumatic stress symptoms following a sex crime conviction. We asked only one question about treatment at the end of the survey, and purposely left it very vague and open-ended. Data were collected through an online survey launched on the Survey Monkey platform in March 2021. People required to register as sex offenders and their family members were recruited with assistance from several registry reform advocacy groups in the U.S. These organizations agreed to send our recruitment email with the survey link to their distribution lists, social media, and networking partners, which also led to snowball sampling. Any registrant or family member who was eligible (over 18, living in the U.S., and required to register) was invited to participate. The anonymous, confidential survey asked questions about the impact of experiences related to the sex crime arrest,

Table 1. Descriptive Stats and Demographics (N = 292).

Demographics		RSO
Age	(Mean)	52.9
Gender	Male	94%
	Female	6%
	Trans/Non-Binary	1.4%
How would you describe your race?	White	88%
	Black	5%
	Other	7%
Are you Hispanic, latino, or of Spanish origin?	yes	8%
Which of the following best describes your current relationship status?	Married	37%
	Widowed	1.4%
	Divorced	24%
	Separated	1.2%
	Partnered	13.4%
	Single never married	22.6%
Which of the following categories best describes your employment status?	Employed full-time	41%
	Employed part-time	14%
What is the highest level of education you completed?	HS grad	7.5%
	College grad	36%
	Graduate degree	23%
Which of the following categories best describes your current income?	<$20,000	34%
	$20,000-$49,999	38%
	$50,000-$79,999	14%
	$80,000+	13%

court proceedings, incarceration, probation/parole, and registration. Of the 379 registrant participants who began the survey, 292 completed the entire survey. The current sample was derived of the registrant participants who answered one open-ended question about their mandated treatment experiences (n = 291).

Participants were given a narrative prompt to describe their experiences in sex-offending treatment programs, which is the topic of analysis for this study. The participants were asked: "If you are registered, please describe your experience in any treatment, counseling, or therapy that you received related to the sex offense (positive and/or negative)." Participants were permitted to write as much as they wished. The Institutional Review Boards at both lead authors' universities approved the project.

The demographics of the sample can be seen in Table 1 and included respondents from 37 states with the highest counts in Florida and California. Offenses included sexual contact with minors (54%) or adults (6%), Internet-related offenses such as downloading or sharing child sexual abuse material (CSAM), and solicitation or traveling to meet a minor (48%). The totals may exceed 100% because respondents were asked to check all that apply, and some people were charged with more than one

type of sex offense. About 59% served a prison sentence (average length 5.25 years), and 94% said they were on probation or parole after conviction, with 31% on community supervision at the time of the survey. They were all required to register as sexual offenders and reported that they had been on the registry for an average of 12.5 years; 71% said they are required to register for life. The participants said they had been in treatment for an average of 4.6 years, with 82% saying five years or less, 12% reporting 6–10 years of treatment, and 6% saying treatment lasted 10 years or more.

Qualitative Data Analysis

A thematic analysis process (Braun & Clarke, 2006; Vaismoradi et al., 2013) was used and followed the constant comparative method (Glaser, 1965; Kolb, 2012; Olson et al., 2016). Thematic analysis involves the creation of codes based on constructs that emerge from the narrative answers; it differs from content analysis by emphasizing the knowledge and meaning that can be discovered through the themes rather than focusing simply on classification (Vaismoradi et al., 2013). Using the constant comparative method, codes are clustered and organized into larger categories that represent the major patterns and ideas from the data (Glaser, 1965; Kolb, 2012; Olson et al., 2016).

In this study, two coders (doctoral students) conducted the analytic process and met regularly with the supervising researcher to discuss data analyses and findings as they emerged to ensure inter-coder reliability (Burla et al., 2008). Using Olson's et al. (2016) 10-step analytic methodology, each researcher: (1) performed open-coding of data within MAXQDA 2020 (Kuckartz & Rädiker, 2019); (2) collaborated to unify codes; (3) recoded the data and incorporated them into MAXQDA 2020; (4) used MAXQDA 2020 to calculate the Kappa; (5) collaborated to discuss each code and identify areas lacking agreement; (6) repeated the above process for each segment of the data, producing a unified codebook applicable to all data subsets; (7) recoded all data using intercoder agreement in MAXQDA 2020, producing themes; (8) selected themes for further analysis; (9) conducted co-occurrence analysis; and (10) constructed an exploratory model to identify thematic findings of the study.

The units of analyses were the sentences within the transcripts, which were used to construct the codes and then develop conceptual or implicit meanings for the ideas shared by the participants (Braun & Clarke, 2006; Burla et al., 2008). The first round of coding yielded 58 codes. After resolving technical errors, three additional rounds of conferencing and coding took place until coder differences produced resolution, and the Kappa score was 1.0 for all codes. The codes were then clustered into primary groups based on the research team's discussions and consensus, and three overarching themes were identified with multiple subthemes (see Table 2): (1) positive and (2) negative treatment experiences and (3) the affiliation between the criminal justice system and clinical services.

