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The Inclusion of Spirituality in Sex Offender Treatment

Vanessa Bennifield
Philadelphia College of Osteopathic Medicine, vanessabe@pcom.edu

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THE INCLUSION OF SPIRITUALITY IN SEX OFFENDER TREATMENT

Vanessa Bennifield

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Psychology

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Dissertation Approval

This is to certify that the thesis presented to us by Vanessa Bennfield on the 24th day of April, 2014, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

Committee Members' Signatures:

Beverly White, PsyD, Chairperson

Stephanie H Felgoise, PhD, ABPP

William F Russell, PhD

Robert A DiTomasso, PhD, ABPP, Chair, Department of Psychology
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Abstract

The management of sex offenders is a collaborative effort that typically includes law enforcement and treatment professionals. The management of sex offenders has focused largely on assessing for risk and need of the offender, with limited attention paid to addressing responsivity factors of the sex offender, such as worldview, interpersonal style, and cultural influences. In an effort to understand how therapists perceive the influence of responsivity factors, this study explored sex offender therapists’ perceptions of the inclusion of spirituality in sex offender treatment. The investigator conducted semistructured interviews with sex offender therapists who had at least 1 year of experience working with sex offenders. In addition, each participant completed a demographic questionnaire and the Brief Multidimensional Measure of Religiousness/Spirituality. Five themes emerged regarding the usefulness and challenges of including spirituality in sex offender treatment: spirituality is an enhancement, spirituality is initiated by the client, safe environment, spirituality is not formally included in treatment, and spirituality can be a barrier to treatment. The contextual factors related to these themes emphasized the importance of training for sex offender therapists to feel confident and skilled to include spirituality in sex offender treatment and the importance of developing a client-centered approach to support autonomy in treatment planning. Implications for further study include training for sex offender therapists and examining treatment outcomes when spirituality is included for specific sexual offending groups in various therapeutic settings.
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Chapter 1

Introduction

Statement of the Problem

The treatment of sex offenders is an area of increasing interest for psychological professionals. Sex offenders are individuals who commit illegal sexual behavior considered a sex crime (Center for Sex Offender Management [CSOM], 1999). Sex offending is not a homogenous offense. Illegal sexual behavior can include unwanted sexual contact among adults or minors, sexual contact between a youth and an adult, or sexual contact between two minors with a difference in age (CSOM, 1999). For the purpose of this study, the term sex offender refers to the heterogeneous population of adult sex offenders who are convicted of an illegal sexual act.

Compared to other crimes committed in the United States, sex offenses represent only 1% of all arrests (CSOM, 1999). The rate of sex offending, however, is significant because approximately 97% of convicted offenders eventually receive probation or parole and return to the community (CSOM, 1999). An increasing number of sex offenders in the community means the safety of the community is potentially at risk for reoffending behavior post conviction.

The number of convictions for sex offenses increased 300% between 1980 and 2004 (CSOM, 2008). Although sex offenders represent a small number of all offenders, this increasing rate of convictions indicates a problem in the management of sex offenders. As the sex offender population becomes larger, the number of sex offenders released into the community also increases. The increased presence of sex offenders in the community supports the need to identify how sex offenders can avoid reoffending. A
step toward decreasing the potential to reoffend includes the depiction of barriers to reducing the risk of recidivism.

**Recidivism**

Recidivism is one common factor that has been linked to poor treatment outcome for sex offenders. On average, the rate of recidivism for this population has been reported at 13.7%, 5 to 6 years post incarceration (Moster, Wnuk, & Jeglic, 2008). Research has focused on factors that are likely to reduce recidivism, such as self-management, affect regulation, and healthy cognitions (Moster et al., 2008; Olver, Stockdale, & Wormith, 2011). Recidivism has been a common focus of treatment outcomes because it is a predictor of the offender’s potential to live safely in the community (CSOM, 2001; Olver & Wong, 2011; Olver et al., 2011). Recidivism is critical to address because it can demonstrate that treatment was ineffective. For example, the ability to understand why offenders recidivate can promote better treatment interventions and better protect society. However, part of the difficulty in studying recidivism is defining the term.

Defining recidivism has been inconsistent and has contributed to the problem of understanding which interventions work (Mandeville-Norden & Beech, 2004). For example, recidivism can refer to reconviction, re-arrest, or re-incarceration (CSOM, 2001). Thus, understanding the approach research takes to the study of recidivism is important, because it can change the way sex offender behavior is viewed. For the purpose of this study, the term *recidivism* refers to an offender who has received a reconviction, re-arrest, or re-incarceration. All possible variables must be addressed when studying the factors that lead to the likelihood of recidivism. As a result, the
predictors of recidivism must be addressed in developing the best practice for treating sex offenders (CSOM, 2001).

**Impacting Sex Offender Behavior**

Risk factors, treatment need, and responsivity (RNR) are principles that have been shown to be pivotal components for organizing treatment for the sex offender (Olver et al., 2011) and, therefore, can reduce the likelihood the offender will recidivate. These principles organize the interventions necessary for treatment and posttreatment. The principles are described as (a) risk that addresses the offender’s level of risk, (b) need that targets the offender’s mental-health functioning and criminal behavior, and (c) responsivity that targets the offender’s individualistic needs to participate, understand, and complete treatment (Olver, et al., 2011). Of the three principles, responsivity has received the least amount of attention. Under the principle of responsivity, the therapeutic experience can be improved for the client by including goals that are meaningful to the individual. In addition to creating a treatment plan that is meaningful to the client, the RNR principles can support the inclusion of factors that are unique to the individual and that can improve treatment outcomes.

**Inclusion of Spirituality**

Spirituality is an area that has received limited attention in sex offender treatment. Because research has shown that spirituality can be effective in such settings as mental health treatment, substance abuse treatment, and inpatient forensic psychiatric treatment (James & Wells, 2003; Mela et al., 2008; Mason, Deane, Kelly, & Crowe, 2009; Propst, 1996), it is hypothesized that the inclusion of spirituality in sex offender treatment can deliver similar effects. Clients’ ratings of the effect of spirituality and religion can be
related to the therapists’ doubts that spiritual beliefs have value in treatment (Post & Wade, 2009). In addition, therapists may have difficulty identifying ways to incorporate clients’ spiritual beliefs into treatment (Propst, 1996). Therefore, the inclusion of spirituality can be useful in improving treatment outcome, but successful inclusion of spirituality involves flexibility of and understanding by the therapist.

Knowledge about whether professionals consider spirituality useful in treatment and whether an incorporation of spirituality has positive treatment outcomes is limited. One way of informing new developments in treatment provision is to elicit therapists’ perspectives on the inclusion of spirituality in sex offender treatment.

**Purpose of the Study**

The purpose of the study was to examine spirituality as a component in sex offender treatment and therapists’ perceptions of the inclusion of spirituality. The RNR principles support the inclusion of intrinsic and extrinsic motivational factors in treatment (Olver et al., 2011). However, sex offender treatment historically has focused on the offender’s level of risk, which includes the offender’s ability to meet treatment goals such as a demonstration of victim empathy, adequate intrapersonal relationships, and legal and safe behavior in the community (Olver & Wong, 2011). Current treatment interventions are used with offenders to decrease the offender’s level of risk and to address the offense behavior.

Although the construct of risk is a necessary focus in treatment, concern remains that current treatments do not sufficiently protect against recidivism. One way to do so is to focus on protective factors as well (Looman, Dickie, & Abracen, 2005). The examination of protective factors can significantly add to the discussion about recidivism.
One possible protective variable, spirituality, can enhance traditional cognitive-behavioral therapy (CBT) treatment for sexual offenders (James & Wells, 2003; Propst, 1996) and support an individualized approach to treatment. Spirituality for sex offenders can increase positive affect, support a healthy well-being, and support healthy coping skills. The incorporation of spirituality may support the client’s ability to address issues in treatment, using a familiar framework.

