

**REHABILITATION COUNSELING STUDENTS' ATTITUDES TOWARD SEX  
OFFENDERS WITH MENTAL ILLNESSES**

**BY**

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Psalm 86:11

Teach me Your way, O Lord that I will walk in Your truth. Unite my heart to fear and honor Your name.

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## ABSTRACT

## REHABILITATION COUNSELING STUDENTS' ATTITUDES TOWARD SEX

## OFFENDERS WITH MENTAL ILLNESSES

BY

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Chair: Dr. Amy B. Spagnolo

This study attempted to compare the attitudes of prospective rehabilitation counselors (PRCs) toward sex offenders with a mental illness to sex offenders without a mental illness, while considering sex offense typology. The Community Attitudes Toward Sex Offenders Scale (CATSO) was used to assess attitudes of 191 students currently enrolled in Council for Accreditation of Counseling and Related Educational Programs (CACREP) from four states.

Employment acquisition for people with a history of criminal activity is indispensable (Singer et al., 2013). In fact, being gainfully employed reduces recidivism for formerly incarcerated individuals, including individuals charged with sex crimes (Nally et al., 2014; Singer et al., 2013). In the Nally study, 63% were employed and 45% did not recidivate. Research shows that employment for people with disabilities is an essential component in the rehabilitative process (Bond et al., 2001). Rehabilitation counselors, based on the principles guiding the vocational rehabilitation field, have a responsibility to work with sex offenders with mental illnesses who are seeking employment, according to CACREP standards. In order to provide equitable employment services to sex offenders with mental illnesses, PRCs should consider what their attitudes convey to this alienated and stigmatized population (Singer et al., 2013).

The findings indicated that PRCs did not have a high degree of negative attitudes towards sex offenders. Their attitudes were overall neutral. Second, there were no differences in attitudes based on sex offense typology. Adult offenders were not viewed more negatively than child offenders and vice versa. Third, PRCs who self-identified as being sexually victimized held more positive attitudes toward sex offenders than PRCs who indicated that they were not sexually victimized. Last, there were no differences in PRCs viewing sex offenders with a mental illness more negatively than a sex offender without a mental illness. This research is essential in contributing to a greater understanding of how attitudes toward sex offenders with mental illnesses can either assist or impede the vocational rehabilitation process.

## **Chapter I**

### **INTRODUCTION AND BACKGROUND**

#### **Context and Background of the Problem**

Assessing the attitudes of prospective rehabilitation counselors (PRCs) toward sex offenders with mental illnesses is critical to the provision of equitable services to an alienated and stigmatized population (Reardon, 1992; Singer, Maguire, & Hurtz, 2013). Regardless of disability classification, the next generation of rehabilitation counselors enrolled in a Traditional or Clinical Rehabilitation Counseling program in Council for Accreditation of Counseling and Related Educational Programs (CACREP) will be tasked with performing various work activities to assist persons with disabilities in becoming gainfully employed, some who will be labeled as sex offenders. Previous research has examined rehabilitation counselors' attitudes toward providing services to various populations such as individuals diagnosed with HIV/AIDS (Lewis, Dutta, Miller, Washington, & Kundu, 2007) and individuals diagnosed with substance use disorders (Rodgers-Bonaccorsy, 2010). The attitudes of nurses, undergraduate psychology students, police officers, probation officers, prison officers, psychologists, and counselors toward sex offenders have been examined (Fitzke, 2009; Harper, 2012; Lea, Auburn, & Kibblewhite, 1999; Nelson, Herlily, & Oescher, 2002; Simon, 2010). However, there is no published research surveying the attitudes of PRCs toward sex offenders with mental illnesses. To further complicate matters, sex offenders are not a homogeneous group (Ferguson & Ireland, 2006; Lea & Kibblewhite, 1999). According to Ferguson et al., there are diverse typologies of sex offenders, i.e., rapists and pedophiles. Even more confounding, sub-sets exist

within the two typologies. For example, within the typology of rapist, there is “acquaintance” or “stranger” rapist(s). Under the typology of pedophiles, “familial” or “stranger” molestation exist. Subsequently, little research has been conducted on the attitudes toward the various typologies and the accompanied sub-sets of sex offenders. In addition to the various typologies, there are numerous behaviors characterizing a sex offender (Stinson & Becker, 2011), from public nudity and urinating in public to sexual relations with a minor who falsified their age (New York Times Magazine, 2011). Despite inappropriateness or severity of charges, if convicted of a sex crime, the person is considered a sex offender.

Measuring attitudes is essential in understanding how perceptions and stereotypes are formed (McCormick, Walkey, & Taylor, 1984). According to Ajzen and Fishbein (1977, 1980), how one feels about a person or an object, can ultimately determine one’s attitude, the behavioral intention, and then the behavior itself. In fact, Ajzen et al. definitively pointed out “people’s actions are found to be systematically related to their attitudes when the nature of the attitudinal predictors and behavioral criteria are taken into consideration” (p. 888). In conjunction with attitudes, Ajzen (1991) suggests that “*Intentions* [italics added] are assumed to capture the motivational factors that influence a behavior; they are indications of how hard people are *willing* [italics added] to try; of how much of an effort they are planning to exert, in order to perform the behavior” (p. 181). Regarding sex offenders, the consensus, among the general population is that they are predators, lacking redemptive qualities (Wevodau, Cramer, Gemberling, & Clark, 2016). This narrative promulgated by the media (Singer, et al., 2013) and insufficient empirical data regarding the proclivity of

sex offenders to engage in deviant sexual behavior (Wevodau, et al.,) could potentially influence the public's attitude about this segment of the population. Consequently, PRCs, not immune to prejudice, (Rosenthal & Berven, 1999) could also internalize the belief that *all* sex offenders are dangerous. For PRCs who harbor these stereotypical views, their intention, according to Ajzen (1991) might be 1) to not work with this population; or 2) work with population but provide inadequate service delivery. Wong, Chan, Cardoso, Lam, and Miller (2004) affirm this notion. They suggest these biases could underestimate the client's potential, thereby hindering their opportunity to become gainfully employed. Ultimately, such biases toward sex offenders can negatively affect their community re-integration and accomplishment of vocational rehabilitation goals. According to Nally, Lockwood, Ho, & Knutson (2014), unemployment is a predictor of recidivism. In fact, the unemployment rate for sex offenders in the state of Indiana from 2005 to 2009 ranged from 96.6% to 77%, respectively (Nally, et al.). This study further revealed that of the 202 sex offenders identified, 17.8% reoffended within 3 to 6 months.

### **The Role of Rehabilitation Counselors**

Rehabilitation counselors (RCs) assist “people with physical, mental, developmental, and emotional disabilities to live independently. They [rehabilitation counselors] work with clients to overcome or manage the personal, social, or psychological effects of disabilities on employment or independent living” (Bureau of Labor Statistics, 2015, p. 1). Regardless of disability, research shows that “employment plays a significant role in assisting PWDs [people with disabilities] to live independently, gain financial stability, and establish social networks” (Huang, et

al., 2014, p. 40). Oftentimes, accompanying the disability, are secondary or tertiary barriers. For instance, unreliable transportation to and from work, coupled with inadequate childcare are secondary and tertiary barriers to acquiring and maintaining employment. Essentially, unaddressed barriers can preclude someone from becoming employed. Community notification laws (Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Program, 1994; Pam Lynchner Sexual Offender Tracking and Identification Act, 1996; Megan's Law, 1999; Adam Walsh Child Protection and Safety Act, 2006) in place to "keep track of sex offenders" (Fitzke, 2009, p. 16), combined with employer background checks, result in sex offenders experiencing unremitting barriers leading to unfulfilled employment aspirations (Holzer, Raphael, & Stoll, 2006).

In their course of study, PRCs become aware of the complexities of various disabilities such as sensory, developmental, neurological, physical, psychiatric, learning, and substance dependencies. Of the disabilities previously mentioned, studies show clinicians and paraprofessionals most negatively view substance dependencies and mental illnesses (schizophrenia, schizoaffective, major depression, and bipolar) (Rogers-Bonaccorsy, 2010; Wong, et al., 2002). With regards to mental illnesses, Olney and Gill (2016) reported that the Council on Rehabilitation Education (CORE), the previous accreditation body responsible for guiding vocational rehabilitation standards in academia, have not adequately prepared PRCs to work effectively with people diagnosed with mental illnesses. Further, within CORE accredited programs, "sex offender" is minimally addressed. In section C.10.14: Programs for specialty populations are intended to "describe programs of services for

specialty populations including but not limited to: spinal cord injury, traumatic brain injury, intellectual disabilities, sensory disability, *correctional* [ital. added] and veterans” (CORE, 2014, p. 15). Consequently, specifically learning about sex offenders with a disability in a CORE accredited program was discretionary; not mandatory. CORE required that 10 curriculum standards were met. Within each standard, there was a minimum of four knowledge domains. A graduate student in a CORE accredited program was expected to graduate with at least 48 semester hours with the knowledgebase of understanding multiple disability groups and counseling techniques. Considering the comprehensive nature of CORE, outside the knowledge domain specifically related to specialty populations, there was no other standard that specifically addressed the issue of sex offenders with disabilities. Considering CORE’s previous accreditation standard of “providing graduates who have the skills, knowledge, and *attitudes* [italics added] necessary to provide rehabilitation counseling services to individuals with physical, mental, and/or emotional disabilities” (CORE, 2014, p. 2), it appeared as if CORE accredited programs may not have adequately prepared the next or prior generation of rehabilitation counselors to work effectively with sex offenders with mental illnesses, and were not expected to with the merger of CORE to CACREP in July, 2017. Similarly, to CORE, CACREP’s 2016 standards for Clinical Rehabilitation Counseling state that students “will demonstrate the professional knowledge and skills necessary to address a wide variety of circumstances within the clinical rehabilitation context” (CACREP, 2020) However, when reviewing the various standards: Foundations, Contextual Dimensions, and Practice, there is no coursework specifically focused on the forensic population.

Further, Rehabilitation Counseling has its own unique CACREP standards. Although they are similar to the Clinical Rehabilitation Counseling standards, Rehabilitation Counseling coursework within the Contextual Dimension mentions stigma and “attitudinal barriers as they relate to disabilities” (CACREP, 2020). While stigma is mentioned, there does not exist specific coursework addressing a forensic population. Further, some of the programs surveyed for this study were dual programs with an emphasis in clinical mental health. Even in clinical mental health, forensic issues are not a requisite.

### **The Rationale for Study**

In a given year, 25% of adults diagnosed with mental illnesses live in the United States (Centers for Disease Control and Prevention [CDC], 2013). Of that percentage, 2% to 5% identify also as sex offenders diagnosed specifically with schizophrenia (Alish et al., 2007). Stinson and Becker (2011) evaluated 245 inpatient psychiatric sex offenders. They found that 60% were diagnosed with mood disorders; 67% with psychotic disorders; 52% with substance use disorders; and 14% with anxiety disorders. Yet, research shows that employment for both groups (sex offenders and people with mental illnesses) is a positive attribute for successful community re-integration (Bond, Resnick, Drake, Xie, McHugo, & Bebout, 2001; Nally, et al., 2014). Basically, employment reduces both recidivism (Nally et al., 2014) and symptomatology (Gold, Macias, & Rodican, 2014). One goal of rehabilitation counselors is to assist people with disabilities to procure employment, despite their barriers. However, if rehabilitation counselors harbor negative attitudes toward sex offenders and/or people with mental illnesses, how would they properly address the rehabilitative needs of a future consumer who identifies as both? In addition, there is



no published research identifying the attitudes of PRCs toward the following groups:

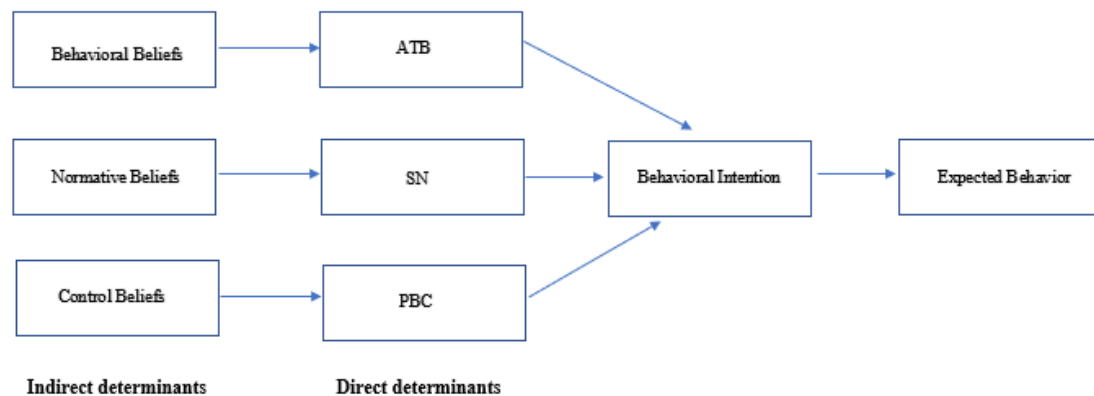
1) sex offenders; 2) people with mental illnesses; or 3) sex offenders with mental illnesses. Further, there is limited research identifying the various typologies of sex offenses. With little knowledge of the typologies, PRCs could provide identical vocational services, thus eliminating individualized vocational rehabilitation goals. In preparation for community reintegration, the next generation of rehabilitation counselors needs to be equipped to assist with goal-setting strategies and skill building techniques for employment. But, if current attitudes of PRCs are stigmatizing, they may prefer to not work with sex offenders with mental illnesses or provide sub-standard services.

### **The Rationale for the Theory of Planned Behavior: Behavioral Beliefs**

Considering the lack of research about the attitudes of PRCs toward sex offenders with mental illnesses, the theoretical framework for this research project was the Theory of Planned Behavior (TPB). This is the first attempt to examine and understand PRCs' attitudes and their intentions as they relate to working with sex offenders with mental illnesses. Therefore, the TPB complements this research endeavor because of its attitudinal predictors (Ajzen et al., 1977) in understanding behavior. Further, in an effort to explain human action, Ajzen's (1991, 2002) TPB suggests that there are three paths influencing human behavior: beliefs about the behavior producing a favorable or unfavorable outcome, Behavioral Beliefs [BB]; beliefs from social normative pressures to perform the behavior, Normative Beliefs [NB]; and beliefs about the presence of factors that may facilitate or hinder performance of the behavior based on past experiences or anticipatory events, Control

Beliefs [CB]. All three components are considered indirect determinants. Next, corresponding with each indirect determinant are three direct determinants: (Attitudes Toward the Behavior [ATB], Subjective Norms [SN], and Perceived Behavioral Control [PBC]). ATB “refers to the degree to which a person has a favorable or unfavorable evaluation or appraisal of the behavior in question” (Ajzen, 1991, p. 188); SN refers to social pressures from others to perform or not to perform the behavior in question (Ajzen, et al.); and PBC refers to the ease or difficulty in performing the behavior in question based on past experiences or anticipatory barriers (Ajzen, et al.). All three direct determinants predict intention to perform the behavior in question (see Figure 1)

Figure 1  
*Theory of Planned Behavior Pathway*



Subsequently, Intention is a high predictor of performing the behavior in question. For example, BB influence ATB; ATB influence Intention which leads to performing the behavior. However, this study will not examine the entire theory. Investigating NB (social pressures to perform a behavior based on others' expectations) and CB (performing the behavior in question based on past experiences or anticipatory

barriers) is not supported for this study since respondents in the subject pool will not hold a master's degree in rehabilitation counseling and thereby will not be practitioners in the field. It is expected that PRCs will have limited experience and exposure providing professional vocational rehabilitation counseling (counseling) to sex offenders with mental illnesses. Consequently, they are not able to determine the social expectations from others in performing the task of counseling sex offenders with mental illnesses. Nor are they able to establish a belief based on past professional experiences of counseling sex offenders with mental illnesses. For these reasons, the indirect determinant BB will be the sole component tested since attitudes toward performing a behavior can be ascertained with or without prior knowledge or experience in performing a behavior. Behavioral beliefs, according to Ajzen (1991, 2002, 2006) are based on consequences of a behavior, asking: Will the behavior produce a comfortable or uncomfortable outcome? These beliefs influence attitudes toward any behavior.

The TPB theorizes that after a person's attitude is established, the intention to engage in a behavior leads to "behavioral achievement" (Ajzen, 1991, p. 184) or termination of an expectant behavior due to its uncomfortable conditions. Fortunately, there has been substantial use of the theory in examining attitudes and behavioral intentions. For instance, graduation rates among African American students have been assessed (Davis, Ajzen, Saunders, & Williams, 2002). Davis et al. found that the TPB was a better predictor of intent to complete an academic year and graduate high school than was the students' GPA. The TPB was also used in examining the behavioral intentions of teachers, school psychologists, and counselors toward intervening and

preventing harassment for the lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) youth (McCabe, Robinson, Dragowski & Utnick, 2013). Educators and school personnel who strongly believed favorably about advocating had greater intentions to advocate, over those who believed less favorably about advocating. Further, rehabilitation counselors' personal attitudes toward engaging in job development and placement was examined by Schultz (2008). It was reported that rehabilitation counselors had negative attitudes toward the job function of placing their clients in employment opportunities, thus limiting their involvement in this work activity category. Regrettably, with scant information about PRCs' attitudes leading to behavioral intentions, it is challenging to gauge their behavioral intentions in working with the sub-population of sex offenders with mental illnesses.

### **Statement of the Problem and Goal of the Study**

Stigma associated with sex offenders is well founded but disconcerting as it relates to desistance, the process of rehabilitating from criminal activities (Willis, Levenson, & Ward, 2014). Without fully comprehending the nature of the sex crime, it is common for some people to automatically assume that all sex offenders are irredeemable. For example, sex offender status can range from public nudity to urinating in public. To complicate matters, there are also various typologies of sex crimes with little research focused on the differences. Further, there is no research on the attitudes of rehabilitation counselors toward sex offenders or sex offenders with mental illnesses. In a field where rehabilitation professionals work with vulnerable populations, sex offenders with mental illnesses are often doubly stigmatized. Supported employment agencies disregard them (Whitley, Kostick, & Bush, 2009).

Employers shun them (Tewksbury & Lees, 2006) and the community fears them (Burchfield & Mingus, 2008; Tewksbury et al.). Despite the negative beliefs associated with sex offenders from the general population, the rehabilitation counselor is responsible for working with this sub-population in preparing them to become self-sufficient through meaningful employment. Ultimately, PRCs need to consider what their attitudes convey to future consumers who are sex offenders with mental illnesses. Through path analysis, the TPB has been effective in demonstrating that attitudes lead to behavioral intention; and intention is antecedent to behavioral performance (Corbiere, et al., 2011; Davis, et al., 2002; Knaeps, Neyens, Donceel, van Weeghel, & Van Audenhove, 2015; Lee, Cerreto, & Lee, 2010; McCabe, et al., 2013; Schultz, 2008; Werner, 2012). Based on numerous studies utilizing the TPB in understanding human behavior, the theory's direct determinant of ATB was the theoretical framework guiding this study. Additionally, because of its adequate psychometric properties (Chui, Kwok-yin Cheng, & Ong, 2013; Church, Wakeman, Miller, Clements, & Sun, 2008; Shelton, Stone, & Winder, 2013; Wevodau, et al., 2016), the Community Attitudes Toward Sex Offenders Scale (CATSO), an 18-item scale, was used to assess the attitudes of PRCs toward sex offenders with mental illnesses.