Table 2. Themes and Sub-Themes.

Theme	Sub-themes
Positive experiences N = 60	Learning about self
	Being part of a group
	Positive experiences with therapist
	Learning new tools and skills
	Learning the "whys" of offending
Negative experiences N = 125	Coercive treatment
	Abusive and demeaning therapists
	Inadequate qualifications of providers
	Unscientific interventions and structural program barriers
Interconnections between criminal justice System and mandated treatment N = 64	Lack of client confidentiality
	Perceived conflicts of interest and role ambiguity

Results

We will first focus on two sets of themes describing positive and negative treatment experiences. We will then describe the third theme: the inextricable interconnection between mandated treatment and the criminal legal system. The word "positive" (n = 57) was specifically used by participants more frequently than the word "negative" (n = 21)[1]. However, these word counts were somewhat misleading. A vast variety of words were used to capture both positive and negative experiences, but the participants tended to use a much more expansive vocabulary of descriptive language and shared more details when explaining their negative experiences. Within each theme, we will summarize sub-themes and provide salient quotes that capture the sentiments of the participants.

Positive Treatment Experiences

The following subthemes emerged as most salient for individuals who felt that their treatment experiences were positive or helpful. Clients appreciated opportunities to make sense of their behavior and contextualize it into their broader self-conception. Treatment felt most positive when it was holistic, individualized, and delivered by a therapist who was warm and non-judgmental. Participants enjoyed being part of a group that allowed for sharing, cohesion, and mutual aid.

Learning about self. Programs were described as positive when participants were able to gain insight about themselves. For example, one person noted "of course at first you think you don't belong there, but after a while you see the benefits." Another stated that treatment was "very revealing and gave me tools if I ever encountered myself feeling that way again…the counseling gave me strength." Therapy was perceived as offering

strategies to deal with life's challenges and "become a better person," as well as "resources which enabled me to really figure out who I was and get an identity for my life for the first time." Others described an "in-depth look into self and exploring causes for acting out," learning to deal with stress, avoiding patterns that led to offending, dealing with childhood trauma, and accountability: "I know I have no one to blame but myself." Another summed up treatment success in this way: "I learned to stop lying to myself, keeping secrets from my wife, and using sexual fantasy like a drug to make myself feel better." One noted: "I learned so much about myself and have been offense free for 30 years."

Being part of a group. Connecting with group members was a salient theme, with many saying that it was helpful to hear from others who "were experiencing the same fears, doubts, and circumstances that I was." Several found camaraderie and support in group sessions, noting that it was useful to "hear their stories, to know I was not alone." For others, who also "felt less alone" in group, it was safe to open up and be more honest. Several appreciated the opportunity to decrease isolation, share information, and discuss experiences: "The biggest advantage of the group therapy for me now is dealing with the ongoing effects of being on probation, and on the registry, and the stigma involved with sexual offenses."

The ability to take on a leadership or mentorship role in group sessions was viewed as a chance to build self-efficacy. One participant described this notion: "I enjoyed the therapy because I liked helping others deal with their issues even though I had difficulty with my own." Another shared that he feels valuable "to other sex offenders in group meetings because I'm a positive role model for them."

Positive experiences with the therapist. Many attributed their positive experiences in treatment directly to the therapeutic alliance with counselors whom they viewed as "wonderful," "introspective, credible, and helpful," "amazing," "remarkable," "useful and insightful," "phenomenal, a great advocate," "understanding," and "invaluable." Participants noted gratitude for professionals who seemed to genuinely care about clients, with one describing his counselor as "supportive" as well as informative. Some participants spoke favorably of therapists who had clear expectations and "assigned a curriculum [and] gave honest professional reports to the court."

Many respondents found it beneficial when a therapist allowed them to express feelings of shame and stigma that were paired with a sexual offense conviction. "Thankfully…his primary approach is based on acceptance and commitment therapy. He understands how counter-productive shaming and the registry are. I am grateful for him." Participants described learning to separate their behavior from their self-perception, with one saying he learned that "I messed up, I am NOT a mess up." Another reported that his therapist "helped me realize that I was not as bad as I felt I was… One cannot change their attraction - only what they do with it."

Learning new tools and skills. Respondents described the importance of learning new life skills and coping strategies for preventing future offenses, improving self-regulation, and dealing the with stress of registration and probation. In their narratives they used expressions such as "learning to be mindful," "self-actualization," and "self-accountability" when describing increased capacities to "discover my triggers, [and] methods to counter them and prevent relapse." Several commented on the importance of learning about risk factors, prevention, coping, and "measures to detect and avert precursor dangerous behaviors." Understanding their "addictive" behavior was seen as useful but they also valued "delving into deeper issues" that contributed to problems in their lives. One summarized how his learning "expanded my knowledge and gave me skills and knowledge I did not have before. It made me grow as a person and helped me deal with my new reality, while providing skills I can apply to live a better life."