This study hopes to contribute to the professional body of knowledge regarding the perceptions of therapists who have worked and are working with sex offenders regarding the potential effectiveness of spirituality as a protective factor of treatment.
Chapter 2

Review of the Literature

Sex offenders represent approximately 10-30% of the U.S. prison population, which reflects a 300% increase of offenders between 1980 and 1994 (CSOM, 2008). The increase in convictions remains a concern, despite the developments of sex offender treatment and the improvement of treatment over time. Knowing the meaning of the term sex offender helps one to understand the impact of this increase. Sex offenders are a heterogeneous group, meaning there is a variety of categories of offending behavior such as rapists, child molesters, and exhibitionists (La Fond, 2005).

The term sex offender refers to a group of offenders who engage in illegal sexual behavior (CSOM, 1999; Mandeville-Norden & Beech, 2004) that may involve physical contact or no physical contact with the victim (CSOM, 2008). In addition, sex offenses may include acts that are not punishable by law and are otherwise labeled as sexually inappropriate behaviors. The category of sex offender can include individuals who are convicted of sexually deviant acts, such as a forcible sexual act with an adult or child, sexual contact with a child, exposure of private parts for sexual arousal, and nonphysical contact behavior (e.g., Internet pornography; CSOM, 1999). Although the population of sex offenders is diverse, for the purpose of this paper, the term sex offender represents an adult individual who is convicted of a sexually deviant act (CSOM, 1999), excluding such offenses as prostitution and sexual human trafficking (Bureau of Justice Statistics, n.d.).
Rate of Offending

The rate of convicted sex offenders has increased (CSOM, n.d.; CSOM, 2008), as has the number of offenders living in the community (CSOM, 2008; Levenson, D’Amora, & Hern, 2007). Although sex offenders represent only 1% of the general offender population, the management of offenders in the community is a concern as the population increases (CSOM, n.d.; CSOM, 2008). For example, the greater the number of offenders who are in the community, the greater the opportunity for offenders to reoffend and for victims to be in danger. The rate of offending is of particular concern since 84% of victims do not report their abuse (CSOM, n.d.; CSOM, 2001). Therefore, studying recidivism can help to support appropriate supervision and treatment approaches.

Recidivism is pivotal in managing offenders and is considered an important treatment outcome. However, the recidivism data can be misleading because recidivism can be defined differently by professionals. For example, recidivism can be a combination of re-conviction, re-arrest, and re-incarceration (CSOM, 2001). Recidivism is critical in the community management of sex offenders because it represents the success of community management and safety of potential victims. In order to effectively manage sex offenders and promote public safety, studying the factors associated with the prediction of re-offending, and examining effective approaches to treatment are important.

Rate of Reoffending

Although the rate of reoffending, or rate of recidivism, is less than that for most other crimes, it is important to consider recidivism must be considered when devising an
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effective sex offender management program (Levenson et al, 2007). Research has found a recidivism rate of less than 10% at 4-year post release follow-up. This rate increased, however, after 6 years post release (Mandeville-Norden & Beech, 2004). Therefore, the longer offenders were in the community, the greater their chance of reoffending.

An offender who is assessed to be at high risk for reoffending is categorized as such. In a study of the different categories of risk, offenders who demonstrated lower risk and higher risk had a 5% and 26% recidivism rate, respectively (Fisher & Thornton, 1993). As the risk level increases the potential to reoffend increases (Fisher & Thornton, 1993; Mandeville-Norden & Beech, 2004). The assessment of reoffending, therefore, is important when considering which treatment interventions are appropriate.

**Impacting Sex Offender Behavior Using the RNR Approach**

The management of sex offenders is commonly based on risk, need, and responsivity (RNR; Schaffer, Jeglic, Moster, & Wnuk, 2010) and has received a significant amount of empirical attention as an approach to offender assessment and treatment (Andrews, Bonta, & Wormith, 2011; Moster et al., 2008). In sex offender treatment, these principles assist in developing a useful approach (Harkins & Beech, 2007). For example, identifying the offender’s level of risk can help to determine the intensity of treatment. Professionals may evaluate each of the principles differently and consider certain components as more important for treatment than other components. Typically, risk is the first factor that is assessed and is instrumental in devising the type of management and treatment the offender will receive (Craig, Browne, Stringer, & Beech, 2005).
**Risk Principle**

Risk is the most commonly used principle in sex offender treatment and assessment. Risk represents the offender’s level of risk for reoffending (Harkins & Beech, 2007; Moster et al., 2008) and can be used to demonstrate the static risk factors (i.e., age, criminal history, and victim characteristics; Olver & Wong, 2011). The purpose of conducting a risk assessment is to determine the offender’s level of risk and match the appropriate level of treatment (Looman et al., 2005). The offender who has a high level of risk receives intensive treatment; however, the offender who is deemed a lower risk receives minimal treatment intervention. The risk principle is concerned with treatment intensity that allows the professional to address the client’s needs.

The use of empirically validated risk assessments is important in predicting risk. Research demonstrates that actuarial risk assessments provide greater predictive accuracy when compared to clinical judgment (Craig et al., 2005). One study demonstrated that actuarial assessments were considered “10% more accurate than clinical predictions” (Craig et al., 2005, p. 73). However, research indicates that actuarial assessments and clinical assessments should not be compared because clinical assessments are not predictions (Craig et al., 2005). Clinical assessments provide insight into the psychological functioning of the offender, not predictions therefore, an individualistic perspective of the offender can be beneficial.

When assessing the individual offender, the professional must consider all relevant client information. The therapist must be careful not to assume that the individual client is characteristically similar to others in the offender group (Vess, 2008). The risk of using predictions about an offender compared to a specific group may lead to
the expectation that the offender will behave like other offenders. Although considering the offender’s association with a specific sex offender group is important, considering individual factors and group factors is ideal (Vess, 2008).

**Need Principle**

The specific client variables can be addressed by the need principle. The need principle represents the behaviors that reinforce the offender’s criminal behavior, such as cognitions and thought patterns and victim empathy (Harkins & Beech, 2007; Looman et al., 2005; Moster et al., 2008). The principle of need is important because it allows the therapist to address important behaviors that link to positive treatment outcome and nonrecidivism behavior (Harkins & Beech, 2007). For example, research indicates that offenders who demonstrate improvement in attitude are less likely to recidivate compared to offenders who do not make improvements in this area (Harkins & Beech, 2007). As expected, treatment that focuses on the offender’s needs can be helpful in supporting the offender’s responsibility to fulfill the requirements of the conviction (Looman et al., 2005). Thus, how the offender’s response to treatment is relevant for successful sex offender management.

**Responsivity Principle**

Responsivity is concerned with understanding how the offender can receive individualized benefit from treatment (Harkins & Beech, 2007; Looman et al., 2005; Moster et al., 2008). The responsivity principle is equally important as risk and need; yet it has received less attention in the treatment and assessment of sex offenders (Looman et al., 2005). According to this principle, the offender’s intrinsic characteristics, such as the offender’s learning style, motivation (Looman et al., 2005; Moster et al., 2008), mental
health, cognitive functioning (Looman et al., 2005), and general ability (Andrews et al., 2011), are of relevance. Despite the limited attention given to the responsivity principle, personal offender characteristics are important to success in treatment.

In summary, the description of sex offender treatment begins with understanding the offender’s level of risk, the offender’s criminal justice needs to function successfully, and the client needs that represents the offender’s response to treatment. The RNR principles are widely used because of their association with reduced recidivism rates and the comprehensive approach that the principles provide to assess and treat offenders. Although RNR principles are a popular approach in sex offender treatment, these principles are not the sole deciding factor used to determine the type of treatment interventions to use.

**Need for treatment.** The RNR principles provide a way to improve understanding of the treatment needs of the offender; however, the type of treatment used is another matter. Because sex offending is a criminal matter and community issue (Brooks-Gordon, Bilby, & Wells, 2006), the focus of treatment is to decrease the offender’s potential to reoffend. Thus, treatment can be used to provide education on the ways to decrease the potential to reoffend, such as learning to demonstrate appropriate social boundaries, developing social stability (employment and housing), and improving self-esteem, all of which are shown to have a moderate effect in reducing offender risk for recidivism (Yates, 2003). Treatment for the sex offender can introduce new skills that will teach the offender how to self-manage behaviors effectively; however, using the information gathered from offenders RNR assessments to determine the appropriate level of treatment is important.
**Level of intensity of treatment.** Once the need for treatment has been determined, the therapist is able to determine the level of treatment for the client. For example, a low risk offender will receive treatment interventions different from those given to a high-risk offender. The treatment for offenders should be matched to each client’s level of risk (Looman et al., 2005). Not matching the offender with the appropriate level of treatment can add risk and can result in unfavorable outcomes, such as an increase in the rate of recidivism (Clipson, 2003; Looman et al., 2005). The common categories of risk that are used include (a) low, (b) moderate, and (c) high.