PRCs have the propensity to view sex offenders negatively. According to Rosenthal and Berven (1999), if these systemic biases were to occur, "Important information may be missed; extraneous information may be given undue weight; observations and other information may be misinterpreted; and the processing and integration of information may be faulty" (p. 22). Therefore, the goal of this study was to examine PRCs overall attitudes toward sex offenders with and without a mental

illness. As a result of this line of examination, systemic biases may be discovered which could be damaging in the vocational rehabilitation process for the consumer who identifies as a sex offender with or without a mental illness.

### **Research Aims and Questions**

The research aim of this study was to compare the attitudes of PRCs toward sex offenders with a mental illness to sex offenders without a mental illness while considering sex offense typology.

The participants for this study were graduate rehabilitation counseling students from five CACREP accredited graduate programs, specializing in traditional or clinical rehabilitation counseling throughout the Northeast region of the United States. The schools Rutgers University, Central Connecticut State University, Hunter College, University of Maryland Eastern Shore, and Hofstra University were selected based on their geographical location in order to increase generalizability; and diversity of respondents surveyed. CACREP accredited programs within a 4-hour driving distance of the researcher's central location were selected.

The research questions guiding this study were as follows:

1. What are the overall attitudes of PRCs toward sex offenders?
2. Will there be differences in attitudes based on age of victim (adult vs. child)?
3. Will PRCs who have been sexually victimized have more positive attitudes toward sex offenders than PRCs who did not have this experience?
4. Will a sex offender with a mental illness be viewed more negatively than a sex offender without a mental illness?

**Hypotheses:**

The following hypotheses were predicted in this study:

1. PRCs will have negative attitudes toward sex offenders.
2. Child victimization will be more negative than adult victimization.
3. PRCs with a history of being sexually victimized will have more positive attitudes toward sex offenders.
4. PRCs will view sex offenders with a mental illness more negatively than a sex offender without a mental illness.

**Rationale for Hypotheses**

The first hypothesis, that participants will have negative attitudes toward sex offenders is based on the finding by Harper (2012) who examined 178 British undergraduate psychology students. According to Harper et al., psychology students held negative beliefs toward sex offenders. In fact, psychology students held more negative attitudes toward sex offenders than non-psychology students. Further, Sanghara and Wilson (2006) examined the stereotypical views of experienced versus inexperienced professionals in the treatment of sex offenders. Sanghara and colleague found that the inexperienced group, who had no known professional contact with sex offenders, had more stereotypical views of sex offenders. Sanghara et al. concluded that less knowledge about sex offenders increased stereotypical biases toward sex offenders.

Bennett and Stennett (2015) investigated attitudes toward persons with a mental illness among 102 nursing students enrolled in an undergraduate program in Jamaica. The overall findings indicated that nursing students had negative attitudes towards persons with mental illnesses. The respondents viewed persons with a mental illness as being dangerous, cold-hearted, and dirty. Research also suggests that

positive attitudes toward sex offenders and persons with a mental illness are correlated with having more professional and personal contact with a sex offender and with a person diagnosed with a mental illness (Stinson & Becker, 2011; Willis, Levenson, & Ward, 2010).

The second hypothesis is that pedophilia (child offenders) will elicit more negative attitudes than adult sex offense types is based on research conducted by Ferguson and Ireland (2006). Using four typologies (adult stranger rapist, adult acquaintance rapist, incest (familiar) child offender, and [stranger] child offender) of sex offense type, Ferguson et al., found that men held less positive attitudes toward perpetrators who violated children than toward perpetrators who violated adults.

The third hypothesis that participants who have been sexually victimized will have more positive attitudes toward sex offenders is based on research conducted by Ferguson and Ireland (2006) and Nelson, Herlily, and Oescher (2002). Ferguson et al. specifically examined attitudes toward sex offenders based on sex offense type. They found that participants who indicated being sexually victimized had more positive attitudes toward sex offenders than those who did not report as being sexually victimized. Nelson et al. found that counselors who reported that they or someone close to them was sexually victimized had more positive attitudes toward sex offenders than those who did not have this experience. Nelson et al. concluded that a familiarity of personal challenges and characteristics of sex offenders, results in less judgmental attitudes.

The forth hypothesis that PRCs will view sex offenders with a mental illness more negatively than a sex offender without a mental illness is based on related



research conducted by Mittal et al. (2014) who compared the attitudes of 205 mental health providers (psychiatrists, psychologists, and mental health nurses) and 146 primary care providers (nurses and physicians) toward persons diagnosed with and without schizophrenia from five Veterans Affairs (VA) facilities. Mittal and colleagues hypothesized that healthcare providers would have more negative attitudes overall toward patients diagnosed with schizophrenia than toward patients without the diagnosis. Using regression models, results indicated that the primary care cohort harbored more negative attitudes toward the patient with schizophrenia compared to the patient without schizophrenia on the Characteristic Scale and Attribution Questionnaire. In examining social distance, both cohorts (mental health providers and primary care providers) desired greater social distance from the patient diagnosed with schizophrenia than the patient without the diagnosis. See Table 1, below for further rationale for hypotheses.

Table 1  
*Rationale for Hypotheses*

Hypotheses	Authors	Sample	Rationale for Hypotheses
PRCs will have negative attitudes toward sex offenders.	Harper (2012)	178 British psychology and non-psychology students' attitudes toward sex offenders	Psychology students held more negative attitudes toward sex offenders than non-psychology students
	Sanghara and Wilson (2006)	Examined stereotypical views of experienced (n=60) vs. inexperienced (n=71) professionals in the treatment of sex offenders	Inexperienced group with no known professional contact with sex
	Bennett and Stennett (2015)	102 nursing students undergraduate nursing students' attitudes toward persons with a mental illness	Viewed persons with a mental illness as being dangerous, cold-hearted, and dirty
Child victimization will be more negative than adult victimization.	Ferguson and Ireland (2006)	139 participants (49 students and 90 forensic staff) assessing attitudes toward sex offenders and the influence of sex offense type	Men held less positive attitudes toward perpetrators who violated children than toward perpetrators who violated adults

Respondents with a history of sexual victimization will have more positive attitudes toward sex offenders.	Ferguson and Ireland (2006)  Nelson, Herlily, and Oescher (2002)	Same as above  437 counselors surveyed about attitudes toward sex offenders	Participants who indicated that they were sexually victimized had more positive attitudes toward sex offenders
PRCs will view sex offenders with a mental illness more negatively than a sex offender without a mental illness.	Mittal (2014)	Attitudes of 205 mental health providers and 146 primary care providers toward patients with schizophrenia vs. patients without schizophrenia	Primary care workers had more negative attitudes toward patients with schizophrenia than toward those without the diagnosis; when examining social distance both cohorts desired greater social distance from the

### Definitions of Terms

The following operational definitions will be used in this study:

#### **Prospective Rehabilitation Counselor:**

A student currently enrolled in a master's level CACREP accredited program specializing in traditional or clinical rehabilitation counseling. (July 2017, the Council on Rehabilitation Education (CORE) merged with CACREP, thus eliminating CORE standards from the vocational rehabilitation field.)

#### **Rehabilitation Counselor:**

A professional who has a master's degree in rehabilitation counseling or is a Certified Rehabilitation Counselor (CRC) who is dedicated to assisting individuals with disabilities obtain vocational goals by means of counseling, case management, client

assessment, service planning, rehabilitation services coordination, job analysis, job development/placement, and advocacy (Commission on Rehabilitation Counselor Certification, [CRCC] 2014; Rubin & Roessler, 2001).

**Sex Offender:**

A person who has been criminally charged and convicted of, or has pled guilty to a sex crime. The term is most commonly associated with rapists, child molesters, including female sex offenders, juvenile sex offenders, and cyber-sex offenders (Robertiello & Terry, 2007).

**Attitudes:**

A belief and an evaluation of an entity in question (Ajzen & Fishbein, 1977).

**Mental Illness:**

An emotional or mental impairment that substantially limits one or more of the major life activities of an individual (National Rehabilitation Information Center, 2014).

**Stigma:**

Negative images that are applied to an individual or group (Fleurantin, 2016).

**Forensic Mental Health Facility:**

Under the jurisdiction of the criminal justice system, a facility used for people who have been found incompetent to stand trial, not guilty by reason of insanity, or a mental illness in order to assist with stabilization of disorders (Jackson & Richards, 2007; Vess, Murphy, & Arkowitz, 2004).

**Civil Confinement:**

A term applied to people considered as sexually violent predators with severe disabilities who pose an imminent danger to self or others (Jackson & Richards, 2007).

**Recidivism:**

The act of a convicted criminal reoffending (Grossman, Martis, & Fictner, 1999).

**Parole Officer:**

Serves under the judicial system to ensure that their clients (who may be sex offenders) do not commit new crimes or violate the terms of their parole (Anderson & Wildeman, 2014).

**Desistance:**

The process of rehabilitating from crime (Willis, Levenson, & Ward, 2010).

**Rehabilitation:**

Any action intended to reduce negative effects of a disorder (Pratt, Gill, Barrett, & Roberts, 2007).

**Inpatient Mental Health Facility:**

A facility dedicated solely for mental health care or a hospital with a distinct mental health section for the treatment of mental illness (Peterson, 2015).

## **Chapter II**

### **REVIEW OF THE LITERATURE**

This review of the literature defines the terms sex offender and rape; review the various typologies associated with sex offenders; describe the prevalence rates of sex offenders with mental illnesses; explain the attitudes of professionals and paraprofessionals toward sex offenders and toward persons with mental illnesses; identify the common vocational barriers sex offenders are confronted with; and discuss the ethical considerations encompassing rehabilitation counselors working with this challenging population. The intention of this study was to determine if stigmatizing attitudes exist toward sex offenders with mental illnesses among prospective rehabilitation counselors (PRCs). Thus, examining the attitudes of PRCs prior to providing counseling services to sex offenders with mental illnesses was necessary in ascertaining if prevailing attitudes could hinder the vocational rehabilitation process for sex offenders with mental illnesses who desire employment.

PRCs were defined as rehabilitation counseling graduate students enrolled in CACREP accredited programs specializing in traditional or clinical rehabilitation counseling. Icek Ajzen's Theory of Planned Behavior (TPB) was the theoretical framework guiding this study (2017). An overview of the three components (Behavioral Beliefs [BB], Normative Beliefs [NB], and Control Beliefs [CB]), associated with the theory are discussed in this chapter. However, investigating NB (social pressures to perform a behavior based on others' expectations) and CB (performing the behavior in question based on past experiences or anticipatory barriers) were not tested in this study since participants in the subject pool do not hold a master's degree in rehabilitation counseling and thereby aren't practicing

rehabilitation counseling. It was expected that PRCs will have limited experience and exposure providing professional vocational rehabilitation counseling (counseling) to sex offenders with mental illnesses. Consequently, PRCs were not able to determine the social expectations from others in performing the task of counseling sex offenders with mental illnesses due to their limited exposure of providing professional counseling services. Furthermore, since PRCs were not professional counselors, they were not able to establish a belief based on past experiences of professionally counseling sex offenders with mental illnesses. For these reasons, Behavioral Beliefs (BB) and Attitudes toward Behavior (ATB) were the sole component and direct determinant tested from the theory, since attitudes toward performing a behavior can be ascertained with or without prior knowledge or experience in performing the behavior. While researching attitudes toward sex offenders for the present study, key terms and phrases include attitudes, attitudes toward sex offenders, attitudes toward people with mental illnesses; rehabilitation counselors, rehabilitation counseling students, the Theory of Planned Behavior, sex crimes, sex offender laws, rape, pedophilia, mental illnesses, supported employment, rehabilitation counseling principles, and stigma. The aforementioned key terms were surveyed from the Academic Search Premier search engine through Rutgers University's library portal, the Commission on Rehabilitation Certification (CRCC), Cornell University Law School's Legal Information Institute's (LII) website and The United States Department of Labor's website.

### **Purpose of the Study**

Employment acquisition for people with a history of criminal activity is indispensable (Singer et al., 2013). In fact, being gainfully employed reduces recidivism for formerly incarcerated individuals, including individuals charged with sex crimes (Nally et al., 2014; Singer et al., 2013). Research shows that employment for people with disabilities is an essential component in the rehabilitative process (Bond et al., 2001). Rehabilitation counselors, based on the principles guiding the vocational rehabilitation field, have a responsibility to work with sex offenders with mental illnesses who are seeking employment. In order to provide equitable services to sex offenders with mental illnesses, PRCs should consider what their attitudes convey to this alienated and stigmatized population (Singer et al., 2013). This study examined and compared the attitudes of PRCs toward sex offenders with a mental illness to sex offenders without a mental illness, using the Community Attitudes Toward Sex Offenders Scale (CATSO) as the instrument to ascertain this information.

### **Typologies of Sex Offenders and Definition of Rape**

According to Robertiello and Terry (2007) and Cornell University Law School's Legal Information Institute [LII] (2014), a sex offender is anyone who has been criminally charged and convicted of or has pled guilty to a sex crime or offense. The term is applied to rapists, child molesters, female sex offenders, juvenile offenders, and cyber-sex offenders. Further, three distinct tiers (Tier I, Tier II, and Tier III) exist, signifying the severity of the sex offense. The upward trajectory from Tier I to Tier III indicates from least to most severe sex offense committed. For example, a Tier I conviction is possession of child pornography, with less than one-year in prison (Adam Walsh Child



Protection and Safety Act, 2006). A Tier II conviction is producing and distributing child pornography, with at least a two-year prison sentence (Adam Walsh Child Protection and Safety Act, 2006). Tier III is engaging in a sexual act with a child under the age of 12, with a prison sentence of more than one or two years (Adam Walsh Child Protection and Safety Act, 2006). In researching attitudes toward sex offenders based on sex offense type, Ferguson and Ireland (2006) identified four typologies of sex offenders: stranger and acquaintance rapists; incest child offender, and child offender where the victim is unknown to the offender. The present study distinguished the typologies of sex offenders in order to examine if attitudes of PRCs were influenced by sex offense type, as the literature suggests (Ferguson et al.). Rape and sexual assault, according to 10 U.S. Code § 920 Art. 120 (LII, 2014) is generally:

Any person subject to this chapter who commits a sexual act upon another person by—

- (1) using unlawful force against that other person;
- (2) using force causing or likely to cause death or grievous bodily harm to any person;
- (3) threatening or placing that other person in fear that any person will be subjected to death, grievous bodily harm, or kidnapping;
- (4) first rendering that other person unconscious; or
- (5) administering to that other person by force or threat of force, or without the knowledge or consent of that person, a drug, intoxicant, or other similar substance and thereby substantially impairing the ability of that other person to appraise or control conduct; is guilty of rape and shall be punished as a court-martial may direct.

### **Acquaintance Rapist**

According to Ferguson et al. (2006), four typologies are associated with sex offenders: rapists (adult acquaintance or adult stranger) and pedophilia-child (familial or molestation from a stranger). The non-stranger sexual assault (Angelone, Mitchell, & Grossi, 2015), known as acquaintance rape, along with other sexual aggression, is persistent and prevalent in the United States (Angelone et al.). Being sexually

victimized by someone known, such as a friend, colleague, dating partner or spouse is considered acquaintance rape. According to the Centers for Disease Control and Prevention [CDC] (2010), close to one in 10 women have been raped by someone familiar to them. For males, nearly one in 45 have been made to penetrate an acquaintance during their lifetime. Unfortunately, under-reporting of sexual assaults, especially cases of acquaintance rape, skews precise figures of victimization (Peterson & Muehlenhard, 2004). According to LII, “interpersonal violence within families and among acquaintances includes behavior commonly referred to as domestic violence, sexual assault, spousal abuse, woman battering, partner abuse, elder abuse, and acquaintance rape” (2014). This assault is viewed as the most common among the sexual offenses (Lundrigan, 2014).

### **Stranger Rapist**

Opposite of acquaintance rape is stranger rape where the victim has no knowledge of the perpetrator (Lundrigan, 2014). It is estimated that stranger rape comprises 18% (Walby & Allen, 2004) to 37% (Perreault & Brennan, 2009) of reported sexual assaults. Behavioral patterns in stranger rape have been researched to show that there is a distinction between the number of “perpetrators involved (lone vs. multiple) and the gender of the victim (male vs. female)” (Lundrigan et al., p. 96). In fact, Lundrigan et al. found that, “male victims were more likely than female victims to experience hostile interactions and be threatened with a weapon and were less likely to experience offender penetration and involvement interactions” (p. 97). Regardless of the encounter, sexual assault with someone unknown to the victim constitutes stranger rape.

**Pedophilia (familial)**

According to LII (n.d.), familial pedophilia or incest is:

Sexual contact between close blood relatives, including brothers and sisters, parents and children, grandparents and grandchildren, or aunts or uncles with nephews or nieces; 18 states also include copulation or cohabitation between first cousins in the definition of incest. Incest is a crime in all states, even if consensual by both parties.

**Pedophilia (child offender)**

The *Diagnostic and Statistical Manual of Mental Disorders*, 5<sup>th</sup> edition (DSM

– 5) defines pedophilic disorder as:

Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges or behaviors involving sexual activity with a prepubescent child or children, generally age 13 or under. The individual has acted on these sexual urges or the sexual urges or fantasies cause distress or interpersonal difficulty. (2013, p. 697)

Pedophilia is viewed as one of the most stigmatized mental disorders according to Jahnke and Hoyer (2013). Although the prevalence of pedophilic disorder is unclear (DSM – 5 et al.), the prevalence rate associated with pedophilia in males is estimated to be between 3% and 5% in the United States (DSM - 5 et al.). For females, the prevalence rate is unknown (DSM – 5 et al.).

**Prevalence of Sex Offenders with Mental Illnesses**

Although there is a sub-population of sex offenders diagnosed with mental illnesses, Booth and Gulati (2014) found that a precise account of sex offenders with severe mental illnesses does not exist. However, several studies have attempted to research this sub-population. Stinson and Becker (2011) reported on 245 sex offenders from an inpatient forensic facility. They found that 60% were diagnosed with a mood disorder; 67% were diagnosed with a psychotic disorder; 14% had an anxiety disorder; 52% were diagnosed with a substance abuse disorder; and 14% were diagnosed with

ADHD/impulse control disorder. After conducting their research, Stinson et al. confirmed that sex offenders are an underrepresented population in the literature with “heterogeneous psychiatric diagnoses”.

Fazel, Sjostedt, Langstrom, and Grann (2007) used a case-control design whereas data was collected from Swedish national crime and hospital discharge registers from 1988 through 2000. There were 8,495 male sex offenders compared to a randomized sample of males (N = 19,935) from the general population. They found that sex offenders were more likely to be diagnosed with a mental illness compared to the general population. In fact, of the 8,495 sex offenders, 24% had a history of psychiatric hospitalization. Schizophrenia accounted for 1.5%; bipolar disorder, 0.3%, and other psychosis, 2.5%. Further, results indicated that sex offenders were six times more likely to have a history of psychiatric hospitalization compared to the general population.