Learning the "why" of the offenses. In addition to learning about their own offense patterns and ways to manage them, they also learned about the influences that contributed to the development of abusive or problematic behaviors. For some, this meant exploring their life history, experiences of trauma, and how they coped (perhaps maladaptively) with adversity. For example, one reported that therapy "was very illuminating. I was a victim when I was very young, and I carried that around inside of me for years … I tried to suppress those feelings with drugs and alcohol." Another shared that:

> Therapy has helped a lot. I had many deaths in my family that led me to deal with the depression and guilt of not being able to be there for them in unhealthy ways. I sought an escape through porn. Now, due to therapy, I have learned how to deal with loss and guilt and feel much more healthy mentally.

Many respondents referred to their own early abuse and explained how treatment offered new opportunities for "dealing with childhood trauma [of] being molested and moving step by step through it all." Others described themselves as "broken" and as a "victim." One wrote that therapy "brought to light previous sexual abuses that I'd ignored for years." Several noted that their therapy helped them to confront past histories of victimization and make direct links between early abuse and offending. For example, one said therapy helped him understand how his early abuse normalized inappropriate boundaries and "allowed me to lower barriers to my offending." Another "received EMDR to help eliminate some of the childhood trauma I suffered." One respondent summed it up this way: "life changing. I was finally able to deal with all my past hurts, current hurts, see myself for who I really was, and start having healthy relationships."

Others described new insights into distorted thinking that enabled offense behavior: "brought me to a realization of the abuse in child pornography, [but] before I only saw an image. Now I know there was a person in that image, one who deserved my protection not sexualization." Another shared how he has used treatment "to get real

and deal with some prior traumas instead of medicating over them." One person summarized the overarching process by sharing how overwhelming treatment can feel as they strive to heal themselves and prevent future harm: "Sometimes I feel that I am fighting an endless battle though. It's tough understanding all of the ways that I have been broken, but at least I am working on fixing those broken parts now."

Negative Treatment Experiences

When describing negative experiences, participants used strong language to portray programs they perceived as inappropriate, ineffective, deleterious, and even "traumatic" and "abusive." To illustrate unhelpful experiences in therapy, various participants used terms such as "demeaning, false-science, hurtful, embarrassing," "laughable," "indoctrinating and brainwashing," "shame-based and barbaric," "bullying and destructive," "humiliating and degrading," and "geared towards judgment and self-hatred." Many people used the words "a joke," "waste of time," and "pointless." A participant described his experience as "atrocious." One stated, "I hated every minute of it" and another said treatment "just adds to the misery of being a sex offender."

Coercive treatment. Feeling a sense of coercion was described in ways that seemed to go beyond the basic premise of being court-mandated. For instance, many respondents reported being required to remain in treatment until the end of parole or probation with no path to graduation or successful completion. Coercive practices were described as overly focused on pushing for "confessions" and admissions of wrongdoing as an end in itself, seemingly with no goal other than "to be reminded weekly of my own failure." One individual shared that "I've never had a positive experience with 'treatment,' they just want you to admit you're a pedophile." Several described therapy as "designed to force us to confess to other sexual offenses even if we had to make them up," with another stating treatment was "traumatizing. Forced to say things that are not true. Degraded." Some respondents maintained that they were wrongly convicted, saying the treatment mandate was based on false allegations and that they felt coerced "to confess to crimes you did or did not do," or "having words put in my mouth that I never said." Another participant wrote about how he managed such an experience:

> They didn't believe me and threatened to return me to custody if I didn't come clean. I returned the following week and told a completely made-up story to which the response was, "I don't know why you waited so long to admit this. Don't you feel better?"

Many expressed significant fear of being perceived by providers as lying or withholding information: "Any resistance is met with punitive actions such as dismissal from group and probation violations under the category of refusing to cooperate." At the same time, ironically, they feared that sharing openly and honestly would be used against them, creating a double bind. For example: "I once admitted my wife and I had

video sex over Skype. She [the therapist] promptly wrote me up as being involved in online porn!"

As a related sentiment, dissatisfaction with services was sometimes compounded by having to pay for treatments they did not view as helpful. Many participants noted that self-pay treatment mandates created significant financial strain because they were "required to participate in weekly group sex offender therapy program at [their] own cost." Some described substantial expenses that added stress to already onerous financial burdens: "taking money out of my pocket, and often times, my family's pocket." One said that he was "forced to attend three sessions per week with an out-of-pocket expense of $180 per week for 5 years [and] there was nothing positive to say about the experience." Some participants revealed threats of arrest or revocation for inability to pay, "even though they knew I was jobless; told me that they were to be my number one budgetary priority, even above housing, food, and even God."

Abusive and demeaning therapists. Negative experiences in therapy were often attributed to the characteristics or styles of therapists who treated clients with disrespect, disdain, or contempt. Some of the language used to refer to therapists included: "liar," "accusatory and domineering," and "lacking compassion." One said he was told he was "dirt and worthless" and another said he was "ridiculed in group therapy." Similarly, another participant observed that group "was horrible, shame based" because the leader was "a vengeance minded person." A few respondents referred to treatment as "traumatic." One respondent simply described their experience as "demeaning and horrific." Another described anxiety triggered by a demanding "overall tone of questioning" in the group and said, "talking about what happened only gave ammunition to shoot at me instead of help me."