For example, a low-risk offender can be managed by community supervision provided by a probation officer and outpatient treatment, whereas a moderate-risk offender may require a higher frequency of outpatient therapy (Clipson, 2003). Moreover, the treatment interventions for the high-risk offender may involve incarceration with therapy (Clipson, 2003) or include residential sex offender treatment or electronic monitoring in conjunction with outpatient therapy (CSOM, n.d.).

The intensity of treatment is primarily based upon the offender’s level of risk. Identifying the appropriate intensity of treatment supports delivery of interventions that will meet the specific needs of the offender. Not all sex offender treatment programs use the same interventions; however, most share similar characteristics (Yates, 2003).

**Type of treatment.** The components of sex offender treatment include focus on victim empathy, changing cognitive distortions, and the development of strategies to self-manage behavior and demonstrate effective problem-solving skills. These components are commonly addressed using CBT interventions and the relapse prevention (RP) approach. In the U.S., 75% of the sex offender treatment programs use CBT (Stalans,
These treatment programs have resulted in a reduction in reoffending behavior, Thus, CBT has received significant attention (Stalans, 2004). The components of CBT appear to be a favorable match for addressing sex offender issues.

**CBT interventions.** The structure of CBT for offenders includes interventions that attempt to address the problematic issues of the offender that may be directly/indirectly related to the offense. For example, the areas that may be addressed by the offender include (a) developing healthy and safe social skills, (b) developing mature interpersonal skills, (c) learning new cognitions, and (d) establishing victim empathy (Clipson, 2003; Moster et al., 2008; Stalans, 2004). Treatment typically includes psychoeducation about the aforementioned areas in order to teach the offender how to live safely in the community and avoid reoffending. In addition to the learning strategies used to increase self-management, sex offender treatment typically includes RP planning (Moster et al., 2008; Stalans, 2004), which is useful for the offender post treatment.

**Relapse prevention.** A component in helping offenders to avoid recidivism appears to be RP planning by applying strategies they learn in treatment (Stalans, 2004). The offender’s ability to self-manage is demonstrated in the completion of the RP plan. The RP plan was included as a critical tool in sex offender treatment in the 1980s and is primarily based upon the format used in substance abuse treatment (Brooks-Gordon et al., 2006). RP is widely used in sex offender treatment programs, despite the limited research regarding its effectiveness in decreasing the rate of reoffending (Stalans, 2004). The purpose of the RP plan is to outline how the offender will address daily stressors through effective management. The RP plan represents ways the offender will avoid problems and the strategies that will be useful to address these
problems. For example, the RP plan may identify strategies, such as avoiding certain places or people, or the plan may identify people as an intervention, such as enlisting family support (Moster et al., 2008; Stalans, 2004). Therefore, each offender has a plan that is individualized. The use of a plan that is unique to the offender’s needs has been shown to have positive treatment effects such as lowering the re-arrest rate (Brooks-Gordon et al., 2006). The RP plan is the last phase of the treatment because the offender at this stage demonstrates the ability to manage risk and safely integrate into society.

**Treatment outcomes.** The offender’s ability to manage risk is critical in living a life absent of offending. Therefore, a significant outcome of treatment for sex offenders can include the measurement of recidivism, the identification of risk factors, and the identification of protective factors. The challenge in understanding treatment outcomes is in determining which variables best correlate with the offender being successful in the community.

*Recidivism.* Recidivism is a commonly used variable in measuring an offender’s ability to maintain nonoffender behavior in the community (Stalans, 2004). However, researchers differ in how to best measure recidivism (Mandeville-Norden & Beech, 2004). The use of re-arrest rates versus reconviction rates is the primary variable used. Determining the best method of reporting recidivism is based upon the information the professional wants to know about the pattern of offending (Craig et al., 2005). For example, using the rate of conviction is a conservative approach that results in lower rates of recidivism. This measure of recidivism may not be the best since it does not give information about whether the offender has had subsequent contact with law enforcement, such as an arrest (Mandeville-Norden & Beech, 2004). The measurement of
recidivism can affect the management of sex offenders are managed in the community. For example, an offender who is rearrested after treatment, but is not reconvicted of a sex offense, may be required to return to outpatient treatment; however, an offender who receives a reconviction may be required to attend an intensive treatment program with intense community restraints (e.g., electronic monitoring, residential placement, earlier curfew; Mandeville-Norden & Beech, 2004). Despite the variability in the ways professionals operationalize recidivism, it is the primary outcome used in sex offender treatment programs (Looman et al., 2005). Therefore, one must understand the factors related to increasing the rate of recidivism.

**Risk factors.** Identifying the risk factors for recidivism is part of the process of understanding why some offenders recidivate and others do not (Olver & Wong, 2011). The best approach to understanding a client’s risk appears to be the adoption of a multifactorial perspective. Risk factors are divided into static and dynamic factors. Static factors represent characteristics of the offender that remain constant over time (Craig et al., 2005). For example, such factors as an offender’s age, gender, previous offense history, and sexual interest are static factors. Dynamic factors are characteristics that change as certain conditions or situations change for the offender (Craig et al., 2005). Dynamic factors can include level of responsibility, cognitive distortions, sexual arousal, and substance abuse (Craig et al., 2005). Static and dynamic factors are important in assessing the level of risk and providing guidance for treatment.

A prior offense history and the offender’s sexual interest are two variables that have been demonstrated to be significantly associated with recidivism (Clipson, 2003). However, research findings differ regarding which static factors of recidivism are
relevant when assessing level of risk. Findings that address which behaviors relate to recidivism can appear contradictory (CSOM, 2001). For example, the sexual arousal of the offender is not considered to be a significant predictor of recidivism, however, in a comparative study on child molesters and rapists, sexual arousal was significantly higher for child molesters than for rapists and was considered a predictor for recidivism (Craig et al., 2005). Although researchers lack consensus about which behaviors are predictors of recidivism, some static factors are considered common predictors, such as type of victim, type of sexual deviance, sexual offense history, and completion of treatment (Clipson, 2003).

By contrast, examples of dynamic risk factors are “unemployment, substance abuse, impulsive behavior, and criminal activity” (Craig et al., 2005, p. 70). Therefore, the dynamic factors are reflective primarily of the offender’s social behavior, cognitions, and attitudes. Studies indicate that the presence of dynamic factors, such as, psychological problems and sexual deviance, contribute to risk (Craig et al., 2005). Although the sole existence of psychological problems, such as distress, anxiety, and low self-esteem, will not result in recidivism, such problems can increase the likelihood of reoffending (Craig et al., 2005). Dynamic factors change over time; however, understanding how the combination of certain factors lead to risk is essential when developing the approach to treatment.

**Protective factors.** The protective factors that support favorable treatment outcomes are seemingly the individual characteristics of the offender. These characteristics are the variables that determine risk of offending, as well as success in the community (Mandeville-Norden & Beech, 2004).
The first protective factor is self-esteem. Research has indicated that a link exists between increasing self-esteem and progress in treatment (Mandeville-Norden & Beech, 2004). Treatment that focuses on increasing the self-esteem of offenders will increase the likelihood of the person engaging in treatment goals, completing treatment, and successfully reintegrating in the community.

The second protective factor is the reframing of cognitive distortions. The implementation of CBT interventions can be useful in addressing cognitive distortions and the relationship these distortions have on the offender’s behavior and feelings (Mandeville-Norden & Beech, 2004; Moster et al., 2008). The offender’s sexual arousal is a strong physical element that reinforces the deviant behavior and creates an opportunity for the offender to justify the offense. Therefore, treatment that assists the offender in learning new and healthier thought patterns makes the offender less likely to engage in reoffending behavior. For example, the offender who learns to think about sex in healthier manner will more likely engage in healthy sexual behavior. In addition, the offender who is able to demonstrate empathy for the victim is more likely to accept responsibility for the offense and apply this principle in daily living. The application of healthy cognitive thinking is important because it supports the offenders opportunity for stability.