In researching the prevalence of mental illness among sex offenders in Germany, Harsch, Bergk, Steinert, Keller, and Jockusch (2005) examined three distinct groups: 40 sex offenders receiving treatment at a forensic psychiatric facility; 30 sex offenders in prison; and 26 violent offenders, not charged with a sex crime, in prison. Upon comparing Axis I disorders, as determined by the Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> edition (DSM – V), between the various groups, they discovered that 55% of sex offenders receiving treatment at a forensic psychiatric facility, 66.7% of incarcerated sex offenders, and 69.2 % of violent offenders had substance use disorders. Mood disorders accounted for 7.5% in sex offenders receiving treatment; 10% of incarcerated sex offenders; and 11.5% of violent offenders. Clearly, substance use disorders were most prevalent in all three

groups. Other researchers have focused on violent sexual predators. Due to variations in state laws, some sex offenders are considered sexually violent predators (SVPs). For sex offenders who are identified as such, they are usually civilly committed or confined to a psychiatric facility used by the court system for those individuals deemed incompetent to stand trial, not guilty by reason of insanity, guilty but insane or determined to have a mental illness and in need of stabilization (Jackson & Richards, 2007; Vess, Murphy, & Arkowitz, 2004). In Washington State, for example, an SVP, is anyone who:

1. Has been convicted of, or charged with sexual violence;
  2. Suffers from a mental abnormality or personality disorder, and
  3. As a result of the mental abnormality or personality disorder is likely to engage in predatory acts of sexual violence if not confined in a secure facility.
- (Jackson et al., p. 315).

Currently, there are 16 states that have similar SVP laws in place: Arizona, California, Florida, Iowa, Illinois, Kansas, Massachusetts, Minnesota, Missouri, New Jersey, North Dakota, Pennsylvania – juveniles aging out, South Carolina, Texas – outpatient only, Virginia, and Wisconsin (Jackson et al.,). Undoubtedly, SVP laws signify that there is a sub-population of sex offenders with mental illnesses. These individuals could reintegrate into the community (Whitley, Kostick, & Bush, 2009). Once deinstitutionalized, employment should be interwoven into their rehabilitation plan.

Singer et al. (2013) compared sex offenders on parole in California who reoffended from 2001 to 2008 with a new sex crime versus sex offenders who did not recidivate from 2001 to 2005. Both groups had a sample of 160 sex offenders. However, the researchers found that individuals in the recidivism group were more

likely to have a mental illness than the group that did not recidivate. Findings of Singer et al., indicated that having a mental illness is a risk factor for sexually reoffending. Sex offenders, similar to the general public, are diagnosed with various disabilities, including, but not limited to schizophrenia, anxiety disorders, depression, ADHD, alcohol and drug abuse, and personality disorders (Alish et al., 2007).

### **Attitudes Toward Sex Offenders**

Nelson, Herlily, and Oescher (2002) examined 437 counselors affiliated with the Association of Mental Health Counselors (N = 206) and Associations of Addictions and Offenders Counselors (N = 231). Nelson et al. assessed counselors' attitudes toward sex offenders while controlling for experience, preparation from sex offender training, and victimization status, (i.e., a victim of sexual offense). Results of this study indicated that counselors had positive attitudes toward sex offenders based on mean scores from the Attitudes Toward Sex Offender Scale (ATS). This study also found that feeling prepared from sex offender training promoted counselors having a positive attitude toward sex offenders. However, there was no significant relationship between attitudes and the extent of training the counselors received throughout their professional careers. Further, counselors who indicated that they or someone close to them, was sexually victimized had more positive attitudes toward sex offenders than those who did not have this experience. This result was contradictory from what the researchers initially predicted. Upon contemplating their result, they concluded that most victims of sexual abuse know the offenders and are able to understand their personal challenges and characteristics. Ultimately, the researchers noted that this familiarity allows the victim to be less judgmental toward sex offenders. This finding

is consistent with Ferguson et al. (2006), indicating that people who have been victims of sexual abuse have more positive attitudes toward sex offenders, than people who have not been sexually victimized. The findings of both Ferguson et al. and Nelson et al. regarding attitudes from persons who were sexually victimized is consistent with the present study's prediction that *Participants with a history of sexual abuse will have more positive attitudes toward sex offenders with mental illnesses than participants who don't have this experience*. There are two major limitations with Nelson et al.'s study. First, is the homogeneity of the subject pool. This study only surveyed counselors. Rehabilitation counselors were not included. Therefore, findings aren't generalizable to other professions such as psychologists, psychiatrics, or social workers. The second limitation is self-reporting. Due to the sensitive nature of the topic, respondents, although anonymous, may have answered survey questions in a socially desirable manner in order to avoid appearing judgmental.

Utilizing the ATS, Simon (2010) examined 272 psychologists' attitudes toward sex offenders while controlling for gender, demographic location, extent of sex offender training, and professional experience. Results indicated that there were no statistically significant differences in attitudes based on gender. However, psychologists who resided in Western and Midwestern states had more positive attitudes than psychologists who resided in the eastern and southern regions of the United States. Psychologists who received more than 30 hours of sex offender training had more positive attitudes than psychologists who had no sex offender training at all or less than 11 hours. Moreover, psychologists who worked with sex offenders had more positive attitudes than psychologists who had not worked with sex offenders.

Upon closer inspection, the researchers found that psychologists who had not worked with sex offenders had significantly more negative attitudes than psychologists who had worked 6 to 20 years with sex offenders. Similar to Nelson et al. (2002), a limitation of this study is the homogeneity of respondents. Only capturing respondents' attitudes toward sex offenders from one profession is not generalizable to other professions, such as psychiatrists, social workers, or even rehabilitation counselors. Additionally, this study only surveyed respondents who were affiliated with membership of a state psychological association. Respondents whose e-mail and website address were posted on their state psychological association website were only surveyed. Consequently, psychologists not affiliated with a state psychological association were not provided the opportunity to participate in the study. Another limitation reaffirms the present study's use of vignettes. This study did not consider sex offense type. The researcher noted that findings could have been different if specific types of sex offenders were included with the administration of the ATS. The researcher pointed out that "psychologists might have different attitudes towards offenders against children than they would toward offenders against adults" (p. 38). Harper (2012) examined 178 British undergraduate psychology students' (N = 98) and undergraduate non-psychology students' (N = 80) attitudes toward adult and juvenile sex offenders. This quantitative study utilized a modified version of the ATS questionnaire to compare the two groups. The word "sex offender" was substituted with a descriptor in one of two vignettes depicting an adult offender and a juvenile offender. Harper et al. found that the adult offender was viewed more negatively than the juvenile offender. Further, psychology students held more negative beliefs toward



sex offenders than non-psychology students. The finding of psychology students holding more negative beliefs toward sex offenders than non- psychology students essentially contradicted the researcher's hypothesis. Based on these findings, three implications were noted. The first implication pointed out by Harper et al. is social. He noted that "There appears to be a need to educate society as a whole with regards to sexual offending" (p. 10). He further states that external sources can negatively influence the mind-set of students, ultimately shaping their beliefs about sex offenders. Without properly educating society about sex offending, the current punitive belief systems may persist toward sex offenders. Second is implications for rehabilitation. The researcher noted that there is a need for training in order to "increase confidence in working with this population" (p. 11). In order for the vocational rehabilitation process to be effective, specific training needs to occur in hopes of alleviating stereotypical views surrounding sex offenders. Last is implications for education. The researcher suggests that coursework and curricula specific to sex offenders should be implemented in educational institutions so that students can learn from experts in the field thereby dismissing stereotypical views of sex offenders oftentimes promulgated by the media (Singer et al, 2013). Despite the study's use of vignettes describing various sexual offenses, there were limitations associated with this study as well. This study only surveyed undergraduate students from psychology and non-psychology programs from one university. Therefore, the findings do not consider psychology and non-psychology undergraduate students from other universities in Britain. Another limitation is the lack of variability in the ages of the respondents. The mean age was 20.83, with a standard deviation of 4.66 years. Consequently, persons in their 30's or

40's was not prominent in the survey. Perhaps, findings would have been different if the researcher expanded the subject pool to include a diverse sample of participants with variations in age.

Fitzke (2009) surveyed 68 nurses' attitudes toward sex offenders. In an attempt to examine their beliefs, four research questions guided the study: what are nurses' attitudes toward sex offenders?; are there differences among the four-factor scores on the Community Attitude Toward Sex Offenders Scale (CATSO)?: (*social isolation, capacity to change, blame attribution, and deviancy*); will nurses who have cared for a sex offender score differently than nurses who have not knowingly cared for a sex offender?; and will nurses who have sex offender education score differently than nurses without sex offender education? Utilizing the CATSO, the researcher found that nurses were non-judgmental and unbiased toward sex offenders; there were no significant differences among the four-factors of the CATSO; there were no significant differences in attitudes between nurses knowingly and not knowingly caring for sex offenders; and *capacity to change* was greater for nurses with specific sex offender education. Overall, the findings from this study revealed that nurses do not have stigmatizing attitudes toward sex offenders. However, the researcher concluded that nursing schools should implement curricula focused on sex offenders for nursing students to engage in critical thinking skills in order to learn about the ethical and legal dilemmas in caring for sex offenders. Limitations of this study occurred as a result of only capturing nurses who were registered with their state's nursing registry. This procedure resulted in a low number of respondents (N = 68). In addition, the subject pool was generated from only one state, Nebraska. Unfortunately,

findings may not generalize to other states or regions throughout the United States. For this reason, the present study intends to capture a diverse sample of participants from multiple states.

Conley, Hill, Church, Stoeckel, and Allen (2011) used the CATSO to examine the attitudes of 307 probation and community corrections workers' attitudes toward sex offenders in Montana. The data revealed the majority of respondents (82%) believed that rehabilitation is beneficial for sex offenders; 55.4% believed that sex offenders can change their deviant behavior with efficacious supports in place; 98% of those surveyed believed acquaintance sex crime is just as heinous as stranger sex crime; and 82.4% believed that sex offenders are dangerous. Overall, probation and correction workers in this region viewed sex offenders as dangerous. But, with adherence to treatment modalities, the respondents believed that rehabilitation is a realistic option. Further, Conley et al. found that assessing attitudes toward the treatment of sex offenders' warrants a multi-factor scale, because sex offenders are "multidimensional". The researchers state that "It may be advisable to specify, prior to administration of the instrument [the CATSO], what level of offender is being considered" (p. 83).

This specific finding reaffirms the present study's use of the vignettes depicting the four typologies, which will be disseminated to PRCs utilizing the CATSO. In addition to not examining sex offense type, this study did not capture respondents' gender. This study cannot conclude if males' attitudes toward sex offenders is different from females' attitudes toward sex offenders. One other limitation is the lack of diversity within the subject pool. This study only considers

respondents from a rural state, Montana. Again, generalizability is limited in that probation and community workers' attitudes toward sex offenders are not examined from other states or regions in the United States.

The Sanghara and Wilson (2006) study examined stereotypical views of experienced and inexperienced professionals in the treatment of sex offenders. The experienced group consisted of 60 specialists (probation officers, clinical/forensic psychologists; rehabilitation staff, social workers, therapists). The inexperienced group consisted of 71 schoolteachers. Three questionnaires were administered: the Stereotypes of Sex Offenders Questionnaire; Attitudes Towards Sex Offenders Scale; and Knowledge of Child Abuse Questionnaire (Sanghara et al.). Six stereotypes were used in their study, each with consistent and inconsistent stereotypical views for the following sex offender profiles: lower intellect, dirty old man, sexually frustrated, sexual obsession, stranger, and psychotic. For example, a description of the lower level intellectual man was a builder (consistent) versus a university professor (inconsistent). Each vignette provided dichotomous scenarios (consistent versus inconsistent) in order to examine the stereotypical views about perpetrators. A mediation analyses was run to assess the scores between each questionnaire. Results of this study revealed that experienced professionals had less stereotypical views than their inexperienced counterparts. Also, experienced professionals had more positive attitudes towards sex offenders and demonstrated more knowledge of child abuse than their inexperienced counterparts.

Overall findings suggest that professionals (probation officers, clinical/forensic psychologists; rehabilitation staff, social workers, therapists) who spend more time

working with sex offenders have less stereotypical views and are more knowledgeable about stereotypes of adult perpetrators than professionals with little to no interaction with sex offenders (i.e., the school teacher cohort). In addition, consistent stereotypes for the inexperienced group were viewed as more guilty than the inconsistent type of perpetrator. Ultimately, less knowledge about sex offenders increased stereotypical biases toward sex offenders. One major limitation with the Sanghara and Wilson study involved response bias. Utilizing post hoc exploratory analyses, participants did not have stereotypical views when asked directly about stereotypes. However, when asked indirectly about stereotypes, participants' responses endorsed stereotypical views of sex offenders.

### **Summary**

There are several findings and common themes among the literature reviewed regarding sex offenders. First, professionals who work closely with sex offenders have more positive attitudes toward them than professionals who do not work with sex offenders. Second, incorporating course work and curricula specific to sex offenders should be implemented in educational institutions (of the helping profession) so that students can learn from experts rather than unreliable sources, like social and media outlets. Third, sex offenders are multidimensional. As a result of their heterogeneity, assessing attitudes toward them should be conducted utilizing a multi-factorial instrument, such as the CATSO. Fourth, use of vignettes in examining attitudes toward sex offenders is beneficial in ascertaining data from the various typologies of sex offenders. Fifth, psychology students viewed sex offenders less negatively than non-psychology students, which was ultimately perplexing to the researchers. Last,

victims of sexual abuse had more positive attitudes toward sex offenders than those who were not a victim of sexual abuse.

In addition to the common themes identified, common limitations were found. Utilizing a self-reporting tool, like the ATS or CATSO can result in socially desirable outcomes. Next, limited diversity of respondents resulted in results not being generalizable to other populations. Researchers limited respondents to either one state, one age group, or one occupation. Finally, researchers neglected to examine outcomes of attitudes based on sex offender typology. See Table 2 below for Attitudes toward Sex Offenders.

Table 2  
*Attitudes Toward Sex Offenders*

<b>Instrument</b>	<b>Author</b>	<b>Participants</b>	<b>Findings</b>	<b>Statistical Analyses</b>
<b>ATS</b>	Nelson, Herlily, & Oescher,	437 counselors surveyed about	Counselors had positive attitudes toward sex offenders	p =.00
<b>ATS</b>	Simon, 2010	272 psychologists	Increased time spent working with sex offenders equates to positive attitudes; less time, more	p <.05
<b>ATS</b>	Harper, 2012	178 British psychology and non-psychology students' attitudes toward sex offenders	Psychology students held more negative attitudes toward sex offenders than non-psychology students although non-	p =.008

<b>CATSO</b>	Fitzke, 2009	68 nurses attitudes toward sex offenders	Nurses attitudes toward sex offenders were non-judgmental; no significant difference among the four scales of the CATSO; no significant difference between nurses who have cared for sex	$p > .17$
			not knowingly cared for sex offenders; capacity to change is greater for nurses who did not have sex offender	
<b>CATSO (Exploratory factor analysis)</b>	Conley, Hill, Church, Stoeckel, & Allen, 2011	307 probation and correction officers attitudes toward sex offenders and their	Two-factor scale most promising	Social isolation $\alpha = .84$ ; capacity to change $\alpha = .77$
<b>The Stereotypes of Sex Offender Questionnaire; ATS; Knowledge of Child Abuse Questionnaire</b>	Sanghara & Wilson, 2006	Examined stereotypical views of experienced (n=60) vs. inexperienced (n=71) professionals in the treatment of sex	Inexperienced group with no known professional contact with sex offenders had more stereotypical views of sex offenders	$p < .001$

**Attitudes Toward Persons with Mental Illnesses**

Peer, Warnecke, Baum, and Goreczny (2015) conducted a qualitative study examining graduate students' attitudes toward people with schizophrenia. Ninety-one students from across three disciplines were assessed. Psychology students (N = 39); occupational therapy students (N = 26); and physical therapy students (N = 26) were administered and completed the Depression Anxiety Stress scale (DASS), General Self-Efficacy Scale, and Satisfaction with Life Scale in order to encapsulate belief systems about themselves (self-report) and belief systems about a person diagnosed with schizophrenia in a narrative depicting a person with schizophrenia (perspective of narrative). Demographic information was collected on gender, race, and age. All students were from a small urban university in Pennsylvania. Outcome measures were derived from repeated-measures MANOVA whereas depression, anxiety, stress, life satisfaction, and self-efficacy were the repeated measures variable (i.e., dependent variables). Self-report and perspective of narrative were the independent variables. Results of this study were consistent with the researchers' hypothesis in that students perceived a person with schizophrenia as being more depressed, anxious, and stressed than themselves. Further, respondents indicated that the person with schizophrenia had lower self-efficacy and life satisfaction than themselves. This particular finding also supported the researchers' hypothesis. In performing univariate ANOVA, there were statistically significant differences on outcome measures of depression, anxiety, and life satisfaction between students in the various disciplines. Psychology students had lower scores on measures of depression and anxiety than occupational therapy and physical therapy students. Although psychology students scored lower than



occupational students on measures of life satisfaction, overall there were no statistically significant differences between physical therapy students, psychology students, and occupational therapy students on measures of life satisfaction. Although the researchers examined stigmatizing beliefs about persons with schizophrenia from various disciplines, there are some limitations with this study. This study only surveyed students from one university. Therefore, findings may not generalize to students attending other universities outside of the respondents' region. Further, demographic information showed that more than 85% of the respondents were White. Only 3.5% of the respondents were Black; 0.9% Asian, and 0.9% Mexican. These percentages are not reflective of the racial make-up of the United States. Perhaps if the researchers would have included other universities, the respondents would have been more racially diverse. For this reason, the present study intends to survey students from various States in hopes of capturing a diverse pool of respondents. Next, the narrative depicting a person with schizophrenia contained the word "schizophrenia". Even though the narrative provided a description of a person with schizophrenia, using the word "schizophrenia" may have conveyed negative connotations that could be inherit with students who receive their messaging about mental illness from media portrayals of persons with mental illnesses. As a result of this finding with labeling, this present study will only utilize descriptors of the various typologies of sex offenders for each vignette, rather than state the sex offense type.

Mittal et al. (2014) compared the attitudes of 205 mental health providers (psychiatrists, psychologists, and mental health nurses) and 146 primary care providers (nurses and physicians) toward persons diagnosed with and without schizophrenia

from five Veterans Affairs (VA) facilities. Mittal and colleagues hypothesized that healthcare providers would have more negative attitudes overall toward patients diagnosed with schizophrenia than toward patients without the diagnosis; primary care providers would have more negative attitudes toward patients with schizophrenia compared to patients without schizophrenia; and mental health providers' attitudes would be consistent for patients with or without schizophrenia. Three surveys were administered: the Characteristic Scale, assessing stereotypical characteristics; Attribution Questionnaire, assessing both behavioral and cognitive reactions to a vignette (patient with schizophrenia versus patient without schizophrenia); and Social Distance Scale, measuring the amount of social distance toward patients with or without schizophrenia. Using regression models, results indicated that the primary care cohort harbored more negative attitudes toward the patient with schizophrenia compared to the patient without schizophrenia on the Characteristic Scale and Attribution Questionnaire. However, there was no significant difference with mental health providers on the two measures (Characteristic Scale and Attribution Questionnaire).