Many participants felt that their therapists posed little curiosity or acknowledgement of individualized risks, needs, and strengths, and assumed that all clients had paraphilic disorders, compulsively repetitive patterns, and substantial risk to reoffend. Several participants felt that therapists projected messages of an unavoidable negative future. In the words of one participant: "the facilitator treated us like we would all eventually reoffend at some point. He was very negative and never gave any of us praise for doing well." Another shared a similar sentiment: "they said many times that they were there to reduce the likelihood of recidivism but that it was going to eventually happen again." One described the sense of hopelessness conveyed by a therapist who would "drill the same thing into your head day after day … you are a sick and depraved person and there is no hope. Only through lifetime supervision and close monitoring you could ever live any kind of life."

The inability to form a meaningful therapeutic relationship with a caring professional who prioritized client well-being was woven throughout many narratives. One was especially poignant:

> I was so crushed mentally that … I could only think of suicide for months. It was so heavy, I can't even put it into words right now. And when I finally, for the first time, ADMITTED I

> FELT SUICIDAL, the therapist didn't even care. She didn't comment or tell me where I could reach out for help or anything. So I didn't talk about it anymore.

The process of therapy was viewed by some as re-traumatizing because it "involved hearing child abusers talk of their cases, when I myself was a child abuse VICTIM (so caused me to re-live that trauma), the whole experience was horrible." Another shared that "group triggered me," and therapists seemed unaware of the potential impact of abuse descriptions on clients. The perception of re-traumatization was conveyed again with this anecdote:

> I am a survivor of military-related sexual assault. The [program] will not acknowledge this and therefore it is never taken into consideration in my "care." On one occasion I was having a panic attack as someone in the group was describing sexual harm that they had caused. To try and protect myself, I put my head down and discretely plugged my ears. The next week I was scolded by my probation officer and therapist at the same time and told that I was in danger of being kicked out of group. Why? Because plugging my ears was disruptive. At that moment I broke down. I was told to apologize to the group for being inconsiderate. When I did, no one in the group knew what I was talking about. None of them had even noticed. That whole ordeal eliminated what little trust I had left in the [program] and their therapists.

In fact, several participants said that treatment was so traumatizing that "I thought I was going to need therapy afterwards for the treatment I got." Another shared a similar sentiment and said that the "state should pay for my mental therapy to try to get over my traumas related to treatment."

Qualifications of the providers. Many participants reflected on encountering unqualified therapists, and some related issues that emerged were high turnover rates, disruptions in continuity of care, and lack of experience or training. "There was a tread mill of replacement therapists," said one respondent, and another described that his "program went through several providers over time." Changes in therapists were sometimes related to the seasonal attrition of student internship training, which intersected with concerns about counselor inexperience. "Unfortunately, the sitting therapists were all temporary students/interns with virtually no experience working with SOs." One participant expressed dismay, saying that "the SOTP "therapist" has a master's in Anthropology! She had zero ethics, had no idea what she was doing." Another simply declared "They need more training."

Gender responsiveness was mentioned only three times, but it seems important to note these observations. One male participant mentioned that he "dislike[d] having to talk about masturbation to female therapists." Another questioned "the rationale of predominately hiring [young] female therapists to work with mostly male prison inmate SOs." He further observed that many of the men in his group seemed to "suppress their true telling of the offense or issues objectifying women… some were flustered to the

point of not being able to speak… about their dark shame and guilt about the female gender." A female participant shared that she "had to have counseling with a group of 15 men because I could not attend the women's group" and indicated that she found this arrangement to be unhelpful.

Unscientific interventions and structural program barriers. Many participants encountered what they perceived as "unscientific" or "outdated" treatment methods, along with rigidly structured programming without individualization or a clear path to completion. For example, one respondent referred to what he called "false science," and another shared in detail his experience of a program that he believed "held on to several archaic and untrue positions very stubbornly… they insisted the re-offense rate was nearly 99%." He said that he brought in a Hanson et al. meta-analysis that showed a low recidivism rate and "met with their disfavor… they were constantly telling me that all sex offenders were liars, were incapable of showing or feeling empathy, etc." Others also commented that when they challenged providers, they were ignored or experienced negative consequences as a result. "You basically had to go by her thought agenda, or you would get shut down; sometimes hard."

Many respondents expressed distress at what they perceived to be intrusive questioning or "invasive" practices: "they force, under threat of revocation, one to undergo unscientific and torturous procedures" (referring to penile plethysmograph (PPG) and polygraph exams). One described his assessment:

> A negative experience was being forced to pull my pants down, have a device attached to my penis and to watch two hours worth of nude and semi nudes of children and adults to determine what my sex orientation was -- very shameful experience.