The third protective factor of reference is social stability. Social stability refers to aspects of functioning such as the offender’s interpersonal relationships, employment status, and stable housing (Beyko & Wong, 2005; Harkins & Beech, 2007; Looman et al., 2005). The presence of social stability provides the offender with a greater opportunity to reside safely in the community with adequate resources. For example, an offender
who is having difficulty with an intimate relationship may experience triggers that increase the chance of not completing treatment and increase potential for recidivism.

Sex offender treatments are designed to provide protection for the offender against recidivating behavior. The aforementioned factors are not an exhaustive list but they are instrumental in helping offenders to demonstrate safe behavior. Although research demonstrates that sex offender treatment provides useful outcomes for the offender and the community, other factors may also further support treatment outcomes.

Inclusion of Spirituality in Assessment and Treatment

Spirituality is one factor that has received increasing attention in mental-health treatment with a variety of populations (Gall, Malette, & Guirguis-Younger, 2011); however, it has received limited focus in sex offender treatment. The use of spirituality in mental-health treatment is found to increase the benefit of treatment. As a result, spirituality has been incorporated into client assessments and treatment, resulting in an individualized approach to treatment. For instance, therapists have included spirituality in assessments through the expansion of the biopsychosocial model (Chattopadhyay, 2005; Moss & Dobson, 2006). Although benefits of including spirituality are documented an understanding of what spirituality entails and how it is perceived must be clear.

Operationalizing Spirituality

Spirituality can be a complex term that represents a different meaning for each individual. However, common themes appear in the operationalization of this construct. The definition of spirituality can vary, and the term can be used interchangeably with the term religion (Frazier & Hansen, 2009). Religion can be understood as the reference to
specific beliefs and principles that represent organized religious activity, whereas spirituality represents the relationship that an individual has with a divine being (Frazier & Hansen, 2009; James & Wells, 2003; Post & Wade, 2009; Worthington & Sandage, 2001). However, what people may consider spiritual can also include a belief in dogmatic principles. Owing to the diversity of religious groups, the use of a global term that captures the commonality of different religious and spiritual principles is helpful.

Spirituality has been linked with such concepts as purpose in life, developing positive self-esteem, acceptance of life events, or representing an individual’s view of a divine being (Gall et al., 2011). Spirituality can represent a belief in a divine being; it can also represent a person’s worldview and the way he or she intends to interact with the world. As determined by the research, the definitions of spirituality may differ; however, the common component of spirituality appear to be related to the sense of value a person experiences and how the person views the world contributing to inner peace and strength (Gall et al., 2011). For the purpose of this paper, spirituality represents personal values reflective of sustainability through inner strength, peace, and personal worldview. In addition to the emerging themes of spirituality, a substantial number of people report being spiritual.

Based upon the number of individuals who report being spiritual, a significant number of people identify with the values associated with spirituality. In the U.S., 82.5% of the population reports some religious affiliation (Gallup, 2011). In 2008, 75% of the people in the U.S. identified themselves as Christians, 4% identified with a religion other than Christianity, and 15% identified with no religious association (U.S. Census Bureau, 2012). Apparently a substantial number of people in the U.S. are spiritual, although
spirituality may look different based upon the person’s religious practice. Because the treatment population represents the general population, addressing clients’ personal values in treatment is important.

**Spirituality and CBT**

The scope of CBT treatment has increased over the years to include components of spirituality. The use of spirituality in CBT has shown to help in treating patients (Andersson & Asmundson, 2006; Barrera, Zeno, Bush, Barber, & Stanley, 2012; Combs, Bufford, Campbell, & Halter, 2000; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992; Rosmarin, Auerbach, Bigda-Peyton, Björgvinsson & Levendusky, 2011). In the Barrera et al. (2012) case study, a 12-week intervention of CBT to treat anxiety, with the inclusion of spirituality, revealed that patients experienced a decrease in anxiety, depression, and worry symptoms. Results indicated a 70% reduction in anxiety symptoms, 66% reduction in depressive symptoms, and 41% reduction in worry symptoms among the patients at the 6-month follow-up period (Barrera et al., 2012). In the Propst et al. (1992) study, the efficacy of religious and nonreligious CBT protocols was compared, and as a result, the religious CBT group demonstrated statistically significant reduction in depressive symptoms compared to the control group as the Beck Depression Inventory demonstrated by posttreatment (BDI) scores, \( t(55) = 3.81, p < .001 \). This study also demonstrated that 84.2% of the patients in the religious CBT group were symptom free, compared to 40% in the control group (Propst et al., 1992). In the Combs et al. (2000) study, which compared a Christian CBT group to a wait list control group, couples in the Christian CBT group demonstrated more improved marital satisfaction than did those in the control group (Hook et al., 2010) as depicted by an effect size of \( d = \)
The Christian CBT also demonstrated sustainability of these results at the follow-up period (Hook et al., 2010), as depicted by an effect size of $d = .78$ (Combs et al., 2000).

After determining that spirituality can be an important treatment component for some clients, deciding how to incorporate interventions is equally significant. The spiritual interventions used can vary based upon the specific needs of the client but have some overarching similarities (Post & Wade, 2009; Propst, 1996). These needs commonly fall within the following categories: (a) implementation of any secular technique to reinforce the client’s faith; (b) modification of nonspiritual techniques to include spiritual content, such as spiritually based CBT; and (c) inclusion of spiritually derived behavior, such as prayer and spiritual literature (Post & Wade, 2009).

Interventions can result in a variety of methods, such as prayer, using biblical references, and using meditation.

**Spirituality in Substance Abuse Treatment**

Research on the use of spirituality in substance abuse treatment has indicated that substance use is reduced by spirituality (Allen & Lo, 2010). In substance abuse treatment, the focus may not represent a relationship with God or a divine being. In substance abuse treatment, spirituality is often associated with self-reliance and self-awareness (Allen & Lo, 2010). Another example of the usefulness of spirituality in substance abuse is the Post and Wade (2009) study that examined the outcome of spiritual self-schema therapy. The results of this study revealed that clients who identified themselves as spiritual beings, versus addicts, demonstrated a decrease in substance use (Post & Wade, 2009). The incorporation of spirituality into substance
abuse treatment can provide an enhancing factor for clients working towards recovery because it is a supportive structure that can increase success in treatment.

**Alcoholics Anonymous and Narcotics Anonymous.** Success in self-help recovery programs, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA,) is partly determined by the incorporation of spirituality (Gross, 2010). AA and NA are support programs that help people who are addicted to alcohol and/or substances maintain recovery or maintain a lifestyle of abstinence. The components of AA and NA include the incorporation of basic principles, such as the Twelve Steps (Gross, 2010; Warfield & Goldstein, 1996) and Twelve Traditions, and encourage the use of spiritual beliefs to guide the individual’s process through recovery (Warfield & Goldstein, 1996). For example, AA and NA suggest that members identify a divine being that will serve as a reminder that there is a being, greater than the addict, who will represent strength and structure. The use of spirituality in AA and NA programs helps the member in addressing issues associated with addiction by using a holistic approach to recovery (Warfield & Goldstein, 1996).

**Inpatient treatment study.**

Another example of the ability spirituality to support change in substance abuse treatment is demonstrated by a patient-treatment matching study that was implemented in two inpatient facilities. In this study, participants were matched into a spiritually focused or less spiritually focused inpatient substance program (Sterling et al., 2006). The study produced significant results and revealed that the inclusion of spirituality can have a positive effect for clients, regardless of their level of spirituality.
The findings indicated that clients who reported lower levels of spirituality but attended the spiritually focused program demonstrated noteworthy outcomes (Sterling et al., 2006). In essence, this study demonstrated that the client’s level of spirituality was not important, but the client’s participation in spiritual activity during treatment was associated with positive outcomes (i.e. decreased urge to drink and increased likelihood to sustain in-treatment abstinence; Sterling et al., 2006).