In examining social distance, both cohorts (mental health providers and primary care providers) wanted greater social distance from the patient diagnosed with schizophrenia than patients without the diagnosis. In fact, the researchers point out that "primary care physicians and psychiatrists desired more social distance from individuals with schizophrenia" than who? (p. 6). These findings suggest that stigmatizing attitudes are prevalent among primary care physicians and to a certain extent mental health providers. As a result of these findings, the researchers suggest

that primary care physicians should increase their contact with individuals diagnosed with schizophrenia in order to “reduce stigmatizing views” (p.5). Further, the researchers suggest that primary care physicians and nurses need specific training to assist in dispelling the stereotypical views and “misattributions” for schizophrenia. In light of comparing mental health providers and primary care physicians toward patients with and without schizophrenia, there are several limitations with this study. First, all respondents were from a VA facility. The healthcare professionals’ responses from the VA may not generalize to other healthcare settings (i.e., non-VA hospital facilities). Second, most of the respondents were White: 50% White for primary care providers and 71% White for mental health providers. Similar to Peer et al., (2015), these percentages may not reflect the racial composition of the United States. What these percentages reveal is that attitudes from other ethnicities are not extensively captured in this study. Perhaps the overall findings of this study, showing negative attitudes toward persons diagnosed with schizophrenia, could have been different if other ethnicities were included.

Eack, Newhill and Watson (2012) examined 60 social work graduate students’ attitudes toward persons with schizophrenia before (pre-course) and after (post-course) completing a course entitled, “Social Work Practice with Severe Mental Illness”. In their quantitative study, the researchers used three instruments: Knowledge About Schizophrenia Questionnaire (KASQ); Attitudes Toward Individuals with Schizophrenia; and Contact with Individuals with Schizophrenia. The KASQ assessed knowledge surrounding the treatment of schizophrenia, side-effects of anti-psychotic

medications, and the etiology of schizophrenia. The remaining measures assessed general attitudes toward persons diagnosed with schizophrenia, attitudes toward working with persons diagnosed with schizophrenia, and the degree and frequency of contact respondents had with persons diagnosed with schizophrenia. Within the course, students were able to read written material by consumers and family members describing their experiences with schizophrenia. Also, the instructor invited consumers and family members to speak with students in order to discuss their experiences and beliefs about schizophrenia. Lastly, the students were assigned to complete a research paper in which they would describe how different life would be if they were diagnosed with a mental illness. Results were generated after conducting linear mixed-effects change models (pre vs. post results). Findings indicated that there were significant improvements in students' knowledge post-course ( $p = .001$ ). General attitudes also improved post-course ( $p = .018$ ). However, there were no significant changes from pre-course to post-course in attitudes toward working with persons diagnosed with schizophrenia ( $M = 4.75$ , pre-course;  $M = 4.58$ , post-course;  $p = .124$ ). In addition, there were no changes over time with respect to the degree and frequency desired to have contact with persons diagnosed with schizophrenia ( $M = 5.98$  pre-course;  $M = 6.19$ , post-course;  $p = .798$ ). Based on the limitations of this study, the findings are not surprising. First, having a convenience sample of 60 students resulted in a low response rate. Increasing the sample size may have generated different findings with respect to attitudes toward working with persons with schizophrenia and overall contact of degree and frequency. Second, the sample lacked homogeneity. All respondents were social work students. There was no comparison group to detect

differences between various cohorts. For example, social work students compared to rehabilitation counseling students would have broadened the study. Further, 88% of the respondents were White. Eighty-three percent were female. Both variables (racial composition and gender) may not generalize to other cultures (males) or ethnicities, thereby overlooking the impact of culture and ethnicities when it comes to assessing the attitudes toward persons with a mental illness.

Bennett and Stennett (2015) investigated attitudes toward mental illness of nursing students (N = 102) enrolled in an undergraduate program in Jamaica. Outcome measures were collected utilizing the Attitudes Towards Acute Mental Health Scale (ATAMHS). This questionnaire has 33-items, divided into five factors (Care or Control; Semantic Differentials; Therapeutic Perspectives; Hard to Help; and Positive Attitude). The overall findings indicated that nursing students had negative attitudes towards persons with mental illnesses. The respondents viewed persons with a mental illness as being dangerous, cold-hearted, and dirty. These findings derived from the semantic differential factor. In addition, the respondents indicated that persons with a mental illness are child-like and immature. It appears as if the underlying emotion of nursing students in this study is fear of dangerousness. Overall, results demonstrated that the respondents fear working with a person who has a mental illness. Based on this outcome, the researchers indicated that “fewer nurses view mental health nursing as a possible career choice” (p. 599). Although the researchers captured baseline data using the existing cohort of nursing students, there are several limitations within this study. As with other studies, there is a lack of homogeneity within the subject pool. Although

the majority of the respondents were black, it doesn't capture other cultures or ethnicities in how they view persons with a mental illness. Next, this study only examined nursing students. There was no comparison group. Are these attitudes only relegated to nursing students? Or, do other disciplines within this region share similar attitudinal beliefs? Including other programs (social work, psychology students, etc.), would have widened the exploration of attitudinal beliefs.

### **Attitudes Toward Sex Offenders with Mental Illnesses**

Viewed as “twice labeled” (Walsh, p. 374, 1990), sex offenders with mental illnesses bear the burden of being stigmatized regardless of the type of sexual offense. Based on the literature review, sex offenders, as well as people diagnosed with mental illnesses experience stigma from many sources. Research has substantiated that prospective healthcare professionals view people with mental illnesses as “dirty”, “child-like”, and “immature” (Bennett et al., 2015) and current professionals view sex offenders as “evil” (Walsh, p. 375, 1990). Therefore, it is imperative to know what the underlying beliefs are from PRCs who are expected to work with sex offenders with a mental illness. After conducting a thorough review of the attitudes of professionals and paraprofessionals toward sex offenders with mental illnesses, sufficient published research incorporating the two labels (i.e., sex offenders and mental illnesses or mental illness) was not identified. Instead, research incorporating the two terms focused on the treatment modalities and approaches of sex offenders with mental illnesses. As a result of this outcome, this examination of the attitudes of PRCs toward sex offenders with mental illnesses will be the first, to the researcher's knowledge. Thus, examining the attitudes of PRCs prior toward providing counseling services to sex offenders with

mental illnesses is necessary in ascertaining if prevailing attitudes could hinder the vocational rehabilitation process for sex offenders with mental illnesses.

### **Common Vocational Barriers for Sex Offenders**

Although seemingly well intentioned, sex offender laws currently in place are viewed as vocational barriers (Burchfield & Mingus, 2008). A case in point is the electronic monitoring of sex offenders which is used to track the whereabouts of the sex offender to help minimize reoffending. However, according to Burchfield et al. in their qualitative study, the following was described to them by a registered sex offender regarding electronic monitoring:

Because I'm on electronic monitoring, they know [the employer] it takes only the slightest thing and you can end up going back on violation. They [the employer] don't want to have to lose an employee for whatever reason. They make it extremely impossible for you to get employment at all. (p. 369)

As evident in the previous scenario, once employers are aware of such devices, or the sex offense charge, the sex offender is typically terminated or was never hired.

Another vocational barrier is mandatory background checks. Typically considered as pre-employment screening, this process is a form of risk management for the employer (Leach & Hayden, 2012). On the one hand, the employer is attempting to safeguard its environment. On the other hand, the prospective employee, who is a sex offender, may not be presented with the opportunity of becoming hired because of stigmatizing views surrounding sex crimes. Without properly educating the general public of the various typologies of sex offenders and the various sex offenses (e.g., predatory versus mistaken age), employers may assume all sex crimes are predatory in nature.

Whitley et al. (2009) conducted a qualitative study examining supported

employment specialists' strategies in working with sex offenders. They found that "one of the hardest" task for supported employment specialists was finding employment opportunities for sex offenders with a mental illness (p. 1367).

Background checks or pre-employment screening, consumer preferences versus societal expectations, and poor work histories were identified barriers to accessing employment. Despite these identified barriers, common themes emerged from their research. The researchers identified three specific strategies used by the respondents that assisted in getting sex offenders hired. First, an incremental approach with the consumer (i.e., sex offender) was identified. This strategy entails supported employment specialists initially looking for entry-level work, in hopes of career advancement over time. The initial job is a springboard position. The consumer is expected to career build while simultaneously enhancing his or her resume. Second, the supported employment specialists identified using a strengths-based model when working with the sub-population. The respondents stated that they sell consumers' strengths, rather than their deficits to employers. Supported employment specialists use the consumers' work experience from time spent being institutionalized (i.e., kitchen work or janitorial work). The researchers found that the respondents, selling consumers' skills and focusing on time spent not being incarcerated also assisted in the hiring process for the sub-population. Last, to avert pre-employment screening, the supported employment specialists focused on employers that do not conduct pre-employment screening or employers without rigid pre-employment screening or background checks.



### **Ethical Considerations**

As with many professions, rehabilitation counselors are guided by ethics. After graduating, PRCs are expected to adhere to the ethical standards like the ones provided by the Illinois Institute of Technology [IIT] (2011):

Rehabilitation counselors are committed to facilitating the personal, social, and economic independence of individuals with disabilities. In fulfilling this commitment, rehabilitation counselors work with people, programs, institutions, and service delivery systems. Rehabilitation counselors provide services within the Scope of Practice for Rehabilitation Counseling ...and recognize that both *action and inaction can be facilitating or debilitating*. [italics added]

Additionally, there are five guiding principles of ethical behavior expected of PRCs after graduating. These are autonomy, beneficence, nonmaleficence, justice, and fidelity (Commission of Rehabilitation Counselor Certification [CRCC], 2017; IIT, 2011). Autonomy is the right to make decisions independently; beneficence is to do good to others; nonmaleficence means to do no harm to others; justice is being fair and to give equally to others; and fidelity, is being an honest practitioner, keeping one's promise. (CRCC et al.; IIT, et al.). Essentially, each principle is "intended to assure the public that the rehabilitation counseling profession accepts its responsibility to provide caring service to individuals with disabilities" (CRCC, 2017). According to Levenson and D'Amora (2005) there are four fundamental purposes to criminal sentencing. These are "retribution (punishment or reprisal for wrongdoing), deterrence (to discourage others from committing crimes), *rehabilitation* [italics added] (to help criminals change their behavior and become responsible citizens), and incapacitation (to protect society from dangerous, law breaking persons)" (p. 146). As rehabilitation counselors, an important goal is rehabilitation through employment. If rehabilitation counselors are inactive in the rehabilitative process of providing vocational services

for sex offenders with mental illnesses, it can be deemed as discriminatory; not adhering to the ethical standards of the field. In other words, it is imperative for PRCs to know that being inactive in the vocational rehabilitation process can in fact be debilitating for the consumer (IIT, et al.).

### **Theoretical Framework: Theory of Planned Behavior**

Attitudes of PRCs toward sex offenders with a mental illness was assessed utilizing Icek Ajzen's Theory of Planned Behavior (TPB). Not only did this study examine the attitudes of PRCs toward sex offenders with mental illnesses, but it uncovered what these attitudes suggest about PRCs working with sex offenders with mental illnesses. It is important to note that the TPB is not an entirely new phenomenon. In fact, it is the successor of the Theory of Reasoned Action (TRA) by Martin Fishbein and his former student Ajzen, stemming from the 1970s (Ajzen, 2002). But, unlike the TRA, underscored only by two components, Behavioral Beliefs (BB) and Normative Beliefs (NB), the TPB has an additional component. The added component is Control Beliefs (CB). As it stands, The TPB encompasses three components, BB, NB, and CB in explaining human action (Ajzen, 2002). Each component has a direct determinant. The direct determinant for BB is Attitudes toward the Behavior (ATB); the direct determinant for NB is Subjective Norm (SN); and the direct determinant for CB is Perceived Behavioral Control (PBC). All three direct determinants lead to intention to perform a behavior of interest. According to Ajzen "... the more favorable the attitude and subjective norm, and the greater the perceived control, the stronger should be the person's intention to perform the behavior in question" (2006, p. 1). Human decision processes can be complex (Ajzen et al., 1991).

However, the theoretical approach of the TPB simplifies the complexities of an arduous task. In TPB, behavior is predicted (Ajzen et al.) based on three components (BB, NB, and CB) and their direct determinants (ATB, SN, and PBC). Although, all three components will be discussed, this study will not examine the entire theory. Investigating NB (social pressures to perform a behavior based on others' expectations) and CB (performing the behavior in question based on past experiences or anticipatory barriers) is not supported for this study since participants in the subject pool will not hold a master's degree in rehabilitation counseling and thereby will not be practicing rehabilitation counseling. It is expected that PRCs will have limited experience and exposure providing professional vocational rehabilitation counseling (counseling) to sex offenders with mental illnesses. Consequently, they are not able to determine the social expectations from others in performing the task of counseling sex offenders with mental illnesses. They are also not able to establish a belief based on past experiences of professionally counseling sex offenders with mental illnesses. For these reasons, the direct determinant BB will be the sole component tested since attitudes toward performing a behavior can be ascertained with or without prior knowledge or experience in performing the behavior.

### **Behavioral Beliefs**

According to Ajzen (1991, 2002), BB is an individual's salient belief about consequences of a particular behavior. The concept is based on the subjective probability that the behavior will produce a favorable or unfavorable outcome (Ajzen, 2006). It is these beliefs that ultimately influence attitudes toward the behavior in question, hence ATB. When attitudes are internalized, they predict intention; and

intention, according to Ajzen, is a high predictor of performing the behavior. Inevitably, the intention is antecedent to the behavior, leading to the behavior in question being executed. In understanding attitudes toward performing a work activity, Schultz (2008) examined factors contributing to public rehabilitation counselors' involvement in job development/placement activities. The researcher hypothesized that personal attitudes toward development/placement activities would be significantly related to hours spent each week in those activities. Path analysis showed low attitudinal scores correlated with hours spent, in that low scores were indicative that public rehabilitation counselors do not place a priority on job development/placement activities. Although job development/placement is one of eight work activities ascribed to rehabilitation counselors (CRCC, 2014), this study demonstrates that many rehabilitation counselors believe that job development/placement activities is not a priority. Their attitudes and intention based on their underlying belief systems was low. Therefore, the study participants did not readily engage in the behavior of performing job development/placement activities, despite job development/placement as a primary function for rehabilitation counselors.

### **Normative Beliefs**

The second component within the TPB is NB. According to Ajzen, (2006), NB is an individual's perception of social pressures or beliefs bestowed from significant others to perform or not to perform the behavior in question. Significant others can range from parents, spouse, siblings, close friends to co-workers. Essentially, the "social pressure" to perform the behavior in question is predicated on what significant others believe you should do (i.e., peer pressure). Next, NB predict the direct

determinant SN. Ajzen (1991, 2002, 2006) suggests that SN are composed of two considerations. First is, what people who mean a lot to you think about the behavior of interest. Second is, are others, who may be in your profession, engaged in the behavior of interest. Both considerations have the potential of determining intention. SN predicts intention; and intention is a high predictor of performing the behavior in question. In constructing a TPB questionnaire for example, Ajzen (2006) suggests, the following language can elicit SN: *Most people who are important to me approve of my exercising for at least 20 minutes, three times per week for the next months* and *Most people like me exercised for at least 20 minutes, three times per week in the three months following their major heart surgery* can elicit ‘what others like you are actually doing’.

### **Control Beliefs**

The third and final component within the TPB is CB which leads to the direct determinant of perceived behavioral control (PBC). According to Ajzen (2002; 2006), PBC consists of two considerations: perceived self-efficacy and perceived controllability. Perceived self-efficacy, according to Bandura is “people’s beliefs about their capabilities to exercise control over their own level of functioning and over events that affect their lives” (Bandura, 1991, p. 257). Bandura’s postulates as part of his Social Cognitive Theory, that one’s confidence level in performing a behavior is a predictor of the behavior occurring, i.e., internal perceptions. Ajzen (et al., 2002) reported that the TRA neglected to address personal efficacy in human action. He then integrated the notion of perceived self-efficacy in TPB to better account for predictive accuracy in a behavior occurring. In explaining perceived controllability, Ajzen (et al.)

suggests that it is volitional or non-volitional control and asks, “How much autonomy does one have in performing a behavior?” Within the TPB, both perceived self-efficacy and perceived controllability are “asking direct questions about capability to perform a behavior or indirectly on the basis of beliefs about ability to deal with specific inhibiting or facilitating factors” (Ajzen et al., p. 668). For example, Ajzen suggested the following question to elicit perceived self-efficacy: *I am confident that I can exercise for at least 20 minutes, three times per week for the next three months* and *My exercising for at least 20 minutes, three times per week for the next three months is up to me* elicits perceived controllability.

### **Previous Research Utilizing the TBP**

Werner (2002) tested the TPB using path analysis to examine the intention to work with individuals diagnosed with intellectual disabilities and mental illness (dual diagnosis [DD]) among students from various disciplines (social work, occupational therapy, nursing, special education students) utilizing a questionnaire developed by the researchers based on recommendations from Ajzen (i.e., TPB questionnaire). Composite indexes of averages for every questionnaire item were created: behavioral intention items (Cronbach's  $\alpha = .93$ ); attitude items (Cronbach's  $\alpha = .73$ ); subjective norm items (Cronbach's  $\alpha = .88$ ); and perceived behavioral control items: controllability (Cronbach's  $\alpha = .70$ ); and self-efficacy (Cronbach's  $\alpha = .38$ ), the lowest internal reliability. Overall, the findings indicated that the students believed that they were not sufficiently equipped to work with people with intellectual disabilities and mental illnesses. Further, students indicated that they had moderate positive attitudes in providing services for the DD population.

Similarly, testing the theory utilizing path analysis, McCabe et al., (2013) surveyed the behavioral intention of teachers, school psychologists, and counselors to intervene and prevent harassment of LGBTQ youth utilizing the TPB questionnaire, developed by the researchers. The results showed behavioral intention (Cronbach's  $\alpha = .72$ ); attitude (Cronbach's  $\alpha = .86$ ); subjective norm (Cronbach's  $\alpha = .79$ ); and perceived behavioral control (Cronbach's  $\alpha = .78$ ).

The researchers found that 'attitudes' were the strongest predictor of intention to advocate. In essence, "those educators who believed advocacy to be a rewarding and valuable experience reported the strongest intentions to advocate" (p. 682). Although both studies were not longitudinal, they indicated that respondents' attitudes predicted behavioral intention.