Another described a similar incident: "I will never forget having to take the computer test and look at pictures of children and rate their attractiveness. I cried for hours. My daughter was two at the time." Said one more: "I felt like I was living in the movie *Clockwork Orange*." Polygraph exams also ignited much angst. Many expressed a fear of "failing" even if they were being truthful. One narrative said, "everything described or discussed in group would be handed to probation/parole and verified by a biased polygraph then used in revocation." While a few comments described the positive experience of a polygraph being used for confirmation of low risk or treatment progress, many questioned its utility, and one said his "therapist refused to believe my responses in session even though polygraph supported [it] all."

A common complaint was a "generic" or "one size fits all" approach, pointing out that without individualized and explicit goals, the treatment was not a good fit or appropriate for their needs. Some observed a perceived lack of oversight over an "ineffective curriculum" or "no curriculum" by courts or state regulators. Programs were described as "rudderless…facilitator did not have clearly defined goals for session" and that there was "no 'path' for completion of treatment." One person reported that it soon became clear that "no one was graduating or completing the

curriculum (no workbook, only weekly handouts to move from 'Weekly' to 'Monthly Individual' status)." Another explained: "there is no set timeline. That's what's been so maddening and has produced such feelings of helplessness. There are no progress markers."

Interconnections between community corrections and mandated treatment (n = 28)

The third prominent theme was the undeniable interconnection between treatment programs and probation/parole requirements. The entanglement between clinical providers and correctional staff was described as problematic primarily because it felt difficult to establish a safe and trusting therapeutic alliance as noted throughout the subthemes below.

Lack of confidentiality. Concerns about confidentiality were described by many as excessive sharing of information between treatment and probation, to a point that in "each session I never knew if the leader was going to give a negative report to my probation officer and what that could mean." Though signing a waiver to release information is conventional in court-ordered services, an all-inclusive, non-discretionary lack of confidentiality seemed to preclude any semblance of clinical sanctity. "Everything is reported to parole, so I tell them what they want to hear. It's not treatment, I wish it was." Another shared a similar sentiment and explained that "it isn't real treatment because you waive confidentiality. It's more just monitoring and supervision. You learn what to say and do to get through it, even if you don't really believe in it." One narrative remarked "there is no anonymity…that should not be allowed." Some participants indicated that probation or parole officers sat in the treatment groups with clinicians, and that this practice was extremely uncomfortable.

Perceived conflicts of interest and role ambiguity. The inseparable relationship between the criminal justice system and treatment providers became interwoven with perceptions of financial conflicts of interest as well as a lack of role clarity. Participants opined that there is a "cottage industry" that is "all about the money," and that the system does "everything they can to keep you there so they can continue that steady supply of income." While seemingly cynical, one respondent described this experience: "Anything I said in treatment was open to being reported to my agent who could (and did) act on it. The provider even said the only way he could keep his contract was to keep the [probation officers] happy." Another individual asserted that "treatment professionals saw us as a bank. We were just a commodity. They gained in power because they were able to have power over us."

Some suggested that programs were incentivized to prioritize relationships with referral sources and that therapists seemed to have little concern about their clients. Whether these opinions were factually true or not, perceptions of structural and role

ambiguity seemed to create daunting obstacles to building positive and meaningful helping relationships with clinical staff:

> The therapist was fed sex offenders by the probation office, and I don't think rehabilitation was the goal. The therapist charged us a weekly fee (which I couldn't afford). If you couldn't pay the weekly fee, then arrest was threatened. I felt that I wasn't in a safe place and couldn't openly talk about the issues I was dealing with or had without thinking that they are trying to find something to lock me back up. I think the therapist …[was] in cahoots with the probation department. How can rehabilitation happen under those feelings? 10–12 people in "class" with the therapist at $40 a week. Nice pay day. That's all we were. We all agreed on this point. I wonder what kickback the probation department received.

Discussion

Experiences in treatment for offending were viewed as positive when clients had safe opportunities to learn about themselves, experience group cohesion, build a positive alliance with a caring therapist, learn tools and skills for emotional health, explore the roots of their offense behavior, and create healthy life plans to reduce risk for re-offending. Negative themes emerged when treatments were viewed as coercive, confrontational, abusive, or demeaning; when therapists were inexperienced or unqualified to help; and when seemingly dubious, outdated, or unscientific methods were emphasized without explanation or dialogue. The inextricable entanglement between court-mandated treatment providers and the criminal legal system led to concerns about confidentiality, conflicts of interest, and role ambiguity.

If the themes could be encapsulated in a few words, they might be trust, emotional safety, client-centeredness, and support. When these conditions were present, clients found their professional counselors and groupmates helpful in promoting personal agency, well-being, and desistance from offending. When the conditions were absent, clients felt disempowered, cynical, or even traumatized by the intervention that was supposed to help them. At the same time, it is possible that some therapists might be perceived positively by some clients and not by others; it is true that every therapist is not a good fit with all clients. As well, some narratives may represent inner ambivalence about treatment; clients might want to change but find it difficult or threatening to share their shameful inner thoughts. These mixed feelings can challenge therapeutic engagement.