In summary, spirituality has shown to be an enhancing factor in various treatments settings. Therefore, spirituality could possibly produce improved outcomes in sex offender treatment.

**Spirituality as a Protective Factor in Sex Offender Treatment**

Research on the protective factor of spirituality for sex offenders is limited (Eshuys & Smallbone, 2006), despite the reported benefit of spirituality among such populations as individuals with mental health and addictions problems (Allen & Lo, 2010; Saunders, Miller, & Bright, 2010; Post & Wade, 2009) violent offenders, and juvenile offenders (Eshuys & Smallbone, 2006). Owing to the reported benefit that spirituality can have across different populations, spirituality could possibly enhance sex offenders’ treatment.

The first benefit of including spirituality in treatment is that the client receives a framework to use in therapy that is familiar and that aligns with their beliefs (James & Wells, 2003; Propst, 1996). Working within a context of spirituality provides the opportunity for clients to process conflicting beliefs and devise an approach that is helpful. The second benefit is that spirituality increases the client’s ability to cope (James & Wells, 2003). Coping is a common intervention to prepare clients for solitary
management of their problems. Based upon the client’s perception of God, spirituality can enhance the client’s perceived ability to handle distressing events. The third benefit is self-regulation (James & Wells, 2003). James and Wells (2003) purported that self-regulation in the form of managing perseverative thoughts and preoccupation with unhealthy thinking can be replaced with healthy self-regulating behavior, such as prayer and reflection on spiritual scripture.

The potential enhancing factors of spirituality are reinforcing coping strategies, supporting client-specific goals, and improving the client’s ability to self-regulate behavior and emotions. Although research identifies benefits of including spirituality in treatment, some therapists demonstrate reluctance to include this component (Frazier & Hansen, 2009). Therefore understanding therapists’ perspectives on spirituality in treatment is important.

**Therapists’ Perception Regarding Spirituality in Treatment**

Traditionally, psychologists have not embraced the use of spirituality in treatment (Frazier & Hansen, 2009). Part of the reluctance with incorporating spirituality is the therapist’s perception that spirituality in treatment is inappropriate. Some therapists feel uncomfortable with including spirituality because it may impede the client’s progress in treatment (Frazier & Hansen, 2009). For example, the therapist can perceive the client’s desire to include spirituality as a way to avoid the goals of treatment. Consequently, some therapists perceive a client’s reference to spirituality as evidence of his or her mental illness. Therefore, the inclusion of spirituality in treatment can be a challenge.
Despite the perceived challenges, research indicates that there are benefits to the inclusion of spirituality has benefits, and some therapists agree with this finding (Frazier & Hansen, 2009). In a survey of psychologists, 83% considered spirituality relevant in treatment (Frazier & Hansen, 2009). Therapists believe spirituality supports therapy; however, therapists have concerns about their ability to address spiritual matters in therapy effectively (Frazier & Hansen, 2009). Thus, therapists’ lack of knowledge in addressing spiritual issues can inhibit treatment outcomes.

Some therapists are not confident about how their ability to combine spirituality and treatment because of their limited skill in delivering spiritually focused treatment. However, therapists are overcoming the challenges through consultation with colleagues and continued study of research regarding clients’ expectations of treatment (Collicutt, 2011). Therapists identify value in spirituality and treatment (Delaney, Miller, & Bisonó, 2007; Worthington, & Sandage, 2001). However, therapists’ consideration of spirituality does not appear to transfer to the treatment of sex offenders.

Research on the inclusion of spirituality among sex offender populations is very limited compared to other populations (Edwards & Webb, 2006). Among the modest research available, spirituality has been linked with positive well-being (i.e., positive affect and life satisfaction) among sex offenders (Edwards & Webb, 2006). This positive outcome is an example of the benefit spirituality may represent in sex offender treatment. As a result, spirituality may provide an opportunity that further improves treatment for sex offenders. However, the inclusion of spirituality is not only client determined, but also therapist determined.
The role of the therapist is important in sex offender treatment (Marshall & Serran, 2004). Marshall and Serran (2004) posit that therapists have a significant influence that can increase offenders’ motivation to remain in treatment. Therapists can best demonstrate this role by modeling appropriate social behavior, displaying flexibility in the treatment process, and providing support that enhances the therapeutic relationship (Marshall & Serran, 2004). Owing to the significant role of the therapist, an uncovering of therapists’ perceptions of including a variable in treatment that is considered a personal reflection of the offender’s beliefs and values would be interesting.

As research has provided limited discussion on therapists’ views of spirituality and religion in sex offender treatment, the purpose of this study was to enhance understanding of how therapists perceive the use of spirituality when working with sex offenders and how this knowledge may enhance current sex offender treatment.
Chapter 3

Research Questions

The topic of this study was the inclusion of spirituality in sex offender treatment. This study explored therapists’ perceptions of using spirituality in treatment of sex offenders. Research shows that cognitive behavioral interventions are primarily used in sex offender treatment (Stalans, 2004; Waldram, 2010). The goal of treatment for offenders is to teach effective self-management skills (Moster et al., 2008; Stalans, 2004). As a result, treatment includes providing psychoeducation to help offenders understand the triggers for their offending behavior and the thoughts and feelings associated with the deviant behavior. This process of treatment is standard for offenders; however, research is sparse on the effect of using spirituality when treating sex offenders (Eshuys & Smallbone, 2006).

Spiritually focused treatment is considered a positive addition to mental-health treatment (Andersson & Asmundson, 2006). Spirituality as an augmenting approach to achieving treatment goals may also be a personal motivating factor. For example, substance abuse programs use spirituality as a focus of personal investment in the program and support for treatment success (Allen & Lo, 2010). Spirituality is perceived as an encouraging factor that supports the individual’s work towards personal recovery by instilling hope and positive esteem. Research demonstrates that spirituality can result in beneficial treatment outcomes (Saunders, Miller, & Bright, 2010). To that end, the inclusion of spirituality can be considered an enhancing factor for clients’ mental health.

Mental-health treatment that includes spirituality appears useful (Propst, 1996); however, conjoining sex offender treatment with spirituality has received minimal
attention in research. As treatment providers continue to address issues with recidivism (Beyko & Wong, 2005; Olver et al., 2011), understanding why the factor of spirituality is not incorporated in treatment when spirituality has demonstrated to be successful in other types of mental-health treatment is important (James & Wells, 2003; Propst, 1996).

The need to understand this phenomenon led to the primary questions that supported this research study. First, what are therapists’ thoughts about the inclusion of spirituality in sex offender treatment? Second, if therapists include spirituality in sex offender treatment, how do they do so? If not, why? Third, can therapists share about the treatment of a specific client for which inclusion of spirituality was particularly important? Fourth, what would therapists like to share on the topic of the inclusion of spirituality in sex offender treatment?
Chapter 4

Method

This study was designed to examine the phenomenon of therapists’ perceptions of the use of spirituality in sex offender treatment. Because treatment is viewed as an individualized program for the client, treatment should include strategies that are meaningful and reinforcing for the client. There are many ways to incorporate such strategies. This study explored therapists’ perceptions of the inclusion of spirituality in sex offender treatment.

Design

The design of this study included the implementation of semistructured interviews with therapists who had experience treating the sex offender population. The interviews were conducted in a private setting based upon the participant’s preference. Before the interview, each participant was given a brief verbal introduction to the study. The interviewer asked each participant four open-ended questions, which were followed by the demographic questionnaire and the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS; Fetzer Institute, 2003, 1999).

Participants

The study was conducted with 12 participants. The participants were recruited from mental-health sex offender programs in the northeastern region of the United States. The participants were therapists who had at least 1 year of experience working with sex offenders in a therapeutic setting.
Inclusion Criteria

The criteria for inclusion in this study required participants to be sex offender therapists who had a master’s degree and who had a minimum of 1 year experience working with sex offenders in a therapeutic setting.

Exclusion Criteria

The exclusion criteria included not possessing a master’s degree and having less than 1 year of experience working with the sex offender population in a therapeutic setting. These criteria were determined to eliminate individuals who had limited experience and training working with the sex offender population. In addition, individuals who were under the age of 18 years were not considered eligible for the study.