However, Davis' et al., (2002) longitudinal study (over the course of 2 ½ years) surveyed the decision of African American students to complete high school using the TPB questionnaire, as developed by the researchers. They found that the TPB was a better predictor of intent to complete an academic year and graduate high school than was the students' grade point average. The coefficient alpha for behavioral intention items in the first year was .46 to .75 on all five items within their questionnaire. The second year, the mean coefficient alpha was .77. Attitude measures in the first year were .50 to .70 on all eight items in the administered questionnaire. In the following year, the mean coefficient alpha for attitude was .82. For all three items used in the questionnaire to examine subjective norms, the coefficient alpha in year one ranged from .69 to .76. The following year, the mean coefficient alpha was .71. Lastly, in measuring perceived behavioral control, the

coefficient alpha on all four items ranged from .45 to .72. The second year, the mean coefficient alpha for was .54. The researchers confirmed the following conclusion:

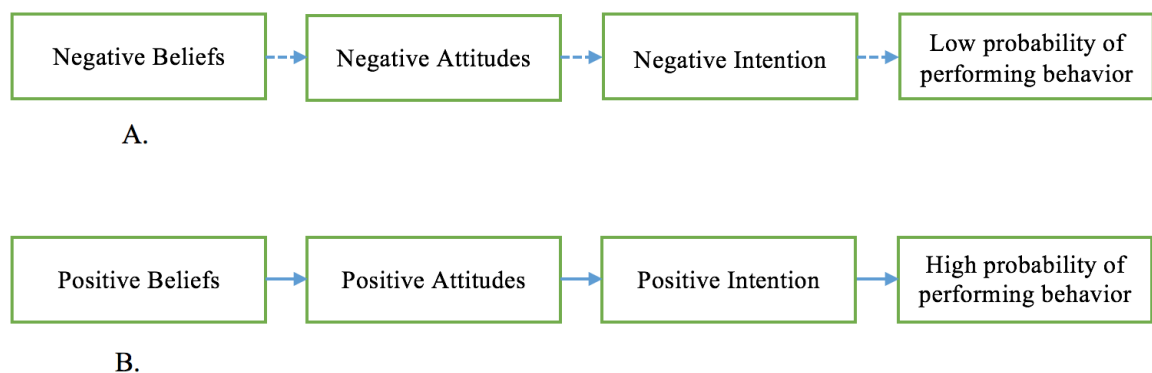
...students who eventually completed high school had, by their second year of studies, formed more favorable attitudes toward staying in school, had perceived stronger social pressure to do so, were more likely to believe that they had control over this behavior, and had formed stronger intentions to stay in school. (p.814)

Knaeps, Neyens, Donceel, van Weegal, and Van Audenhove (2015) examined three types of vocational rehabilitation counselors' [VR counselors] (N = 236) (i.e., gatekeepers, case managers, and specialists) underlying beliefs about competitive employment for persons with severe mental illnesses (SMI) using all three components of the TPB (i.e., BB, NB, CB). The researchers defined gatekeepers as performing intakes, assessments of competencies, and sending referrals to specialized agencies. Case managers also assess competencies of clients, but they also plan and monitor the rehabilitation process, while job developing on behalf of the client. The specialists are more hands on by providing on-the-job support for the client and employers, as well as being responsible for follow-up services. The researchers note that specialists often work outside of the traditional vocational rehabilitation system. Specialists tend to work in mental health centers, psychiatric rehabilitation agencies or in psychiatric hospitals. Based on the recommendation of Ajzen (2002), the TPB questionnaire was developed by the researchers and administered to each group of VR counselors. Composite averages for each questionnaire item were created: attitude items (Cronbach's  $\alpha = .77$ ); subjective norm items (Cronbach's  $\alpha = .77$ ); and perceived behavioral control items, self-efficacy (Cronbach's  $\alpha = .79$ ). Data were analyzed using a one-way analysis of variance (ANOVA). Within the determinant BB, all three groups indicate that supportive employment for persons with SMI results in



increased integration in society, being more self-confident, generating a higher income, and greater autonomy. However, there were differences in VR counselors' BB. Although VR counselors indicated that they believed supported employment provided more self-confidence, the specialist group and the case manager group thought that competitive employment "will (very) often lead to self-confidence" (Knaeps, et al., 2015, p. 180). Regarding NB, VR counselors believed their clients and supervisors would want them to focus on competitive employment. Specialists were the only VR counselors convinced that their clients, supervisors, and colleagues appreciate a focus on securing competitive employment for their clients. Concerning CB, each group indicated that socio-economic issues and "instable psychiatric problems are impediments for attaining competitive employment" (p. 181). In conclusion, the researchers note "The TPB is used as it is a well-known theory that makes it possible to form a comprehensive understanding of beliefs of people and adaptable to local conditions" (p.182).

*Figure 2A and 2B*



*Figure 2A.* Proposed path analysis of TPB with negative belief system: Negative beliefs about sex offenders with mental illnesses, lead to negative attitudes toward sex offenders with mental illnesses, which leads to not intending to work with the targeted sub-population resulting in inadequate counseling techniques.

*Figure 2B.* Proposed path analysis of TPB with positive belief system: Positive beliefs about sex offenders with mental illnesses, lead to positive attitudes toward sex offenders with mental illnesses, resulting in having the intention to work with the targeted sub-population; to ultimately performing the expected behavior (i.e., counseling).

### **Summary**

After graduating from a master's program in rehabilitation counseling, PRCs are expected to perform at least eight work activities categories: Counseling, Case Management, Client Assessment, Service Planning, Rehabilitation Service Coordination, Job Analysis, Job Development/Placement, and Advocacy (CRCC, 2014) for people with disabilities in search of employment opportunities. Despite the disability, if the person is ready to work, the rehabilitation counselor's job is to assist the person, guided by 5 ethical principles (CRCC et al.). According to literature, research shows that there is a subpopulation of people with disabilities deemed "twice labeled" (Walsh, p. 375, 1990). This particular subpopulation is sex offenders with a mental illness. According to research, both terms are stigmatizing (Bennett et al., 2015; Mittal et al., 2014; Peer et al., 2015; Walsh et al.), with both populations having a challenging time finding employment (Burchfield et al., 2008). Further, with the term sex offender, there are four typologies that should not be ignored in the rehabilitative process (Conley et al., 2011; Ferguson et al., 2006). Although there are conflicting outcomes regarding the attitudes toward sex offenders or people with mental illnesses from students, professionals, and paraprofessionals, one common theme persists: professionals who work more with sex offenders or with people with a mental illness are less judgmental than those who do not (Fitzke et al., 2009; Nelson et al.; Sanghara et al., 2006). Also, research shows that people who are victims of sexual

abuse are more inclined to view sex offenders as less judgmental compared to those who did not have this experience (Ferguson et al.; Nelson et al., 2002).

Concerning the TPB, it has been used in understanding and explaining health-care, consumerism (business settings), African-American students and their graduation rates (Davis et al., 2002), the LGBTQ community and the intention of their teachers, school psychologists, and counselors to intervene and prevent harassment (McCabe et al., 2013) and in various settings such as supported employment agencies (Corbiere et al., 2011); in school systems within the United States (Davis et al.) and in Korea (Lee, Cerrato & Lee, 2010). In fact, according to Davis (et. al.), the TPB was a better predictor of intent to complete an academic year and graduate high school than was the students' GPA, in a longitudinal study. In addition, the TPB was used as a framework to explain competitive job acquisition of individuals with severe mental illness enrolled in supported employment programs. Path analysis, conducted by Corbiere (et al.) showed that rehabilitation counselors' attitudes, SN, and PBC directly correlated with their clients becoming employed. Although there has been substantial use of the TPB and research surrounding the attitudes of various professions and populations (i.e., students) toward sex offenders, as presented in this literature review, there has not been research examining the attitudes of PRCs toward sex offenders with mental illnesses using the TPB as a theoretical framework. Ultimately, examining the attitudes of PRCs prior to providing counseling services to sex offenders with mental illnesses is necessary in identifying if prevailing attitudes are beneficial in the vocational rehabilitation process for sex offenders with mental illnesses.

### **Chapter III**

## **METHODS**

### **Purpose of the Study**

The uncertainty surrounding the attitudes of PRCs toward sex offenders with mental illnesses laid the ground work for the following queries in this study: 1) What are the overall attitudes of PRCs toward sex offenders?; 2) Will there be differences in attitudes based on age of victim (adult vs. child)?; 3) Will PRCs who have experienced sexual abuse have more positive attitudes toward a sex offender than PRCs who did not have this experience?; and 4) Will a sex offender with a mental illness be viewed more negatively than a sex offender without a mental illness?

### **Conceptual Definitions**

Prospective rehabilitation counselor (PRC) will be defined as a student currently enrolled in a master's level CACREP accredited program, specializing in traditional or clinical rehabilitation counseling. A sex offender will be defined as a person who has been criminally charged and convicted of or has pled guilty to a sex crime (Robertiello & Terry, 2007). Forensic mental health facility will be defined as an institution under the jurisdiction of the criminal justice system used for people who have been found incompetent to stand trial, not guilty by reason of insanity, or a mental illness in order to assist with stabilization of disorders (Jackson & Richards, 2007; Vess, Murphy, & Arkowitz, 2004). Inpatient mental health facility was defined as a facility dedicated solely for mental health care or a hospital with a distinct mental health section for the treatment of mental illness (Peterson, 2015). Further, attitude will be defined as a feeling toward sex offenders with a mental illness or a feeling

toward sex offenders without a mental illness. Gender will be male, female, or transgender. Results yielded from the CATSO will either be of low or high degree of positivity or negativity.

### Research Design/Survey Distribution

In order to acquire foundational knowledge surrounding the attitudes of PRCs toward sex offenders with a mental illness and sex offenders without a mental illness, a quasi-experimental design using eight different surveys was implemented. Each survey depicted one of the four typologies from either Group 1 or Group 2 as demonstrated in Table 3 below.

Table 3: *Sex Offender with a Mental Illness (Group 1) vs. Sex Offender without a Mental Illness (Group 2)*

Typologies		Sex Offender with Mental Illness Group 1	Sex Offender without Mental Illness Group 2
A. Acquaintance Rapist	R	XO <sub>1</sub>	O <sub>2</sub>
B. Stranger Rapist	R	XO <sub>3</sub>	O <sub>4</sub>
C. Acquaintance Child Offender	R	XO <sub>5</sub>	O <sub>6</sub>
D. Stranger Child Offender	R	XO <sub>7</sub>	O <sub>8</sub>

R = Respondents randomly provided with a Group 1 survey or Group 2 survey

XO = Respondents receiving surveys depicting a sex offender **with a mental illness** (Group 1)

O = Respondents receiving surveys depicting a sex offender **without a mental illness** (Group 2)

A, B, C, D = Corresponds with the four typologies (ex. A = Acquaintance Adult Rapist, B = Stranger Adult Rapist, C = Acquaintance Child Offender, D = Stranger Child Offender)

This quantitative study tested the relationship between and within two Groups

(Sex Offender with a Mental Illness Group [Group 1] versus Sex Offender without a Mental Illness Group [Group 2]) and one dependent variable (i.e., total outcome measure scores from the CATSO). Again, within each Group, there were four typologies of sex offenses. A major strength of this study is that there is no published research examining the combined effect of the attitudes of PRCs toward sex offenders with a mental illness versus sex offenders without a mental illness, while considering sex offense typology.

As previously stated, to make comparisons between and within each Group, each survey had a vignette describing a sex offender with a mental illness or a sex offender without a mental illness. Although the vignettes appeared plausible regarding the appropriateness of the research topic (Liyanapathirana, Samkni, Low, & Davey, 2016), the vignettes in this study were not validated. For instance, Liyanapathirana and colleagues suggest each new vignette should be “pre-tested by experts or professionals not involved in the study to confirm the ‘realness’ of the hypothetical situations presented” (2016, p. 34). In addition, because the administered survey was a self-reporting instrument, there is the possibility that the respondents answered the survey questions based on social norms (i.e., social desirability). Another potential weakness is that targeted CACREP accredited programs were from the Northeast corridor (New Jersey, New York, Connecticut, and Maryland). Consequently, the participants’ responses may not generalize to areas outside of the aforementioned region.

### **Delimitations**

The CACREP accredited programs specializing in traditional or clinical rehabilitation counseling were selected based on their convenience to the researcher in

terms of time and costs associated with traveling to and from each accredited program. CACREP programs within a 4-hour driving distance of the researcher's central location were selected.

### **The Role of the Researcher**

The researcher was responsible for visiting CACREP accredited programs in order to distribute the informed consent forms and the surveys. Also, the researcher was responsible for collecting and analyzing the data. Rutgers University, Hunter College, Central Connecticut State University, University of Maryland Eastern Shore, and Hofstra University were the participating institutions, i.e. programs.

### **Target Population and Participant Selection**

Approval to collect and analyze the survey data was obtained from Rutgers, The State University Institutional Review Board (IRB) prior to disseminating the survey. The participants for this study were PRCs from 5 CACREP accredited programs, specializing in traditional or clinical rehabilitation counseling. Information about the project was sent to the program directors of selected CACREP accredited programs, specializing in traditional or clinical rehabilitation counseling, via email. In addition, to increase generalizability and diversity of respondents surveyed, the selected schools were from various states. To incentivize participants, financial compensation was provided, i.e., a \$25.00 VISA gift card for 10 randomly selected respondents. Entering the gift card drawing was voluntary.

### **Procedures**

Each survey was coded to depict the Group and typology of the sex offense. For example, surveys were coded as Group 1A or Group 2A; Group 1B or Group 2B;

Group 1C or Group 2C; and Group 1D or Group 2D, respectively. Using RANDOM.ORG, an on-line random sequencing generator tool, the researcher placed the surveys in the order specified by the on-line tool. The researcher inputted the integers 1 to 8 into RANDOM.ORG. Integer 1 represented survey 1A and integer 8 represented survey 2D. For example, if 136 surveys were needed, the researcher generated 17 random sequences ( $17 \times 8 = 136$ ) to derive at 136 randomly ordered surveys. After the random sequences were generated, the surveys were numbered 000101 to 000324. All distributed surveys remained in the sequential order throughout the research study. See Table 4 below for coding and survey assignment.

Table 4

*Coding and Survey Integer Assignment*

Survey 1A Coded: 1	Sex Offender with a Mental Illness Typology: Adult Acquaintance Rapist
Survey 1B Coded: 3	Sex Offender with a Mental Illness Typology: Adult Stranger Rapist
Survey 1C Coded: 5	Sex Offender with a Mental Illness Typology: Acquaintance Child Offender
Survey 1D Coded: 7	Sex Offender with a Mental Illness Typology: Stranger Child Offender
Survey 2A Coded: 2	Sex Offender without a Mental Illness Typology: Adult Acquaintance Rape
Survey 2B Coded: 4	Sex Offender without a Mental Illness Typology: Adult Stranger Rapist



Survey 2C Coded: 6	Sex Offender without a Mental Illness Typology: Acquaintance Child Offender
Survey 2D Coded: 8	Sex Offender without a Mental Illness Typology: Stranger Child Offender

Selected CACREP accredited programs specializing in traditional or clinical rehabilitation counseling, were recruited for this study, via email or telephonic communication. The preliminary information sent to each school included information about the study; the informed consent form detailing the purpose of the study, which included the survey procedures, risks or discomforts, benefits of the study, inclusion criteria, and an agreement to participate. Inclusion criteria consisted of respondents currently enrolled in a CACREP accredited program, specializing in traditional or clinical rehabilitation counseling. Next, the researcher had telephonic communication with the program directors of the CACREP accredited programs to confirm receipt of email, to solicit and solidify participation by the school. With Hunter College, the researcher completed their IRB process. After approval from each school, the researcher arranged data collection dates with the assigned program director/professors.

Upon arrival at the school, the researcher met with the PRCs during the allotted time and destination to distribute and collect both the informed consent forms and the surveys. First, the informed consent was read aloud to those in attendance. Following the informed consent information, each PRC who choose to participate randomly received one of the eight surveys to complete. The coded surveys were

distributed to each participating PRC inside the classroom. Written on the survey, after the last survey question, the PRC was instructed to turn the survey face-down to see if the number '25' was on the back page of the survey. If the number '25' was indicated on the survey, the PRC collected the \$25 VISA gift card at the end of the survey collection session if they chose to participate. After the PRCs completed their surveys, the researcher collected the surveys and placed them in an envelope coded for their school. After collecting all the surveys, the data was entered into IBM SPSS, v26. After entering the data, the researcher visually checked the inputted data for missing values. Next, the researcher checked all continuous variables in SPSS to ensure range accuracy. Paired with a colleague, all surveys were pulled to check the accuracy of inputted data for each program, i.e., school. Next, a second visual check was performed by the researcher and colleague. All surveys with missing values were pulled to ensure data accuracy. Then, the researcher and colleague randomly pulled 10% of the surveys to check for data entry accuracy. After consulting with research associates, the researcher and colleague then pulled an additional 90% of surveys to check for data accuracy. After checking all surveys, if errors were discovered, they were corrected. After performing the previous steps, no data entry errors existed. Then data analyses procedures commenced. First, three items in the CATSO were reversed scored (1,9,13):

Q1: With support and therapy, someone who committed a sexual offense can learn to change their behavior?

Q9: The prison sentences sex offenders receive are much too long when compared to the sentence lengths for other crimes?

Q13: Only a few sex offenders are dangerous.

To have significant results with confidence, a moderate effect size ( $f^2 = .23$ ) with a power level of .80, utilizing alpha ( $\alpha = 0.05$ ); and having a 2X4X2 factor model was calculated at N=211 through G\*Power (Fual, Erdfelder, Buchner, & Lang, 2009). Of the 211 surveys needed, 198 were collected. Due to copying errors, seven surveys were removed from the data set. A total of 191 surveys were analyzed.

### **Demographic Variables**

Race was Black/African American, and White. Ethnicity was Asian, Hispanic, or other. The name of the CACREP program. Age range (20-35; 35-50; 50-65; and 65 and up) was the participants' age at the time upon completion of the survey. Tenure in program indicated whether the student was currently or will participate in an internship. Finally, Years Worked indicated work history. This variable was not affiliated with the research design. It was only included to observe if the duration of time spent in a professional environment could determine attitudinal dispositions.

### **Independent and Dependent Variables**

The independent variables for this study were the two sex offender groups: Sex Offender with a Mental Illness (Group 1) and Sex Offender without a Mental Illness (Group 2). Each group will have 4 levels signifying the four typologies of sex offense type: adult acquaintance rapist; adult stranger rapist; an acquaintance child offender; and a stranger child offender. These four levels are independent variables also. Further, history of sexual victimization status, indicating either "yes" or "no" is also an independent variable. The dependent variable for this present study will be the total outcome scores on the CATSO scale.