Of course, treatment providers and community supervision agents might be inclined to dismiss client voices as disgruntled, unmotivated, manipulative, or pathological. In some cases, there might be truth to these assertions. But many of the participants made efforts to qualify their criticisms with descriptions of what they had hoped therapy would offer – the same factors known to empirically explain the most variance in therapy outcomes – warmth, positive regard, mutual respect, and collaboration between

expert and patient (Duncan et al., 2010; Prescott et al., 2017; Rogers, 1961; Wampold, 2015).

Perhaps therapists can be more effective when keeping in mind that despite their crimes, our clients are more similar to other therapy clients than they are different. They arrive in our offices only after perpetrating sexual harm, but like "regular" clients, they seek support, acceptance, guidance, and knowledge to help navigate what is probably the most challenging period of their lives. Treatment is not something we do *to* clients. It should be a collaborative process that honors self-determination while exploring the meaning that clients attach to their experiences. These concepts are difficult to measure quantitatively, which is why qualitative research is useful to capture the inner experiences of those we seek to help. Drawing upon literature related to therapeutic alliance, trauma-informed care, RNR, and dynamic risk, we offer some ideas for integrating the feedback offered by participants in this study.

Implications for Practice

Therapeutic alliance. Treatment that induces fear is not therapeutic. Let's put the therapy back into treatment and utilize the theories and skills known to enhance engagement and self-actualization for all clients who seek social and psychological services. Although it is appropriate for therapists to address entitlement, victim-blaming, and denial, confrontational styles were perceived by participants as dismissive, demeaning, shaming, and bullying. As noted widely in the psychotherapeutic literature over many decades (but surprisingly often overlooked in our own field), clients need safe spaces for self-reflection, healthy modeling, and the mutual aid of groupwork to help them harness positive change (Beech & Fordham, 1997; Blagden et al., 2016; Rogers, 1961; Wampold, 2010; Willemsen et al., 2016; Yalom, 1995). Potentially harmful therapies can lead to client deterioration or drop-out, and professional helpers tend to attribute treatment failures to client variables when therapist factors are more likely responsible (Binder & Strupp, 1997; Lilienfeld, 2007). Clinicians should remember that attending to the quality of the relationship is the most important factor in predicting treatment outcomes (Baldwin et al., 2007; Wampold, 2019).

We might sometimes doubt that a client is being honest with us, which can feel frustrating. Because we feel responsible for preventing future victimization, we might be eager to defend against perceived manipulation. We might be better able to create conditions that encourage honesty, however, if we reframe resistance as ambivalence (a simultaneous struggle between a genuine desire for change and the need to maintain what is familiar) or self-protection (concern about disclosing unlawful behavior or paraphilic interests due to fear of judgment and consequences). It is difficult for most people to share shameful secrets or to give up maladaptive coping strategies. Therapists should *expect* resistance and prepare to provide an accepting (of the person and their feelings, not of victimizing behavior) and safe environment to reflect upon past actions and explore the hopes and fears of future change (Miller & Rollnick, 2012; Teyber & Teyber, 2017; Willemsen et al., 2016).

Seeking help for any psychosocial problem can produce feelings of vulnerability (Pattyn et al., 2014) and being mandated to treatment undoubtedly exacerbates these anxieties. According to the participants in our study, treatment for sexual offending often feels punitive, shaming, coercive, and financially burdensome. Our clients wish to be viewed as individuals, understood by professional helpers, approached with respect, curiosity, and compassion, and helped to build strengths (Blagden et al., 2016; McCartan et al., 2021; Scott & Jenney, 2022). For therapists, the responsibility of preventing future victimization can feel daunting, being exposed to details of sexual crime can create negative countertransference, and organizational or community pressures can create stressful work environments (Hardeberg Bach & Demuth, 2018).

Professional associations provide guidance for providing non-voluntary services in their codes of ethics (American Psychological Association, 2017; National Association of Social Workers, 2018). We must respect clients' right to autonomy and self-determination, ensuring that informed consent is given freely and without undue influence, coercion, or duress. Clients' choice and right to refuse services should be discussed. Limits of confidentiality should be explained in clear and understandable language, and clinicians should recognize that a release of information allows but does not necessarily compel sharing of all clinical material without reason and discretion. One size does not fit all, and our ethical codes require us to collaborate with clients to determine a clear path to successful completion of individualized goals (which is consistent with RNR). The ultimate goal of any therapy is to enhance psychological well-being, which is also likely to contribute to desistance from crime.

There are a few other considerations to highlight in response to these survey participants. First, given evidence of DNA exonerations in sexual assault cases (Saber et al., 2022), it is possible that a small number of our clients were indeed falsely accused or wrongly convicted. This creates an inherent dilemma for both the mandated client and the treatment provider, but denials should be explored in treatment and not unilaterally dismissed as untrue. Second, we should be willing to hear the discomfort of clients who underwent PPG and computerized sexual interest assessments. We should be sensitive to the intrusive and embarrassing nature of these procedures and recognize that they might be re-traumatizing for survivors of past sexual or physical abuse (Raja et al., 2015). Physical touch by professionals can trigger reminders and hyperarousal about past violations including abuse, medical trauma, or mistreatment perpetrated by an authority figure in an institution of trust (Raja et al., 2015). Finally, we should be aware of the potential vicarious trauma and/or reminders of one's own victimization when clients hear other group members share details of their abusive behavior.