Recruitment Process

Participants were recruited via the use of e-mail invitations that were distributed to mental-health sex offender programs, to national organizations, and to a college campus. In addition to the e-mail distribution invitation, participants were also recruited using the snowball sampling method.

Instruments

The instruments used in the study included a four-item semistructured interview (Appendix C); a brief demographic questionnaire (Appendix A); and the BMMRS (Appendix B). The definition of spirituality can vary based upon the individual and can be used interchangeably with the term religion (Frazier & Hansen, 2009). Therefore, at the beginning of each interview, the participants received a definition of spirituality to consider as they answered each question. Participants were informed, according to the
semistructured interview instructions, that spirituality was the frame of reference they should use when responding to the interview questions. The researcher defined spirituality as “beliefs, values, and activities that support and represent your efforts to achieve inner strength, peace, and balance”. Religion was not defined or presented to the participants for consideration in this study. The BMMRS, which was administered to the participants after the semistructured interview, provided a review of the participants’ personal views and practices of spirituality/religiousness.

The four-item, semistructured interview was designed to use open-ended interview questions to inquire about each therapist’s perception of spirituality in sex offender treatment. The interview questions were the following:

1. What are your thoughts about the inclusion of spirituality in sex offender treatment?

2. If you include spirituality in sex offender treatment, how do you do so?
   a. Probe: If not, why?

3. Can you tell me about the treatment of a specific client for which inclusion of spirituality?

4. Is there anything I have not asked you related to this topic that you would like to discuss?

Data Collection

The interviews were audio recorded. The recordings were catalogued as anonymous data entries, which required assigning each participant with a fictitious name. Each name was representative of an alphabetical ordering system. The audio-recorded
interviews were stored in a locked cabinet until transcribed by the investigator. After transcription, the audio recordings were destroyed. In addition to the audio-recorded interviews, the interviewer maintained a journal that consisted of content and personal reactions related to each interview.

**Data Analysis**

Data analysis was conducted using the grounded theory methodology depicted by Creswell (2007). In this study, each interview was transcribed and reviewed for salient categories using the open-coding process. The open-coding process was implemented with each subsequent interview until no further new insight was gleaned from the data.

The resulting categories were further analyzed for a single category that seemed central to the phenomenon of interest. This central phenomenon was the central feature of the developing theory. The initial categories were placed in subcategories, which represented the axial-coding process. During this process, the subcategories were analyzed for relatedness to the central phenomenon in four specific areas: causal condition, context and intervening conditions, strategies to address phenomenon, and consequences of implementing strategies. The completion of the axial coding provided the components necessary to begin the selective-coding process, which resulted in identifying trends and emerging themes.

The coding team consisted of two first-year doctoral students in clinical psychology who met for three 3-hour sessions to discuss the transcripts and identify the emergence of core themes. The method of using two reviewers in addition to the investigator was chosen to support the triangulation process in that multiple sources were used to validate the study’s data and emerging themes (Creswell, 2007; Thompson, Cole,
& Nitzarim, 2012). Subsequently, the validity of this qualitative study was supported by the investigator’s assurance that the trends and emerging themes were formed after analysis of all data.

The use of multiple coders, the transcription of audio tape, and the maintenance of detailed memos or fieldnotes for each interview enhanced the consistency of the data (Creswell, 2007; Miles & Huberman, 1994). The use of multiple coders supported intercoder agreement, in that the coders agreed to assign a specific category, subcategory, and theme and that they eliminate certain outlier information (Creswell, 2007). As previously mentioned, the data from each transcription were discussed in the three 3-hour sessions to establish intercoder agreement. As the interviews took place, the investigator took note of important content that emerged, as well as of any personal biases or responses experienced with each interview.

Quality Control

Specific standards referenced in this study reinforced a quality process and analysis of the study. According to Miles and Huberman (1994), certain standards are important for protecting the quality of the data and demonstrating transparency in the findings in a qualitative study. The standards addressed in this study included objectivity/confirmability, reliability/dependability/auditability, internal validity/credibility/authenticity, external validity/transferability/fittingness, and utilization/application/action orientation (Miles & Huberman, 1994).

Objectivity/Confirmability

This standard targeted the transferability of the study (Miles & Huberman, 1994). To ensure that the study could be generalized to other settings, careful and explicit
documentation of the procedures and methods was recorded. The investigator and coders documented all relevant data from the study, such as personal assumptions, the process for developing the hypothesis, and the process used to analyze the data.

**Reliability/Dependability/Auditability**

This standard targeted the stability of the data over time and across reviewers (Miles & Huberman, 1994). It was important that the findings of the study demonstrated congruence among the research questions and that connection between paradigms and the central theory was reasonable. For this study, quality control was maintained by using the same semi-structured interview by the coders for each interview, clear documentation that shows how the data connected to the central phenomena (or an explanation of how data did not relate), and relevant research questions that paralleled the focus of the study.

**Internal Validity/Credibility/Authenticity**

The underlying focus was the truthfulness of the data and whether the analysis was a true representation of the findings (Miles & Huberman, 1994). In this qualitative study, the transcription of interviews provided a clear and unmodified description of the data, which was supported through congruence among the data (Miles & Huberman, 1994). In the current study, credibility was enhanced using the triangulation process that demonstrated the findings as plausible and related to the central theme.

**External Validity/Transferability/Fittingness**

Transferability demonstrated the generalizability of the data to other settings (Miles & Huberman, 1994). Ensuring inclusion of such factors as diversity of the sample to support application in other contexts, identification of threats to transferability, and explicit description of the sample characteristics to support comparison with other
samples was important (Miles & Huberman, 1994). For the purposes of this study, a
description of the participants was recorded, identifying key characteristics, such as age,
race/ethnicity, gender, marital status, therapeutic orientation, and years of experience
working with the sex offender population. The investigator identified the potential
barriers to transferability of findings to comparable sample groups.

**Utilization/Application/ Action Orientation**

This standard targeted how the results applied to practice (Miles & Huberman, 1994). Miles and Huberman (1994) posited that identification of the future utilization of
the study for the participants and other professionals becomes clearer as the study
develops. For example, the findings may have indicated that the participants had an
increased awareness of their perspective on the inclusion of spirituality in sex offender
treatment or participants may have felt encouraged to facilitate additional research on
best practices.
Chapter 5
Results

This chapter presents the results of the participants’ responses to the study topic of the inclusion of spirituality in sex offender treatment. Each of the 12 participants received a semistructured interview, demographic questionnaire, and the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS). This was a qualitative study using grounded theory method. This section will provide an analysis of the participant’s responses, the outcome of the measures and the themes displayed in the data.

Participant Descriptions

The study was conducted using 12 participants (i.e., therapists with experience working with the sex offender population). The participants had experience providing individual and group therapy for the sex offender population; however most sex offenders participated in group therapy (Serran & Marshall, 2010). The therapists were from various programs in the northeastern region of the U.S.. Participants were recruited from mental-health sex offender programs, a national organization, and a college campus. Seven female participants and five male participants ranged in age from 26 to 57 years. The marital status among the participants was as follows: 50% married, 42% never married, and 8.3% divorced. Therapeutic orientation was reported as cognitive behavioral therapy (CBT) for a majority of the group (83%). The remaining orientations endorsed were rational emotive behavior therapy (REBT), solution focused therapy, systems theory, and structural therapy. Additional demographic information describing each participant is located in Table 1.