Each survey had a vignette depicting one of the four typologies. The vignettes only described the typology; without specifically naming a sexual offense. To assist in lessening the possibility of stigma, each vignette in Group 1 did not specify the mental illness. Rather, the vignette specified the amount of time spent in an inpatient mental health facility. Also, each vignette was gender neutral. The vignettes only read as Client A, Client B, Client C, or Client D. In essence, the respondents were able to visualize for themselves the perpetrator, the mental health condition, the sexual offense, and the profiles of the victims, without manipulation and extraneous variables. Moreover, to keep the vignettes parsimonious, each vignette, as suggested by Liyanapathirana et al. (2016) had less than 35 words. The respondents answered 18 items from the CATSO while considering their Group assignment specified on the survey and the sex offender typology. The vignettes were as follows:

Sex Offender **with** a Mental Illness (Group 1):

1. Client A is re-integrating in the community after spending 10 years in an inpatient mental health facility. Client A sexually assaulted an adult who was known to the offender.
2. Client B is re-integrating in the community after spending 10 years in an inpatient mental health facility. Client B sexually assaulted an adult who was not known to the offender.
3. Client C is re-integrating in the community after spending 10 years in an inpatient mental health facility. Client C sexually assaulted an under aged child familiar to the offender.
4. Client D is re-integrating in the community after spending 10 years in an inpatient mental health facility. Client D sexually assaulted an under aged child unfamiliar to the offender.

Sex Offender **without** a Mental Illness (Group 2):

1. Client A is re-integrating in the community after spending 10 years incarcerated. Client A sexually assaulted an adult who was known to the offender.
2. Client B is re-integrating in the community after spending 10 years incarcerated. Client B sexually assaulted an adult who was not known to the offender.
3. Client C is re-integrating in the community after spending 10 years incarcerated. Client C sexually assaulted an under aged child familiar to the offender.
4. Client D is re-integrating in the community after spending 10 years incarcerated. Client D sexually assaulted an under aged child unfamiliar to the offender.

(See Appendix A for Surveys Group 1A to Group 2D)

**Community Attitudes Toward Sex Offender Scale (CATSO)**

In an effort to examine attitudes toward sex offenders from the general public, Church, et al. (2008) developed the Community Attitudes Toward Sex Offenders Scale (CATSO). The CATSO is a four-factor, 18-item instrument designed to examine social isolation (five items), capacity to change (five factors), dangerousness (five items), and deviancy (three items) (Church, et al., 2008; Wevodau, Cramer, Gemberling & Clark, 2016). The social isolation factor, according to Wevodau et al. (2016) is defined as “perceptions of sex offenders as isolative loners lacking in social skills” (p. 214). The capacity to change factor is viewed as “sex offenders unwilling or unable to control their sexual behavior and who therefore are deserving of severe punishment and infringement of their civil rights” (Wevodau et al., p. 214). The dangerousness factor suggests that sex offenders are “predatory individuals who use force and manipulation in offending” (Wevodau, Cramer, Gemberling, & Clark, 2016, p. 214). Lastly, the deviancy factor suggests that sex offenders are “hypersexual” (Wevodau et al., p. 214).

The CATSO uses a 6-point Likert Scale with the following choices as (1) strongly disagree, (2) disagree, (3) probably disagree, (4) probably agree, (5) agree, and (6) strongly agree. There are three items reverse scored to ensure consistency in the direction of each item throughout the scale with higher scores indicating more negative attitudes (Church, et al.). Example items are “Most sex offenders do not have close friends” (social isolation); “Sex offenders should wear tracking devices so their location can be pinpointed at any time” (capacity to change); “A sex offense committed against someone the perpetrator knows is less serious than a sex offense committed against a stranger” (dangerousness); and “People who commit sex offenses want to have sex more often than the average person” (deviancy).

The final version of the CATSO was generated after Church and colleagues (2008) conducted exploratory factor analysis and confirmatory factor analysis. The following Cronbach’s alpha for each factor was discovered: social isolation .80; capacity to change, .80; dangerousness, .70; and .43 for deviancy. The cumulative alpha level for the CATSO is .74. These findings are rather consistent with Shelton, Stone and Winder (2013) who evaluated the factor structure and reliability of the CATSO for each factor: social isolation, .80; capacity to change, .82; dangerousness, .44; and deviancy, .41. The alpha level for the entire scale is .73. In the final version of the CATSO, items 6, 7, 8, 14, and 16 are social isolation factor items. Items 1, 2, 11, 12, and 18 are capacity to change factor items. Items 4, 9, 13, 15, and 17 are dangerousness factor items. Items 2, 3, and 10 are deviancy factor items. Items 1, 9 and 13 are the reverse scored items. One significant weakness, outside of the low alpha levels for dangerousness and deviancy factors, is the scale’s inability to “distinguish

between the perpetrators of adults and child offences” (Shelton et al., 2013, p. 123; Wevodau, Cramer, Gemberling & Clark, 2016). As a direct result of the limitation found by the researchers to distinguish between perpetrators of adults and child offenses, this present study will incorporate the various typologies describing perpetrators of adults and child offenses.

Wevodau and colleagues (2016) found that the CATSO could be useful in predicting legislative policy outcomes relating to sex offender laws after conducting their study with 199 jury panel members. Wevodau et al. evaluated the psychometric properties of the CATSO, testing its factor structure, construct and predictive validity for public policy, trial, and research implications. Only using a two-factor structure, social isolation ( $\alpha = .82$ ) and capacity to change ( $\alpha = .77$ ) construct and predictive validity were identified. Results demonstrated that construct validity patterns occurred in “capacity to change” beliefs in three areas: 1) political ideology; 2) attribution of blame toward offenders; and sentencing decisions. Further, when examining capacity to change, the only significant predictor ( $r = .85$ ;  $p < .001$ ), Wevodau et al. (2016) discovered that the CATSO displayed predictive validity associations with sentencing recommendations, placement decisions, and blame attribution. According to Wevodau et al. (2016), the CATSO demonstrated model discrepancy across studies. Conley, Hill, Church, Stoekel and Allen (2011) also affirmed the model discrepancy of the CATSO by indicating strong support in using a two-factor model (social isolation,  $\alpha = .80$  and capacity to change,  $\alpha = .74$ ). However, Wevodau and colleagues (2016) point out that the “original four-factor model may fit best with samples similar to undergraduate students and with limited adaptations...” (2016, p. 218). Church (2008)

reported that the CATSO is needed to understand the attitudes toward sex offenders from non-professionals. The respondents in this research are considered as non-professional, based on their lack of credentialing in the rehabilitation counseling profession. Further, Wevodau et al. and Church et al. support the administration of the CATSO to a student body population. Therefore, in examining attitudes toward sex offenders, this present study utilized all four factors of the CATSO (social isolation, capacity to change, dangerousness, and deviancy).

### **Hypotheses**

The research aim of this study was to collect data and compare the attitudes of PRCs toward sex offenders. In examining the attitudes of PRCs toward sex offenders with a mental illness and sex offenders without a mental illness, the following hypotheses were predicted for this study:

1. PRCs will have negative attitudes toward sex offenders.
2. Child victimization will be more negative than adult victimization.
3. PRCs with a history of sexually victimized will have more positive attitudes toward sex offenders.
4. PRCs will view sex offenders with a mental illness more negatively than a sex offender without a mental illness.

### **Data Collection and Data Analyses**

The questionnaire solicited demographic data specific to each respondent. Demographic variables for this study included gender, age range, race/ethnicity, geographic location of program, tenure in rehabilitation counseling program, sexual victimization status, and years worked. After collecting all the surveys, the data was



inputted and analyzed utilizing IBM SPSS, v26. To have significant results with confidence, a moderate effect size ( $f^2 = .23$ ) with a power level of .80, utilizing alpha ( $\alpha = 0.05$ ); having a 2X4X2 factor model was calculated at N=211 through G\*Power (Fual, Erdfelder, Buchner, & Lang, 2009).

To address the first hypothesis, “Prospective rehabilitation counselors will have negative attitudes toward sex offenders,” the researcher analyzed the mean scores of the 6-point Likert scale of the 18 item CATSO for each typology within each group. Higher scores indicated more negative attitudes. Descriptive statistics (mean, standard deviation, and range) was analyzed to ascertain this information. In addition, after setting the bottom of the CATSO range to zero, the researcher computed the center of the distribution and then performed a one-sample t-test to determine if the mean CATSO score from the sample was significantly higher than the center of the CATSO range.

The second hypothesis, “Child victimization will be more negative than adult victimization”. The total mean score on the CATSO for pedophilia-child offenders were compared to the total mean score on the CATSO to adult victimization. Total mean scores were run using a comparative analysis generated by a two-way between-groups ANOVA, i.e. pedophilia-child typologies vs. adult typologies, while taking into consideration mental health condition.

To address the third hypothesis, “Prospective rehabilitation counselors with a history of being sexually victimized will have more positive attitudes toward sex offenders”, an independent-samples-t-tests was conducted to compare the total mean CATSO scores for the two distinct types of PRCs (history of sexual victimization vs.

no history of sexual victimization).

To examine the final hypothesis, “Prospective rehabilitation counselors will view sex offenders with a mental illness more negatively than a sex offender without a mental illness,” mean scores provided by Group 1 were compared to mean scores provided by Group 2. Total mean scores were run using a comparative analysis generated by a two-way between-groups ANOVA, i.e. pedophilia-child typologies vs. adult typologies. Comparatively, the results indicated which Group (Group 1 or Group 2) viewed sex offenders more negatively, while taking into account sex typology.

## Chapter IV

### RESULTS

A total of 198 prospective rehabilitation counseling (PRCs) students participated in this study from five universities throughout the northeastern region of the United States (Rutgers University, Hunter College, Central Connecticut State University, University of Maryland Eastern Shore, and Hofstra University). Of the 198 respondents surveyed, seven surveys were removed due to insufficient data. A total of 191 surveys were analyzed. Overall, prospective rehabilitation counselors in this study were predominately White (40%) and female (76%). And, nearly 40% of the PRCs self-identified as being sexually victimized. Demographic information is shown in Table 5.

Table 5  
*Demographic Characteristics*

Variable	n	%
<b>Age</b>		
20-35	139	73.9
35-50	38	19.9
50-65	10	5.2
65 and up	1	.5
Not Specified	3	1.6
<b>Gender</b>		
Male	42	22.0
Female	148	77.5
Transgender	0	0
Not Specified	1	.5
<b>Race/Ethnicity</b>		
Black/AA	53	27.7
White	77	40.3
Asian	16	8.4
Hispanic	25	13.1
Other	19	9.9
Not Specified	1	.5
<b>Victimization Status</b>		
Yes	73	38.2

No	116	60.7
Not Specified	2	1.1
Program/Schools		
Rutgers	87	45.5
Central Conn.	37	19.4
Hunter	26	13.6
UMES	27	14.1
Hofstra	14	7.3
Tenure in Program		
No Internship	149	78.0
Yes Internship	39	20.4
Not Specified	3	1.6
Years of Work		
Less than 5	115	60.2
5 to 10	34	17.8
More than 10	39	20.4
Not Specified	3	1.6
Survey Distribution		
Surveys		
1A	24	12.6
1B	25	13.1
1C	26	13.6
1D	19	9.9
2A	24	12.6
2B	25	13.1
2C	25	13.1
2D	23	12.0

1A=Adult known to offender w/MI

1B=Adult not known to offender w/MI

1C=Child familiar with offender w/MI

1D=Child unfamiliar with offender w/MI

2A=Adult known to offender W/O MI

2B=Adult not known to offender W/O MI

2C=Child familiar with offender W/O MI

2D=Child unfamiliar with offender W/O MI

Higher scores on the CATSO denote more negative attitudes toward sex offenders.

The hypotheses for this study were as follows:

1. PRCs will have negative attitudes toward sex offenders.
2. Child victimization will be more negative than adult victimization.

3. PRCs with a history of being sexually victimized will have more positive attitudes toward sex offenders.
4. PRCs Prospective will view sex offenders with a mental illness more negatively than a sex offender without a mental illness.

#### Hypothesis One

Descriptive statistics were run to ascertain if PRCs have negative attitudes toward sex offenders. The minimum score was 38.00, maximum 85.00, mean 55.54, range 47.00, and standard deviation, 8.11. The mid-range of the scale was 45, with a mean of 41.72, and standard deviation, 9.01. Therefore, there were no significant differences between the mean CATSO score of the sample and the mid-range of the scale, thus the researcher failed to reject the null and concluded that PRCs do not have a high degree of negativity toward sex offenders.

#### Hypothesis Two

A two-way between groups ANOVA was executed to determine if there would be differences in attitudes based on the age of the victim (adult vs. child). It was hypothesized that pedophilia (child offenders/victims) would elicit more negative attitudes than adult offenders/victims. There was not a statistically significant difference for the child victim cohort ( $M = 55.66$ ,  $SD = 7.08$ ) and the adult victim cohort ( $M = 55.43$ ,  $SD, 8.42$ ),  $F(1, 189) = .037$ ,  $p = .847$ , with a  $\eta^2 = .00$ , with an observed power of 5.4%. These results show PRCs did not demonstrate more negative attitudes toward child offenders or vice versa. Due to the nature of this question, a post-hoc test was run to detect if the sample size was sufficient. In GPower, the  $\eta^2$  was calculated at 1%, with a  $f = .1$ ; the numerator  $df = 1$ . It was calculated, with an

80% probability, that in excess of 770 cases were needed to detect significance with a 1% effect size.

#### Hypothesis Three

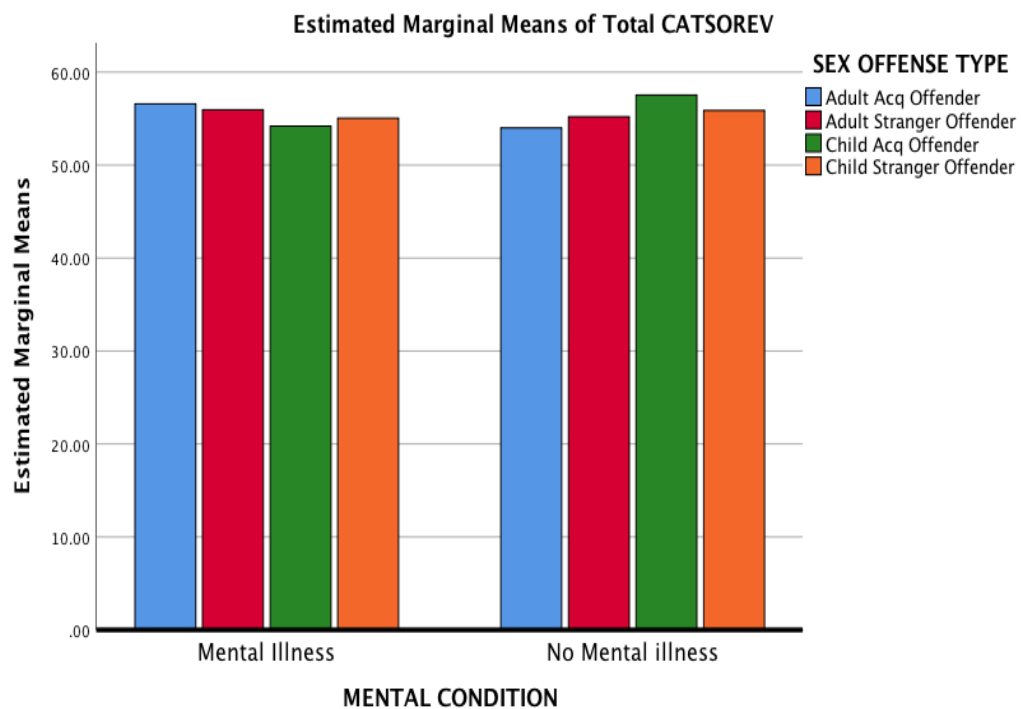
An independent sample t-tests was conducted to compare the total means CATSO scores for the two distinct groups of PRCs (history of sexual victimization vs. no history of sexual victimization). There was a statistically significant difference in scores for respondents with a history of being sexually victimized ( $M = 53.57$ ,  $SD = 7.24$ ) and respondents with no history of being sexually victimized,  $M = 56.87$ ,  $SD = 8.47$ ;  $t(187) = -2.76$ ,  $p = .006$  (two-tailed), which shows the results are not due to chance. Although results were significant, there is no published research with CATSO measures to determine if a small shift in scores reflect meaningful attitudinal dispositions. The amount of the differences between means was small ( $\eta^2 = .03$ ). Typically, a one tailed t-test is conducted for a directional hypothesis. However, a two-tailed was performed in order to examine both sides of the sampling distribution (history of sexual victimization and no history of sexual victimization) since this specific research question has not been extensively studied.

#### Hypothesis Four

A two-way between groups ANOVA was executed to determine if prospective rehabilitation counselor students viewed sex offenders with a mental illness more negatively than a sex offender without a mental illness. The mental illness group mean was 55.44,  $SD = 8.83$  and the mean score for the no mental illness group was 55.64,  $SD = 7.38$ . The interaction between the mental health condition and typology was not statistically significant,  $F(3, 183) = 1.156$ ,  $p = .328$ . Based on the results, prospective

rehabilitation counselors did not view sex offenders with a mental illness more negatively than a sex offender without a mental illness, while considering sex offense typology. As shown in Figure 3, means scores of mental health condition while considering sex offense typology.

Figure 3  
*Two-Way Between Group Means*



## **Chapter V**

### **DISCUSSION**

The purpose of this study was to collect and analyze data using IBM SPSS, v 26 to compare the attitudes of prospective rehabilitation counselors (PRCs) toward sex offenders with a mental illness to sex offenders without a mental illness, while considering sex offense typology (adult acquaintance offender, adult stranger offender, child acquaintance offender, and child stranger offender). The Community Attitudes Toward Sex Offenders Scale (CATSO) was the instrument used to ascertain this information. This chapter will discuss utilization of The Theory of Planned Behavior (TPB) as the theoretical framework, results of this study, limitations, and future research.

As previously stated concerning the TPB, it has been used in understanding and explaining health-care, consumerism (business settings), African-American students and their graduation rates (Davis et al., 2002), the LGBTQ community and the intention of their teachers, school psychologists, and counselors to intervene and prevent harassment (McCabe et al., 2013) and in various settings such as supported employment agencies (Corbiere et al., 2011); in school systems within the United States (Davis et al.) and in Korea (Lee, Cerrato & Lee, 2010). In fact, according to Davis (et. al.), the TPB was a better predictor of intent to complete an academic year and graduate high school than was the students' GPA, in a longitudinal study. In addition, the TPB was used as a framework to explain competitive job acquisition of individuals with severe mental illness enrolled in supported employment programs. Although the theory has three components (Behavioral Beliefs, Normative Beliefs,



and Control Beliefs) only one component was used for this study, Behavioral Beliefs which examine attitudes toward behaviors and behavioral intention.

According to Ajzen (1991, 2002, 2006) behavioral beliefs are based on consequences of a behavior, asking: Will the behavior produce a comfortable or uncomfortable outcome? These beliefs influence attitudes toward any behavior. The TPB theorizes that after a person's attitude is established, the intention to engage in a behavior leads to "behavioral achievement" (Ajzen, 1991, p. 184) or termination of an expectant behavior due to its uncomfortable conditions. Based on previous research which analyzed attitudes of various occupations toward sex offenders, it was hypothesized that PRCs would overall have negative attitudes toward sex offenders, regardless of mental health condition. Also, based on previous research, it was hypothesized that PRCs who self-identified as being sexually victimized would have more positive attitudes toward sex offenders. Below, is a summation of the hypotheses for this study.

1. PRCs will have negative attitudes toward sex offenders.
2. Child victimization will be more negative than adult victimization.
3. PRCs with a history of being sexually victimized will have more positive attitudes toward sex offenders.
4. PRCs will view sex offenders with a mental illness more negatively than a sex offender without a mental illness.