Incorporating trauma-informed practices. Negative childhood experiences are not uncommon for people who sexually offend, and early adversity can cause loneliness, boundary confusion, and lack of social skills (Grady, Levenson, Glover, & Kavanagh, 2022; Kåven et al., 2019; Levenson et al., 2018). Complex trauma can precipitate deficiencies in executive functioning (such as attention, inhibition, problem-solving, flexibility, and planning) (Ansbro, 2008; Grady et al., 2016; Masten & Cicchetti, 2010;

van der Kolk, 2006). These characteristics can contribute to the dysfunctional antisocial lifestyle described within the central eight criminogenic risk factors (Bonta & Andrews, 2017; Cheng et al., 2019; Vaske, 2017). Case conceptualization that integrates the neuroscience of trauma provides a nexus between the etiology of problematic sexual behavior, assessment of risk factors, and strengthening of protective factors for prevention (Craig & Rettenberger, 2018; de Vries Robbé et al., 2015; Swaby et al., 2020).

Trauma should therefore be viewed as a salient aspect of treatment rather than viewed as an excuse for offending and avoided (Grady, Levenson, Glover, & Kavanagh, 2022). Clients report that psycho-education about dysregulation and hyperarousal helps them understand how past traumas might influence subsequent offense behavior and dynamic risk factors (Grady et al., 2022; Scott & Jenney, 2022). It is also clear (though often ignored) that involvement in the criminal legal system creates real and ongoing traumatic stress, which can contribute to maladaptive coping and dynamic risk (Glantz et al., 2017; Harris & Levenson, 2021; LeBel & Richie, 2018; Pettus-Davis et al., 2019; Western et al., 2015).

Treatment programs serving clients who perpetrated sexual harm should apply trauma-awareness, create emotional safety for help-seeking, foster opportunities for connection, and facilitate skill-building so clients can meet their needs in healthy ways that are neither victimizing nor self-destructive (Levenson et al., 2017; Scott & Jenney, 2022; Swaby et al., 2020). In treatment, clients may appear to be either agitated or detached, which can be misinterpreted by therapists as resistance or lack of motivation. Overly confrontational or invalidating responses can re-activate past trauma and exacerbate hyperarousal and dysregulation. In order to avoid and/or repair therapeutic ruptures that disrupt treatment progress, therapists must be attuned to the maladaptive relational patterns that clients re-enact (Teyber & Teyber, 2017; Watson et al., 2015). Scott and Jenney (2022) emphasized that coercive or confrontational interventions with people who perpetrate violence will paradoxically reinforce distorted beliefs that relationships involve imposing power over others. When we reduce the sense of emotional threat, we offer a corrective experience that better enables clients to explore and change distorted thinking, dysphoric emotions, and dysregulated behavior.

Translating risk-need-responsivity concepts to practice realities. Many participants in this study related their dissatisfaction with programs that utilized a one-size-fits-all approach. The principles of effective correctional rehabilitation require case planning based on individualized risks, needs, and responsivity factors (Andrews & Bonta, 2010; Hanson et al., 2009; Jung, 2017). Not all clients present the same level of risk for reoffense, and not all possess the same risk factors or treatment needs. Responsivity principles call for a treatment provider to be prepared with a flexible repertoire of strategies to empower the capacity to benefit from treatment. It is important to distinguish client motivation (which is about the client's readiness for change) from responsivity (which is about the clinician reducing engagement barriers and enabling an environment conducive for change) (Ward et al., 2004).

Interestingly, attempts to apply RNR directly to sex offending treatment practice (Jung, 2017) have largely neglected trauma knowledge. For instance, although adverse childhood experiences are briefly discussed in Jung's (2017) list of specific responsivity factors (p. 63), no tangible examples follow to describe assessing for trauma and conceptualizing how it might interfere with treatment engagement or amenability. Likewise, current RNR models lack tools for building in trauma-informed case planning and trauma-responsive interventions. In order to improve treatment services, we need an integrative bio-psycho-social conceptualization of personality pathology, dysregulation, cognitive schemas, dynamic risk, criminogenic needs, and client strengths -- all in the context of clients' collective life experiences (Levenson et al., 2022; Swaby et al., 2020).

Dynamic risk factors include antisocial attitudes, behaviors, or peers, sexual entitlement or preoccupation, intimacy deficits, impulsivity, substance abuse, lack of prosocial activities, negative moods, or hostility (Hanson & Harris, 1998; Ward & Fortune, 2016). These factors can stem from dysregulation and maladaptive patterns related to trauma, so the link between traumagenic life experiences and dynamic risk should be considered (Grady, Levenson, Glover, & Kavanagh, 2022). Practitioners should also recognize the intersectionality of disempowering life experiences (e.g. child maltreatment, family dysfunction, poverty, structural racism, oppression of marginalized groups, and incarceration) to inform our understanding of the client's response to treatment (Anda et al., 2006; Bryant-Davis, 2019; Glantz et al., 2017; Pettus-Davis et al., 2019; Scott & Jenney, 2022; Swaby et al., 2020; Western et al., 2015).