Table 1
Summary of Demographic Information

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Race</th>
<th>Religious Affiliation</th>
<th>Years in field</th>
<th>Licensure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alicia</td>
<td>Caucasian</td>
<td>Islam</td>
<td>2</td>
<td>NO/BCBA</td>
</tr>
<tr>
<td>Becky</td>
<td>Caucasian</td>
<td>Christianity</td>
<td>2</td>
<td>NO</td>
</tr>
<tr>
<td>Carl</td>
<td>Caucasian</td>
<td>No religion</td>
<td>1</td>
<td>NO</td>
</tr>
<tr>
<td>David</td>
<td>Caucasian</td>
<td>Christianity</td>
<td>4</td>
<td>YES/PSY.D</td>
</tr>
<tr>
<td>Erik</td>
<td>Caucasian</td>
<td>No religion</td>
<td>2</td>
<td>YES/LPC</td>
</tr>
<tr>
<td>Felicia</td>
<td>Hispanic</td>
<td>Christianity</td>
<td>1.9</td>
<td>NO</td>
</tr>
<tr>
<td>Greg</td>
<td>African American</td>
<td>No religion</td>
<td>1.5</td>
<td>NO</td>
</tr>
<tr>
<td>Helen</td>
<td>Caucasian</td>
<td>Christianity</td>
<td>6</td>
<td>YES/LMFT</td>
</tr>
<tr>
<td>Isaac</td>
<td>Caucasian</td>
<td>Christianity</td>
<td>15</td>
<td>NO</td>
</tr>
<tr>
<td>Julie</td>
<td>Asian/Hispanic</td>
<td>No religion</td>
<td>4</td>
<td>YES/LMFT</td>
</tr>
<tr>
<td>Karen</td>
<td>Caucasian</td>
<td>Christianity</td>
<td>16.5</td>
<td>NO</td>
</tr>
<tr>
<td>Louise</td>
<td>Caucasian</td>
<td>Buddhism/Theosophy/Quaker</td>
<td>27</td>
<td>YES/LCSW</td>
</tr>
</tbody>
</table>

Note. BCBA = Board Certified Behavior Analyst  
PSY.D = Doctor of Psychology  
LPC = Licensed Professional Counselor  
LMFT = Licensed Marriage and Family Therapist  
LCSW = Licensed Clinical Social Worker

A brief description of each participant in the study follows. The names assigned were given by the investigator using a list of randomly selected names (male and female) to represent each letter of the alphabet. As discussed later in greater detail, each participant received a BMMRS survey and the semistructured interview. For the purposes of this study, the participants were given a standardized definition of spirituality to use as the basis for responding to the semistructured interview.

Alicia is a 29-year old, single Caucasian woman who identified herself as Muslim. She has no children. She has worked with adult male sex offenders for 2 years. She holds a master’s degree in psychology and is completing her Psy.D. in clinical psychology. Her therapeutic orientation is CBT. Alicia reported that she believes in God and uses her faith to deal with life stressors.
Becky is a 29-year-old, single, Caucasian woman who was raised Catholic but does not practice her religion on a regular basis. She reported that she attends church at times but is not practicing her faith like she did when she was younger. Becky has worked in the field of sex offender treatment for 2 years and has a master’s degree in psychology. She identified her therapeutic orientation as CBT. Becky provides mostly group therapy to adult male clients, and she facilitates one female group a week. She believes that, as a therapist she should not bring her own beliefs about spirituality into treatment and that it helps to keeping an appropriate therapeutic boundary between herself and her clients is helpful.

Carl is a 36-year-old, married, Caucasian man who self-identified as atheist. He has worked in the field of sex offender treatment for a year. He works in an outpatient setting where he provides group therapy to adult men. He reported no involvement in religious or spiritual practices and stated that he does not see spirituality as something that needs to be a specific part of treatment. Carl has a master’s degree and has worked with the sex offender population in an outpatient setting. He reported REBT and solution focused therapy as his therapeutic orientations.

David is a 32-year-old, married, Caucasian man who identified as a Christian. He reported that religious faith is a strong protective factor in reducing the risk of an offender reoffending. David has a Psy.D. in clinical psychology and is a member of the American Psychological Association (APA) and Association for Behavioral Analysis (ABA). He reported his therapeutic orientation to be CBT. He has worked with sex offender clients for 4 years and provides individual therapy, but mostly group therapy. Although he believes that spirituality is a protective factor, he does not include it in
treatment for concern of creating conflict among group members who may have differing views of spirituality.

Erik is a 36-year-old, married, Caucasian man who identified as having no religion. He has worked in the field for 2 years as a licensed therapist. Erik reported his therapeutic orientation to be CBT. He identified spirituality as an “important dynamic” and reported that “traditional church is an important network” for clients. Erik works in an outpatient sex offender treatment program for adults and juveniles where he provides group and individual treatment.

Felicia is a 32-year-old, single, Hispanic woman who identified Christianity as her religious affiliation. She has worked in the field 1 year and 9 months. She currently works in an outpatient forensic mental-health program for adults and juveniles. She provides group therapy, with limited individual therapy. Felicia reported that “spiritual activities. . . is something positive for [clients] to have.”

Greg is a 26-year-old, single, African-American man who identified as having no religion. Greg reported that it is important "for therapists to have a center or background . . . a kind of a connection to spirituality, to incorporate it into their work.” He has worked in the field for 1 year and 6 months, and he provides outpatient therapy for juvenile clients placed in a residential sex offender program. Greg identified his therapeutic orientation as CBT.

Helen is a 29-year-old, single, Caucasian woman who identified Christianity as her religious affiliation. She reported that she believes spirituality is “not one definition for everybody.” Helen has a background in family therapy and working with the juvenile sex offender population. She identified systems theory and structural family therapy as
her therapeutic orientations. She has worked in the field for 6 years as an outpatient therapist in a juvenile residential sex offender program.

Isaac is a 41-year-old, married, Caucasian man who identified Christianity as her religious affiliation. He identified spirituality as “important,” “difficult . . . from the client perspective or from the treatment expectations,” and “a powerful and positive thing.” Isaac has worked in the field for 15 years. He works as an outpatient therapist in a juvenile residential sex offender program.

Julie is a divorced, 31-year-old, Asian Hispanic woman who identified as having no religion. She reported that spirituality “is seen as a hindrance to [children’s] sex offender treatment” and “beneficial to adult sex offenders in treatment.” She has worked in the field for 4 years and reported her therapeutic orientation as CBT. She works with the juvenile and adult population as an outpatient therapist in a juvenile residential sex offender program.

Karen is a 55-year-old married, Caucasian woman who identified Christianity as her religious affiliation. She worked in the sex offender field for 16 ½ years and works primarily with the juvenile population. She reported “that every human being needs to be in touch with some aspect of their spirituality, whatever that means for them.”

Louise is 57-year-old, married, Caucasian woman who identified her religious affiliations as Buddhism, Theosophy, and Quaker. Louise is a licensed clinical social worker who reported wising that spirituality “was a little more common for people to talk about.” She worked in the sex offender field for 27 years and works with the adult sex offenders in private practice providing group and individual therapy.
Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS)

Daily Spiritual Experiences

The intent of this domain is to measure one’s perceptions about the daily activities that relate to one’s interaction and involvement with God. The measure uses a Likert scale with the following choices: 1 (many times a day), 2 (every day), 3 (most days), 4 (some days), 5 (once in a while), and 6 (never or almost never). Table 2 represents the participants’ responses to the statements within this domain.

Table 2
Participants’ Responses to the Daily Spiritual Experiences Domain of the BMMRS

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>S1</th>
<th>S2</th>
<th>S3</th>
<th>S4</th>
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<td>(M = 2.92)</td>
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<td>(M = 3.58)</td>
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</tr>
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</tbody>
</table>

Note. BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality
Statements from the Daily Spiritual Experiences domain (S represents statement):
S1 = I feel God’s presence;
S2 = I find strength and comfort in my religion;
S3 = I feel deep inner peace or harmony;
S4 = I desire to be closer to or in union with God;
S5 = I feel God’s love for me, directly or through others;
S6 = I am spiritually touched by the beauty of creation.
Meaning

The intent of this domain is to measure one’s perception of religious/spiritual meaning as it relates to the events in one’s life. This domain measures one’s perceptions of meaning using a Likert scale with the following choices: 1 (strongly agree), 2 (agree), 3 (disagree), and 4 (strongly disagree). Table 3 represents the participants’ responses to the statements within this domain.

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<td>Louise</td>
<td>2</td>
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</tbody>
</table>

Note. BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality

Statements from the Meaning Domain (S represents statement):

S7 = The events in my life unfold according to a divine or greater plan;
S8 = I have a sense of mission or calling in my own life.