### **Demographic Findings**

Most of the respondents were between the ages of 20-35 (73.9%). In addition, the majority of the PRCs were White (40%) and female (77%). This figure may

indicate White females as the dominant provider of rehabilitation counseling services, in the northeast region of the United States. No one self-identified as transgender. Victimization status was staggering. Nearly 40% of the PRCs identified as being sexually victimized. Sexual assault victimization is a traumatic experience. As a counselor, personal trauma can (re)surface in the rehabilitation counseling process in the form of countertransference or “fear about one’s own vulnerability” (Artman & Daniels, 2010, p. 445). Without properly addressing sexual trauma, it can negatively affect the therapeutic alliance. As a result of this phenomenon, what can ultimately transpire is a counselor who is emotionally impaired attempt to effectively counsel. Based on the predominant age range of 20-35, many (78.0%) had not participated in an internship. Further, the majority of PRCs had less than five years of work experience. Out of the five universities surveyed, only one was classified as a Historically Black College or University (HBCU), the University of Maryland Eastern Shore (UMES). This designation is given to colleges or universities founded by or for African American students. UMES, which is in a rural section of Maryland had a total of 27 participants. Out of the 27 participants, three did not answer question 18: “Convicted sex offenders should never be released from prison.” Upon introspection, this question may trigger unpleasant emotions. On the one hand, many educated African Americans understand the escalated rate of incarceration for Black/African Americans. On the other hand, Black/African Americans may harbor beliefs that sex offenders should be incarcerated. Rather than answer the question, perhaps they opted to avoid it.

### **Summation of Findings**

The rationale for the first hypothesis, “PRCs will have negative attitudes toward sex offenders” was based on previous studies indicating that psychology students held more negative attitudes toward sex offenders than non-psychology students (Harper, 2012). Bennett and Stennett (2015) found that nursing students viewed individuals with mental illness as being “dangerous, cold-hearted, and dirty”. Further, Sanghara and Wilson (2006) found that people with less professional contact with sex offenders had more stereotypical views of them. Findings in this study do not confirm the hypothesis. This finding would suggest that PRCs do not have a high degree of negativity toward sex offenders. In fact, their attitudes were non-judgmental. Although this finding is contradictory to the hypothesis, this is a positive outcome for the field. PRCs do not elicit high negative attitudes toward sex offenders.

The rationale for the second hypothesis, “Child victimization will be more negative than adult victimization” was based on the study by Ferguson and Ireland (2006). Ferguson, et. al. found that men held less positive attitudes toward perpetrators who violated children than toward perpetrators who violated adults. However, this research yielded no statistically significant results to support the hypothesis of this study. Again, although this finding does not confirm the hypothesis in this study, this is also a positive outcome for the field in that there does not exist a high degree of negativity toward sex offenders while specifically taking into age of victimization.

The rationale for the third hypothesis, “PRCs with a history of being sexually victimized will have more positive attitudes” was based on the study by Ferguson and Ireland (2006) and Nelson, Herlily, and Oescher (2002). There were significant

differences between the two groups. PRCs who self-identified as being sexually victimized had more positive attitudes toward sex offenders than respondents who did not have this experience. Therefore, the null hypothesis was rejected. According to Nelson et al., since most sex offenses occur with acquaintances, most people who have been victimized view the perpetrator as a holistic person; not just a sexual predator. The findings confirm the hypothesis in this study.

The rationale for the fourth hypothesis, “PRCs will view sex offenders with a mental illness more negatively than a sex offender without a mental illness” was based on previous research by Mittal (2014). In Mittal’s study (2014), patients with schizophrenia were viewed as more negative than patients without schizophrenia, by mental health professionals. For this hypothesis, the interaction between the mental health condition and typology was not significantly significant. Based on the results, PRCs do not view sex offenders with a mental illness more negatively than a sex offender without a mental illness. Upon further exploration, the child acquaintance offender within the no mental illness group indicated the most negative attitude. Meanwhile, the adult acquaintance offender within the mental illness group indicated the most negative attitude. This finding would suggest that PRCs may be more forgiving toward a person with a mental illness when it comes to victimizing a child. Although the findings do not support the hypothesis, this outcome is positive for the field.

### **Limitations of the Study**

There were several limitations to this study. Firstly, it was determined that 211 surveys needed to be analyzed to have enough power to ascertain if significant

differences exist. One hundred ninety-one surveys were analyzed, a shortfall of 20. Therefore, findings do not yield a high level of confidence. However, securing the additional surveys from the same region may have generated similar findings, i.e. data saturation, which leads to the next limitation. Findings were not generalizable. The sample is taken from the northeast region of the United States. PRCs from other regions such as the west coast, mid-west, southeast, etc. may have dissimilar views than PRCs in this study. Further, seven surveys were removed from the study due to insufficient data. Third, this study utilized a self-reporting instrument. Although the CATSO has sound psychometric properties, PRCs may have responded based on social norms, i.e. social desirability. This is a limitation with any self-reporting instrument. Third, there was no comparison group, resulting in the sample being homogeneous. Forth, the vignettes used were not validated or pre-tested for authenticity. On the surface, the vignettes appear plausible. However, without being validated there is room to question their authenticity. Next, research shows that the more time one spends exposed to sex offenders, the less judgmental they are (Simon, 2010). This finding leads to the final limitation. The respondents were not directly asked if they had previous exposure to sex offenders, either professionally or personally in order to determine attitudinal dispositions.

### **Future Research**

This research can contribute to a greater understanding of how perception of individuals can either assist or impede the rehabilitative process for sex offenders with mental illnesses. Unfortunately, there is no research examining [current] rehabilitation counselors' attitudes toward sex offenders with mental illnesses. Due to the dearth of

research, assessing rehabilitation counselors' attitudes is warranted. It would benefit rehabilitation counselors to examine their attitudes to uncover what their attitudes could convey (e.g. I have a problem working with this person or I do not). Further, a comparison of the attitudes of prospective rehabilitation counselors versus current rehabilitation counselors may allow professionals in the field to ascertain if stark differences or similarities in attitudes exist. Ultimately, more research examining attitudes toward sex offenders with mental illnesses need to extend beyond the northeastern region of the United States with prospective and current rehabilitation counselors. Regarding typology, there was no research question aimed at examining relationship status (stranger vs. acquaintance). It would be beneficial to ascertain if attitudes of PRCs varied based on victim "familiarity" to identify what these attitudes could convey to service recipients who are sex offenders. Lastly, research exploring why counselors who have been sexually victimized elicit more positive attitudes toward sex offenders than those who have not been victimized is warranted. With regard to implications for curricula, CACREP standards should broaden its scope to include forensic standards. And, within the vein of forensics, sex offenders and its complexities should be addressed. Without a forensic standard in place, coursework surrounding criminal justice issues will only be optional and will fail to address CACREP's aim of having "a wide variety of circumstances" (CACREP, 2020) which could enrich the counseling experience. Since nearly 40% of PRCs in this study indicated they were sexually victimized, an area of focus for curricula should also include addressing sexual trauma, its associated complexities, and how these factors contribute to the therapeutic alliance.

**Summary**

As a rehabilitation counselor, there is the duty to perform at least 8 work activities (Counseling, Case Management, Client Assessment, Service Planning, Rehabilitation Service Coordination, Job Analysis, Job Development/Placement, and Advocacy) (CRCC, 2014) for individuals with disabilities in search of employment opportunities. Despite the disability one has, if the person is eager to work, guided by 5 ethical principles (autonomy, beneficence, nonmaleficence, justice, and fidelity), the rehabilitation counselor's job is to assist the consumer find employment. According to the literature, there is a sub-population of people who are twice labeled as a sex offender with a mental illness. Both terms can be stigmatizing. But, it is expected that this sub-population in need of employment would turn to the rehabilitation counselor for assistance. Although there were conflicting findings regarding the attitudes of sex offenders or persons with mental illnesses from previous research, PRCs in this study overall did not have a high degree of negative attitudes toward sex offenders. This finding would indicate that PRCs would not be apprehensive with providing vocational rehabilitation services for sex offenders with a mental illness. Further, PRCs who self-identified as being sexually victimized held more positive attitudes toward sex offenders as previous research suggests. The study could be replicated with other PRCs and rehabilitation counselors, utilizing the CATSO, beyond and within the northeast region of the United States.

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### Appendices - Surveys

#### Community Attitudes toward Sex Offenders Scale

(Church, Wakeman, Miller, Clements, & Sun, 2008)

#### Group 1A

Below there are 18 items about sex offenders and sex offenses. Select the corresponding number from the rating scale provided below for the answer that best describes how you feel or what you believe about issues surrounding sex offenders based on the following statement:

**Client A is re-integrating in the community after spending 10 years in an inpatient mental health facility. Client A sexually assaulted an adult who was known to the offender.**

There are no right or wrong answers. We are more interested in your attitudes about sex offenders. Even if you have no knowledge about sex offenders, please provide an answer for each question. Please circle only ONE response.

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

1. With support and therapy, someone who committed a sexual offense can learn to change their behavior\*.

1                      2                      3                      4                      5                      6

2. People who commit a sex offense should lose their civil rights (e.g., voting and privacy).

1                      2                      3                      4                      5                      6



3. People who commit sex offenses want to have sex more than the average person.

1      2      3      4      5      6

4. Male sex offenders should be punished more severely than female sex offenders.

1      2      3      4      5      6

5. Sexual fondling (inappropriate unwarranted touch) **is not** as bad as rape.

1      2      3      4      5      6

6. Sex offenders prefer to stay home alone rather than be around lots of people.

1      2      3      4      5      6

7. Most sex offenders do not have close friends.

1      2      3      4      5      6

8. Sex offenders have difficulty making friends even if they try real hard

1      2      3      4      5      6

9. The prison sentences sex offenders receive are much too long when compared  
to the sentence lengths for other crimes\*.

1      2      3      4      5      6

10. Sex offenders have high rates of sexual activity.

1      2      3      4      5      6

11. Trying to rehabilitate a sex offender is a waste of time.

1      2      3      4      5      6

12. Sex offenders should wear tracking devices so their location can be pinpointed at any time.

1      2      3      4      5      6

13. Only a few sex offenders are dangerous\*.

1      2      3      4      5      6

14. Most sex offenders are unmarried men.

1      2      3      4      5      6

15. Someone who uses emotional control when committing is not as bad as someone who uses physical control when committing a sex crime.

1      2      3      4      5      6

16. Most sex offenders keep to themselves.

1      2      3      4      5      6

17. A sex offense committed against someone the perpetrator knows is less serious than a sex offense committed against a stranger.

1      2      3      4      5      6

18. Convicted sex offenders should never be released from prison.

1      2      3      4      5      6

PLEASE CONTINUE

Demographic  
Questions

The below section contains questions about you and your tenure in your CACREP accredited clinical rehabilitation counseling program. Please answer all questions honestly by circling your responses. Your responses are confidential.

1. Are you:

Black/African

American White

Asian

Hispanic

Other \_\_\_\_\_(Write in ethnicity/race)

2. Are you:

Male

Female

Transgender

3. What is the geographical location of your CACREP/accredited rehabilitation counseling program?

New Jersey

New York

Pennsylvania

Maryland

Connecticut

Other \_\_\_\_\_(Write in location)

4. What is your age range?

20-35

35-50

50-65

65 and up

5. Have you ever been sexually victimized?

Yes

No

6. How long have you been enrolled in your CACREP Accredited program?

Please check ONLY one item

I have not yet participated in my internship \_\_\_\_\_

I am currently participating in my internship \_\_\_\_\_

7. How many years of work experience do you have?

Please check ONLY one item

Less than 5 years \_\_\_\_\_

5 to 10 years \_\_\_\_\_

More than 10 years \_\_\_\_\_

PLEASE CONTINUE

Thank you for participating. Please turn your survey face down. If you see \$25.00 on the back page of your survey, you have won a \$25.00 VISA gift card. Your receiving the gift card is up to you. You do not have to collect the gift card. But, if you choose to do so, please see the researcher with your survey to collect your gift.

Community Attitudes toward Sex  
Offenders Scale (Church, Wakeman,  
Miller, Clements, & Sun, 2008) Group 1B

Below there are 18 items about sex offenders and sex offenses. Select the corresponding number from the rating scale provided below for the answer that best describes how you feel or what you believe about issues surrounding sex offenders based on the following statement:

**Client B is re-integrating in the community after spending 10 years in an inpatient mental health facility. Client B sexually assaulted an adult who was NOT known to the offender.**

There are no right or wrong answers. We are more interested in your attitudes about sex offenders. Even if you have no knowledge about sex offenders, please provide an answer for each question. Please circle only ONE response.

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

1. With support and therapy, someone who committed a sexual offense can learn to change their behavior\*.

1                      2                      3                      4                      5                      6

2. People who commit a sex offense should lose their civil rights (e.g., voting and privacy).

1                      2                      3                      4                      5                      6

3. People who commit sex offenses want to have sex more than the average person.

1      2      3      4      5      6

4. Male sex offenders should be punished more severely than female sex offenders.

1      2      3      4      5      6

5. Sexual fondling (inappropriate unwarranted touch) **is not** as bad as rape.

1      2      3      4      5      6

6. Sex offenders prefer to stay home alone rather than be around lots of people.

1      2      3      4      5      6

7. Most sex offenders do not have close friends.

1      2      3      4      5      6

8. Sex offenders have difficulty making friends even if they try real hard

1      2      3      4      5      6

9. The prison sentences sex offenders receive are much too long when compared to the sentence lengths for other crimes\*.

1      2      3      4      5      6

10. Sex offenders have high rates of sexual activity.

1      2      3      4      5      6

11. Trying to rehabilitate a sex offender is a waste of time.

1      2      3      4      5      6

12. Sex offenders should wear tracking devices so their location can be pinpointed

at any time.

1      2      3      4      5      6

13. Only a few sex offenders are dangerous\*.

1      2      3      4      5      6

14. Most sex offenders are unmarried men.

1      2      3      4      5      6

15. Someone who uses emotional control when committing is not as bad as  
someone who uses physical control when committing a sex crime.

1      2      3      4      5      6

16. Most sex offenders keep to themselves.

1      2      3      4      5      6

17. A sex offense committed against someone the perpetrator knows is less serious  
than a sex offense committed against a stranger.

1      2      3      4      5      6

18. Convicted sex offenders should never be released from prison.

1      2      3      4      5      6

PLEASE CONTINUE

Demographic  
Questions

The below section contains questions about you and your tenure in your CACREP accredited clinical rehabilitation counseling program. Please answer all questions honestly by circling your responses. Your responses are confidential.

1. Are you  
  
Black/African  
  
American White  
  
Asian  
  
Hispanic  
  
Other\_\_\_\_\_ (Write in ethnicity/race)
2. Are you  
  
Male  
  
Female  
  
Transgender
3. What is the geographical location of your CACREP accredited clinical rehabilitation counseling program?  
  
New Jersey  
  
New York  
  
Pennsylvania  
  
Maryland  
  
Connecticut  
  
Other\_\_\_\_\_ (Write in location)
4. What is your age range?



20-35

35-50

50-65

65 and up

5. Have you ever been sexually victimized

Yes

No

6. How long have you been enrolled in your CACREP Accredited program?

Please check ONLY one item

I have not yet participated in my internship \_\_\_\_\_

I am currently participating in my internship \_\_\_\_\_

7. How many years of work experience do you have?

Please check ONLY one item

Less than 5 years \_\_\_\_\_

5 to 10 years \_\_\_\_\_

More than 10 years \_\_\_\_\_

PLEASE CONTINUE

Thank you for participating. Please turn your survey face down. If you see \$25.00 on the back page of your survey, you have won a \$25.00 VISA gift card. Your receiving the gift card is up to you. You do not have to collect the gift card. But, if you choose to do so, please see the researcher with your survey to collect your gift.

Community Attitudes toward Sex Offenders Scale

(Church, Wakeman, Miller, Clements, &amp; Sun, 2008)

## Group 1C

Below there are 18 items about sex offenders and sex offenses. Select the corresponding number from the rating scale provided below for the answer that best describes how you feel or what you believe about issues surrounding sex offenders based on the following statement:

**Client C is re-integrating in the community after spending 10 years in an inpatient mental health facility. Client C sexually assaulted an under aged child familiar to the offender.**

There are no right or wrong answers. We are more interested in your attitudes about sex offenders. Even if you have no knowledge about sex offenders, please provide an answer for each question. Please circle only ONE response.

Strongly Disagree	Disagree	Probably Disagree	Probably Agree	Agree	Strongly Agree
----------------------	----------	----------------------	-------------------	-------	-------------------

1                      2                      3                      4                      5                      6

1. With support and therapy, someone who committed a sexual offense can learn to change their behavior\*.

1                      2                      3                      4                      5                      6

2. People who commit a sex offense should lose their civil rights (e.g., voting and privacy).

1                      2                      3                      4                      5                      6

3. People who commit sex offenses want to have sex more than the average person.

1      2      3      4      5      6

4. Male sex offenders should be punished more severely than female sex offenders.

1      2      3      4      5      6

5. Sexual fondling (inappropriate unwarranted touch) **is not** as bad as rape.

1      2      3      4      5      6

6. Sex offenders prefer to stay home alone rather than be around lots of people.

1      2      3      4      5      6

7. Most sex offenders do not have close friends.

1      2      3      4      5      6

8. Sex offenders have difficulty making friends even if they try real hard

1      2      3      4      5      6

9. The prison sentences sex offenders receive are much too long when compared  
to the sentence lengths for other crimes\*.

1      2      3      4      5      6

10. Sex offenders have high rates of sexual activity.

1      2      3      4      5      6

11. Trying to rehabilitate a sex offender is a waste of time.

1      2      3      4      5      6

12. Sex offenders should wear tracking devices so their location can be pinpointed

at any time.

1      2      3      4      5      6

13. Only a few sex offenders are dangerous\*.

1      2      3      4      5      6

14. Most sex offenders are unmarried men.

1      2      3      4      5      6

15. Someone who uses emotional control when committing is not as bad as  
someone who uses physical control when committing a sex crime.

1      2      3      4      5      6

16. Most sex offenders keep to themselves.

1      2      3      4      5      6

17. A sex offense committed against someone the perpetrator knows is less serious  
than a sex offense committed against a stranger.

1      2      3      4      5      6

18. Convicted sex offenders should never be released from prison.

1      2      3      4      5      6

PLEASE CONTINUE

## Demographic Questions

The below section contains questions about you and your tenure in your CACREP accredited clinical rehabilitation counseling program. Please answer all questions honestly by circling your responses. Your responses are confidential.