Traditional cognitive-behavioral relapse prevention programs been deficit-focused. They strongly emphasized assumptions of paraphilic disorders, repetitive offense cycles with predictable elements, and offense-related distorted cognitions and attitudes. A broader construction of individual risks and needs could be re-envisioned in the following ways. Treatment goals should focus not only on thinking errors about sexual abuse, but also on early maladaptive schemas about self and others (Young et al., 2003) that thereby shape offense-supportive beliefs. Attending to relational and attachment patterns (Alexander, 2013; Birrell & Freyd, 2006; Tosone, 2013) can address intimacy deficits. Reoffense prevention should be re-imagined as a broader scope of general, emotional, and sexual self-regulation skills along with applicable interpersonal boundaries rather than a prescribed template of cyclical factors and avoidance tactics (Levenson et al., 2017; Yates et al., 2010). Finally, strengths-based models should identify and build protective factors (de Vries Robbé et al., 2015) and healthy sexuality (Watter & Hall, 2020). Programs can transform interventions from being content-driven and psychoeducational to a more collaborative, flexible, process-oriented, and corrective experience that guides clients to meet relational needs in healthy ways.

Implications for research and policy

Qualitative research can elucidate what works to prevent recidivism from the perspective of service users. Consumer research can inform the integration of trauma-

responsive and client-centered practices into RNR models of treatment for sex offending. Policymakers should reconsider social policies that unnecessarily impede protective factors, and allow research evidence to guide individualized application of relevant restrictions (Hanson et al., 2018; Levenson et al., 2016). Legislators, sex offender management boards, and licensing or certification bodies should consider qualitative research in addition to quantitative data when formulating clinical program design, implementation, delivery to clients, and training for mental health professionals. Interdisciplinary partnerships between researchers, community supervision officers, judges, and clinicians would facilitate collaboration about treatment goals and individualized case planning.

Limitations

A limitation of our research is that it lacked a rich diversity of participants and therefore may not be representative of the sex-offense treatment client population across the U.S. Our online survey required Internet access which some registrants may be prohibited from accessing. The registry reform advocacy groups who helped us recruit participants seem to be populated by more educated, affluent, and resourceful families. Minority groups are under-represented in this study but over-represented in criminal justice systems, and therefore we recognize the need to reach diverse racial and ethnic groups, those from other marginalized (e.g., LBGTQ+), underserved, or impoverished communities, and female clients. The sample might reflect self-selection bias, and we have no way to confirm their self-reported experiences. Those with a grievance to vent might be more motivated to seek an opportunity to engage in survey research. On the other hand, many participants shared positive treatment experiences, and these are informative in our efforts to understand what was helpful.

Conclusion

The voices of service users can contribute valuable knowledge about treatment interventions. We should welcome and embrace the participation of clients in narrative data collection to inform the effectiveness of treatment to prevent sexual reoffending. As with other consumer communities, who declare "nothing about us without us!" (Charlton, 1998), justice system clients should be empowered to play a crucial role in improving service delivery (Ahmed et al., 2021; McCartan et al., 2021). Qualitative criminology research is limited, but there is a need to give voice to the personal experiences of justice-involved persons to enhance correctional and rehabilitative services (Copes et al., 2020; LeBel & Richie, 2018; Waldram, 2007).

It is unsurprising that we sometimes grapple with engaging or believing our clients. The dilemma of strengths-based rehabilitation requires us provide humane treatment while reckoning with the harm caused by our clients' egregious acts. There is a need to disentangle treatment, which should be empowering and client-centered, from the criminal legal system and its duty to punish wrong-doers (Kewley, 2017). The burden

of trust is on mental health professionals to create safe environments for clients to share without fearing (as one participant eloquently described) that clinicians will use their words as "ammunition to shoot at me instead of help me." If we want to continue to move forward to enhance effectiveness, risk reduction, and sexual harm prevention, we need to be willing to hear and believe what our clients tell us about their experiences in treatment (Waldram, 2007).

Author's Note

In this paper, in accordance with journal and APA guidelines, we strive to use person-first language. We use the term "sex offender" in the abstract, however, knowing that potential readers might search for that keyword when seeking relevant literature. Otherwise, we used the term only when it was a quote from a participant, part of a reference/citation, or describing a public policy (e.g. sex offender registry).

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Note

1. Because the question asked participants to "describe your experience in any treatment, counseling, or therapy that you received related to the sex offense (positive and/or negative)" we conducted word counts on those two words as a first step in looking for themes. The vocabulary used to describe these two themes was so diverse that further word counts were less informative. Frequencies of thematic content are noted in Table 2.

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