1. Are you

Black/African American

White

Asian Hispanic

Other \_\_\_\_\_(Write in ethnicity/race)

2. Are you Male

Female

Transgender

3. What is the geographical location of your CACREP accredited clinical rehabilitation counseling program?

New Jersey

New York

Pennsylvania

Maryland

Connecticut

Other \_\_\_\_\_(Write in location)

4. What is your age range?

20-35

35-50

50-65

65 and up

5. Have you ever been sexually

victimized Yes

No

6. How long have you been enrolled in your CACREP Accredited program?

Please check ONLY one item

I have not yet participated in my internship \_\_\_\_\_

I am currently participating in my internship \_\_\_\_\_

7. How many years of work experience do you have?

Please check ONLY one item

Less than 5 years \_\_\_\_\_

5 to 10 years \_\_\_\_\_

More than 10 years \_\_\_\_\_

PLEASE CONTINUE

Thank you for participating. Please turn your survey face down. If you see \$25.00 on the back page of your survey, you have won a \$25.00 VISA gift card. Your receiving the gift card is up to you. You do not have to collect the gift card. But, if you choose to do so, please see the researcher with your survey to collect your gift.

Community Attitudes toward Sex Offenders Scale (Church, Wakeman,  
Miller, Clements, & Sun, 2008) Group 1D

Below there are 18 items about sex offenders and sex offenses. Select the corresponding number from the rating scale provided below for the answer that best describes how you feel or what you believe about issues surrounding sex offenders based on the following statement:

**Client D is re-integrating in the community after spending 10 years in an inpatient mental health facility. Client D sexually assaulted an under aged child unfamiliar to the offender.**

There are no right or wrong answers. We are more interested in your attitudes about sex offenders. Even if you have no knowledge about sex offenders, please provide an answer for each question. Please circle only ONE response.

Strongly Disagree	Disagree	Probably Disagree	Probably Agree	Agree	Strongly Agree
----------------------	----------	----------------------	-------------------	-------	-------------------

1                      2                      3                      4                      5                      6

1. With support and therapy, someone who committed a sexual offense can learn to change their behavior\*.

1              2              3              4              5              6

2. People who commit a sex offense should lose their civil rights (e.g., voting and privacy).

1              2              3              4              5              6

3. People who commit sex offenses want to have sex more than the average person.

1              2              3              4              5              6

4. Male sex offenders should be punished more severely than female sex offenders.

1      2      3      4      5      6

5. Sexual fondling (inappropriate unwarranted touch) **is not** as bad as rape.

1      2      3      4      5      6

6. Sex offenders prefer to stay home alone rather than be around lots of people.

1      2      3      4      5      6

7. Most sex offenders do not have close friends.

1      2      3      4      5      6

8. Sex offenders have difficulty making friends even if they try real hard

1      2      3      4      5      6

9. The prison sentences sex offenders receive are much too long when compared  
to the sentence lengths for other crimes\*.

1      2      3      4      5      6

10. Sex offenders have high rates of sexual activity.

1      2      3      4      5      6

11. Trying to rehabilitate a sex offender is a waste of time.

1      2      3      4      5      6

12. Sex offenders should wear tracking devices so their location can be pinpointed  
at any time.

1      2      3      4      5      6



13. Only a few sex offenders are dangerous\*.

1      2      3      4      5      6

14. Most sex offenders are unmarried men.

1      2      3      4      5      6

15. Someone who uses emotional control when committing is not as bad as  
someone who uses physical control when committing a sex crime.

1      2      3      4      5      6

16. Most sex offenders keep to themselves.

1      2      3      4      5      6

17. A sex offense committed against someone the perpetrator knows is less serious  
than a sex offense committed against a stranger.

1      2      3      4      5      6

18.      Convicted sex offenders should never be released from prison.

1      2      3      4      5      6

PLEASE CONTINUE

## Demographic Questions

The below section contains questions about you and your tenure in your CACREP accredited clinical rehabilitation counseling program. Please answer all questions honestly by circling your responses. Your responses are confidential.

1. Are you

Black/African American

White

Asian Hispanic

Other \_\_\_\_\_(Write in ethnicity/race)

2. Are you

Male

Female

Transgender

3. What is the geographical location of your CACREP accredited clinical rehabilitation counseling program?

New Jersey

New York

Pennsylvania

Maryland

Connecticut

Other \_\_\_\_\_(Write in location)

4. What is your age range?

20-35

35-50

50-65

65 and up

5. Have you ever been sexually victimized?

Yes

No

6. How long have you been enrolled in your CACREP Accredited program?

Please check ONLY one item

I have not yet participated in my internship \_\_\_\_\_

I am currently participating in my internship \_\_\_\_\_

7. How many years of work experience do you have?

Please check ONLY one item

Less than 5 years \_\_\_\_\_

5 to 10 years \_\_\_\_\_

More than 10 years \_\_\_\_\_

PLEASE CONTINUE

Thank you for participating. Please turn your survey face down. If you see \$25.00 on the back page of your survey, you have won a \$25.00 VISA gift card. Your receiving the gift card is up to you. You do not have to collect the gift card. But, if you choose to do so, please see the researcher with your survey to collect your gift.

Community Attitudes toward Sex Offenders Scale (Church,  
Wakeman, Miller, Clements, & Sun, 2008) Group 2A

Below there are 18 items about sex offenders and sex offenses. Select the corresponding number from the rating scale provided below for the answer that best describes how you feel or what you believe about issues surrounding sex offenders based on the following statement:

**Client A is re-integrating in the community after spending 10 years incarcerated.  
Client A sexually assaulted an adult who was known to the offender.**

There are no right or wrong answers. We are more interested in your attitudes about sex offenders. Even if you have no knowledge about sex offenders, please provide an answer for each question. Please circle only ONE response.

Strongly Disagree	Disagree	Probably Disagree	Probably Agree	Agree	Strongly Agree
----------------------	----------	----------------------	-------------------	-------	-------------------

1                      2                      3                      4                      5                      6

1. With support and therapy, someone who committed a sexual offense can learn to change their behavior\*.

1                      2                      3                      4                      5                      6

2. People who commit a sex offense should lose their civil rights (e.g., voting and privacy).

1                      2                      3                      4                      5                      6

3. People who commit sex offenses want to have sex more than the average person.

1                      2                      3                      4                      5                      6

4. Male sex offenders should be punished more severely than female sex offenders.

1      2      3      4      5      6

5. Sexual fondling (inappropriate unwarranted touch) **is not** as bad as rape.

1      2      3      4      5      6

6. Sex offenders prefer to stay home alone rather than be around lots of people.

1      2      3      4      5      6

7. Most sex offenders do not have close friends.

1      2      3      4      5      6

8. Sex offenders have difficulty making friends even if they try real hard

1      2      3      4      5      6

9. The prison sentences sex offenders receive are much too long when  
compared to the sentence lengths for other crimes\*.

1      2      3      4      5      6

10. Sex offenders have high rates of sexual activity.

1      2      3      4      5      6

11. Trying to rehabilitate a sex offender is a waste of time.

1      2      3      4      5      6

12. Sex offenders should wear tracking devices so their location can be pinpointed at any time.

1 2 3 4 5 6

13. Only a few sex offenders are dangerous\*.

1 2 3 4 5 6

14. Most sex offenders are unmarried men.

1 2 3 4 5 6

15. Someone who uses emotional control when committing is not as bad as someone who uses physical control when committing a sex crime.

1 2 3 4 5 6

16. Most sex offenders keep to themselves.

1 2 3 4 5 6

17. A sex offense committed against someone the perpetrator knows is less serious than a sex offense committed against a stranger.

1 2 3 4 5 6

18. Convicted sex offenders should never be released from prison.

1 2 3 4 5 6

PLEASE CONTINUE

## Demographic Questions

The below section contains questions about you and your tenure in your CACREP accredited clinical rehabilitation counseling program. Please answer all questions honestly by circling your responses. Your responses are confidential.

1. Are you

Black/African American

White

Asian

Hispanic

Other \_\_\_\_\_(Write in ethnicity/race)

2. Are you

Male Female

Transgender

3. What is the geographical location of your CACREP accredited clinical rehabilitation counseling program?

New Jersey

New York

Pennsylvania

Maryland

Connecticut

Other \_\_\_\_\_(Write in location)

4. What is your age range?

20-35

35-50

50-65

65 and up

5. Have you ever been sexually

victimized? Yes

No

6. How long have you been enrolled in your CACREP Accredited program?

Please check ONLY one item

I have not yet participated in my internship \_\_\_\_\_

I am currently participating in my internship \_\_\_\_\_

7. How many years of work experience do you have?

Please check ONLY one item

Less than 5 years \_\_\_\_\_

5 to 10 years \_\_\_\_\_

More than 10 years \_\_\_\_\_

PLEASE CONTINUE

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Community Attitudes toward Sex  
Offenders Scale (Church, Wakeman,  
Miller, Clements, & Sun, 2008) Group

2B

Below there are 18 items about sex offenders and sex offenses. Select the corresponding number from the rating scale provided below for the answer that best describes how you feel or what you believe about issues surrounding sex offenders based on the following statement:

**Client B is re-integrating in the community after spending 10 years incarcerated.  
Client B sexually assaulted an adult who was NOT known to the offender.**

There are no right or wrong answers. We are more interested in your attitudes about sex offenders. Even if you have no knowledge about sex offenders, please provide an answer for each question. Please circle only ONE response.

Strongly Disagree	Disagree	Probably Disagree	Probably Agree	Agree	Strongly Agree
----------------------	----------	----------------------	-------------------	-------	-------------------

1                      2                      3                      4                      5                      6

1. With support and therapy, someone who committed a sexual offense can learn to change their behavior\*.

1              2              3              4              5              6

2. People who commit a sex offense should lose their civil rights (e.g., voting and privacy).

1              2              3              4              5              6

3. People who commit sex offenses want to have sex more than the average person.

1      2      3      4      5      6

4. Male sex offenders should be punished more severely than female sex offenders.

1      2      3      4      5      6

5. Sexual fondling (inappropriate unwarranted touch) **is not** as bad as rape.

1      2      3      4      5      6

6. Sex offenders prefer to stay home alone rather than be around lots of people.

1      2      3      4      5      6

7. Most sex offenders do not have close friends.

1      2      3      4      5      6

8. Sex offenders have difficulty making friends even if they try real hard

1      2      3      4      5      6

9. The prison sentences sex offenders receive are much too long when compared to the sentence lengths for other crimes\*.

1      2      3      4      5      6

10. Sex offenders have high rates of sexual activity.

1      2      3      4      5      6

11. Trying to rehabilitate a sex offender is a waste of time.

1      2      3      4      5      6

12. Sex offenders should wear tracking devices so their location can be pinpointed at any time.

1 2 3 4 5 6

13. Only a few sex offenders are dangerous\*.

1 2 3 4 5 6

14. Most sex offenders are unmarried men.

1 2 3 4 5 6

15. Someone who uses emotional control when committing is not as bad as someone who uses physical control when committing a sex crime.

1 2 3 4 5 6

16. Most sex offenders keep to themselves.

1 2 3 4 5 6

17. A sex offense committed against someone the perpetrator knows is less serious than a sex offense committed against a stranger.

1 2 3 4 5 6

18. Convicted sex offenders should never be released from prison.

1 2 3 4 5 6

PLEASE CONTINUE

## Demographic Questions

The below section contains questions about you and your tenure in your CACREP accredited clinical rehabilitation counseling program. Please answer all questions honestly by circling your responses. Your responses are confidential.

1. Are you

Black/African American

White

Asian

Hispanic

Other \_\_\_\_\_(Write in ethnicity/race)

2. Are You

Male

Female

Transgender

3. What is the geographical location of your CACREP accredited clinical rehabilitation counseling program?

New Jersey

New York

Pennsylvania

Maryland

Connecticut

Other \_\_\_\_\_(Write in location)

4. What is your age range?

20-35

35-50

50-65

65 and up

5. Have you ever been sexually victimized?

Yes

No

6. How long have you been enrolled in your CACREP Accredited program?

Please check ONLY one item

I have not yet participated in my internship \_\_\_\_\_

I am currently participating in my internship \_\_\_\_\_

7. How many years of work experience do you have?

Please check ONLY one item

Less than 5 years \_\_\_\_\_

5 to 10 years \_\_\_\_\_

More than 10 years \_\_\_\_\_

PLEASE CONTINUE

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## Community Attitudes toward Sex Offenders Scale

(Church, Wakeman, Miller, Clements, &amp; Sun, 2008)

## Group 2C

Below there are 18 items about sex offenders and sex offenses. Select the corresponding number from the rating scale provided below for the answer that best describes how you feel or what you believe about issues surrounding sex offenders based on the following statement:

**Client C is re-integrating in the community after spending 10 years incarcerated.  
Client C sexually assaulted an under aged child familiar to the offender.**

There are no right or wrong answers. We are more interested in your attitudes about sex offenders. Even if you have no knowledge about sex offenders, please provide an answer for each question. Please circle only ONE response.

Strongly Disagree	Disagree	Probably Disagree	Probably Agree	Agree	Strongly Agree
----------------------	----------	----------------------	-------------------	-------	-------------------

1                      2                      3                      4                      5                      6

1. With support and therapy, someone who committed a sexual offense can learn to change their behavior\*.

1              2              3              4              5              6

2. People who commit a sex offense should lose their civil rights (e.g., voting and privacy).

1              2              3              4              5              6

3. People who commit sex offenses want to have sex more than the average person.

1              2              3              4              5              6

4. Male sex offenders should be punished more severely than female sex offenders.

1      2      3      4      5      6

5. Sexual fondling (inappropriate unwarranted touch) **is not** as bad as rape.

1      2      3      4      5      6

6. Sex offenders prefer to stay home alone rather than be around lots of people.

1      2      3      4      5      6

7. Most sex offenders do not have close friends.

1      2      3      4      5      6

8. Sex offenders have difficulty making friends even if they try real hard

1      2      3      4      5      6

9. The prison sentences sex offenders receive are much too long when  
compared to the sentence lengths for other crimes\*.

1      2      3      4      5      6

10. Sex offenders have high rates of sexual activity.

1      2      3      4      5      6

11. Trying to rehabilitate a sex offender is a waste of time.

1      2      3      4      5      6

12. Sex offenders should wear tracking devices so their location can be  
pinpointed at any time.

1      2      3      4      5      6

13. Only a few sex offenders are dangerous\*.

1      2      3      4      5      6

14. Most sex offenders are unmarried men.

1      2      3      4      5      6

15. Someone who uses emotional control when committing is not as bad as  
someone who uses physical control when committing a sex crime.

1      2      3      4      5      6

16. Most sex offenders keep to themselves.

1      2      3      4      5      6

17. A sex offense committed against someone the perpetrator knows is less  
serious than a sex offense committed against a stranger.

1      2      3      4      5      6

18. Convicted sex offenders should never be released from prison.

1      2      3      4      5      6

PLEASE CONTINUE



## Demographic Questions

The below section contains questions about you and your tenure in your CACREP accredited clinical rehabilitation counseling program. Please answer all questions honestly by circling your responses. Your responses are confidential.

1. Are you

Black/African American

White

Asian Hispanic

Other \_\_\_\_\_ (Write in ethnicity/race)

2. Are you

Male

Female

Transgender

3. What is the geographical location of your CACREP accredited clinical rehabilitation counseling program?

New Jersey

New York

Pennsylvania

Maryland

Connecticut

Other \_\_\_\_\_ (Write in location)

4. What is your age range?

20-35

35-50

50-65

65 and up

5. Have you ever been sexually victimized?

Yes

No

6. How long have you been enrolled in your CACREP Accredited program?

Please check ONLY one item

I have not yet participated in my internship \_\_\_\_\_

I am currently participating in my internship \_\_\_\_\_

7. How many years of work experience do you have?

Please check ONLY one item

Less than 5 years \_\_\_\_\_

5 to 10 years \_\_\_\_\_

More than 10 years \_\_\_\_\_

PLEASE CONTINUE

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## Community Attitudes toward Sex Offenders Scale

(Church, Wakeman, Miller, Clements, &amp; Sun, 2008)

## Group 2D

Below there are 18 items about sex offenders and sex offenses. Select the corresponding number from the rating scale provided below for the answer that best describes how you feel or what you believe about issues surrounding sex offenders based on the following statement:

**Client D is re-integrating in the community after spending 10 years incarcerated.  
Client D sexually assaulted an under aged child unfamiliar to the offender.**

There are no right or wrong answers. We are more interested in your attitudes about sex offenders. Even if you have no knowledge about sex offenders, please provide an answer for each question. Please circle only ONE response.

Strongly Disagree	Disagree	Probably Disagree	Probably Agree	Agree	Strongly Agree
----------------------	----------	----------------------	-------------------	-------	-------------------

1

2

3

4

5

6

1. With support and therapy, someone who committed a sexual offense can learn to change their behavior\*.

1

2

3

4

5

6

2. People who commit a sex offense should lose their civil rights (e.g., voting and privacy).

1

2

3

4

5

6

3. People who commit sex offenses want to have sex more than the average person.

1      2      3      4      5      6

4. Male sex offenders should be punished more severely than female sex offenders.

1      2      3      4      5      6

5. Sexual fondling (inappropriate unwarranted touch) **is not** as bad as rape.

1      2      3      4      5      6

6. Sex offenders prefer to stay home alone rather than be around lots of people.

1      2      3      4      5      6

7. Most sex offenders do not have close friends.

1      2      3      4      5      6

8. Sex offenders have difficulty making friends even if they try real hard

1      2      3      4      5      6

9. The prison sentences sex offenders receive are much too long when compared  
to the sentence lengths for other crimes\*.

1      2      3      4      5      6

10. Sex offenders have high rates of sexual activity.

1      2      3      4      5      6

11. Trying to rehabilitate a sex offender is a waste of time.

1      2      3      4      5      6

12. Sex offenders should wear tracking devices so their location can be pinpointed at any time.

1      2      3      4      5      6

13. Only a few sex offenders are dangerous\*.

1      2      3      4      5      6

14. Most sex offenders are unmarried men.

1      2      3      4      5      6

15. Someone who uses emotional control when committing is not as bad as someone who uses physical control when committing a sex crime.

1      2      3      4      5      6

16. Most sex offenders keep to themselves.

1      2      3      4      5      6

17. A sex offense committed against someone the perpetrator knows is less serious than a sex offense committed against a stranger.

1      2      3      4      5      6

18. Convicted sex offenders should never be released from prison.

1      2      3      4      5      6

PLEASE CONTINUE

## Demographic Questions

The below section contains questions about you and your tenure in your CACREP accredited clinical rehabilitation counseling program. Please answer all questions honestly by circling your responses. Your responses are confidential.

1. Are you:

Black/African American

White

Asian

Hispanic

Other \_\_\_\_\_(Write in ethnicity/race)

2. Are you:

Male

Female

Transgender

3. What is the geographical location of your CACREP accredited clinical rehabilitation counseling program?

New Jersey

New York

Pennsylvania

Maryland

Connecticut

Other \_\_\_\_\_(Write in location)

4. What is your age range?

20-35

35-50

50-65

65 and up

5. Have you ever been sexually victimized?

Yes

No

6. How long have you been enrolled in your CACREP Accredited program?

Please check ONLY one item

I have not yet participated in my internship \_\_\_\_\_

I am currently participating in my internship \_\_\_\_\_

7. How many years of work experience do you have?

Please check ONLY one item

Less than 5 years \_\_\_\_\_

5 to 10 years \_\_\_\_\_

More than 10 years \_\_\_\_\_

PLEASE CONTINUE

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