Values/Beliefs

The intent of this domain is to measure the value one places on religion and beliefs. This domain measures one’s perceptions of his or her expression of values and
religious beliefs using a Likert scale with the following choices: 1 *(strongly agree)*, 2 *(agree)*, 3 *(disagree)*, and 4 *(strongly disagree)*. Table 4 represents the participants’ responses to the statements within this domain.

Table 4  
*Participants’ Responses to Values/Beliefs Domain of the BMMRS*

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</tbody>
</table>

*Note.* BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality Statements from the Values/Beliefs Domain (S represents statement):  
S9 = I believe in a God who watches over me;  
S10 = I feel a deep sense of responsibility for reducing pain and suffering in the world.

**Forgiveness**

The intent of this domain is to measure one’s perception of forgiveness based on one’s religious and spiritual belief and one’s practice of forgiveness. This domain measures one’s perceptions of their expression of forgiveness using a Likert scale with
the following choices: 1 (always or almost always), 2 (often), 3 (seldom), and 4 (never).

Table 5 represents the participants’ responses to the statements within this domain.

### Table 5
**Participants' Responses to Forgiveness Domain of the BMMRS**

<table>
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<td>Louise</td>
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</table>

Pseudonym SD = .83  SD = .60  SD = 1.14

*Note. BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality*

Statements from Forgiveness Domain (S represents statement):
- S11 = I have forgiven myself for things that I have done wrong;
- S12 = I have forgiven those who hurt me;
- S13 = I know that god forgives me.

### Private Religious Practices

The intent of this domain to measure one’s behavior related to religious practices.

This domain measures one’s expression of religious practices using a Likert scale with

the following choices: 1 (more than once a day), 2 (once a day), 3 (a few times a week), 4
(once a week), 5 (a few times a month), 6 (once a month), 7 (less than once a month), and
8 (never). Table 6 represents the participants’ responses to the statements within this domain.

Table 6
Participants’ Responses to Private Religious Practices Domain of the BMMRS

<table>
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<th>Q16 M = 7.42</th>
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</tbody>
</table>

Note. BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality
Questions from the Private Religious Practices Domain (Q represents questions):
Q14 = How often do you pray privately in places other than at church or synagogue?
Q15 = Within your religious or spiritual tradition, how often do you meditate?
Q16 = How often do you watch or listen to religious programs on TV or radio?
Q17 = How often do you read the Bible or other religious literature?
Q18 =: How often are prayers or grace said before or after meals in your home?

**Religious and Spiritual Coping**

The intent of this domain is to measure one’s pattern of coping with stressful life events. This domain measures spiritual and religious coping using a Likert scale with the following choices: 1 (a great deal), 2 (quite a bit), 3 (somewhat), and 4 (not at all).

Table 7 represents the participants’ responses to the statements within this domain.
### Table 7

**Participants’ Responses to Religious and Spiritual Coping Domain of the BMMRS**

<table>
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<th>S20</th>
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</table>

Note. BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality Statements and questions from the Religious and Spiritual Coping Domain (S represents statement; Q represents question):

- **S19** = I think about how my life is part of a larger spiritual force;
- **S20** = I work together with God as partners;
- **S21** = I look to God for strength, support, and guidance;
- **S22** = I feel God is punishing me for my sins or lack of spirituality;
- **S23** = I wonder whether God has abandoned me;
- **S24** = I try to make sense of the situation and decide what to do without relying on God;
- **Q25** = To what extent is your religion involved in understanding or dealing with stressful situations?

### Religious Support

The intent of this domain is to measure one’s perception of one’s social relationships among others who share one’s place of worship. This domain measures one’s perceptions of religious support using a Likert scale with the following choices: 1
(a great deal), 2 (some), 3 (a little), and 4 (none). Table 8 represents the participants’ responses to the statements within this domain.

Table 8  
Participants’ Responses to Religious Support Domain of the BMMRS

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Q26 ($M = 2.67$)</th>
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</tbody>
</table>

Note. BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality Questions from the Religious Support Domain (Q represents question):  
Q26 = If you were ill, how much would the people in your congregation help you out?;  
Q27 = If you had a problem or were faced with a difficult situation, how much comfort would the people in your congregation be willing to give you?;  
Q28 = How often do the people in your congregation make too many demands on you?;  
Q29 = How often are the people in your congregation critical of you and the things you do?

Religious/Spiritual History

The intent of this domain is to measure one’s perception of his or her religious/spiritual participation over the course of one’s life. This domain measures assessment of religious spiritual history using a Likert scale with the following choices:
yes or no. Participants who responded with a yes were requested to provide the respective age of occurrence. Table 9 represents the participants’ responses to the statements within this domain.

Table 9
Participants’ Responses to Religious/Spiritual History Domain of the BMMRS

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Note. BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality

Questions from the Religious/Spiritual History Domain (Q represents question):
Q30 = Did you ever have a religious or spiritual experience that changed your life? If Yes, how old were you when this experience occurred?;
Q31 = Have you ever had a significant gain in your faith? If Yes, how old were you when this occurred?;
Q32 = Have you ever had a significant loss in your faith? If Yes, how old were you when this occurred?
Commitment

The intent of this domain is to measure one’s performance and commitment to one’s religious/spiritual beliefs. This domain measures the participants’ perceptions of his or her expression of commitment using a Likert scale with the following choices: 1 (strongly agree), 2 (agree), 3 (disagree), and 4 (strongly disagree). Table 10 represents the participants’ responses to the statements within this domain.

Table 10
Participants’ Responses to Commitment Domain of the BMMRS

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>S33</th>
<th>Q34</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alicia</td>
<td>2</td>
<td>2 hours</td>
</tr>
<tr>
<td>Becky</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Carl</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>David</td>
<td>2</td>
<td>2-3 hours</td>
</tr>
<tr>
<td>Erik</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Felicia</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Greg</td>
<td>2</td>
<td>2 hours</td>
</tr>
<tr>
<td>Helen</td>
<td>2</td>
<td>Less than 1 hour</td>
</tr>
<tr>
<td>Isaac</td>
<td>3</td>
<td>1-2 hours</td>
</tr>
<tr>
<td>Julie</td>
<td>3</td>
<td>No Response</td>
</tr>
<tr>
<td>Karen</td>
<td>1</td>
<td>3 hours</td>
</tr>
<tr>
<td>Louise</td>
<td>4</td>
<td>1 hour</td>
</tr>
</tbody>
</table>

Note. BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality Statement and Question from the Commitment Domain (S represents statement; Q represents question):
S33 = I try hard to carry my religious beliefs over into all my other dealings in life;
Q34 = In an average week, how many hours do you spend in activities on behalf of your church or activities that you do for religious or spiritual reasons?
Organizational Religiousness

The intent of this domain is to measure one’s involvement in a formal religious institution. This domain measures one’s perceptions and expression of organizational religiousness using a Likert scale with the following choices: 1 (more than once a week), 2 (every week or more often), 3 (once or twice a month), 4 (every month or so), 5 (once or twice a year), and 6 (never). Table 11 represents the participants’ responses to the statements within this domain.

Table 11
Participants’ Responses to Organizational Religiousness Domain of the BMMRS

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Q35</th>
<th>Q36</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alicia</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Becky</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Carl</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>David</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Erik</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Felicia</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Greg</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Helen</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Isaac</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Julie</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Karen</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Louise</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Note. BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality
Questions from the Organizational Religiousness Domain (Q represents question):
Q35 = How often do you go to religious services;
Q36 = Besides religious services, how often do you take part in other activities at a place of worship?
Religious Preference

The intent of this domain is to reveal the religious tradition or denomination with which one identifies. This domain records one’s religious preference using an open-ended question. Table 12 represents the participants’ responses to the questions within this domain.

Table 12
Participants’ Responses to Religious Preference Domain of the BMMRS

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>S37</th>
<th>Denomination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alicia</td>
<td>Islam</td>
<td>Blank</td>
</tr>
<tr>
<td>Becky</td>
<td>Catholic</td>
<td>Blank</td>
</tr>
<tr>
<td>Carl</td>
<td>Atheist</td>
<td>Blank</td>
</tr>
<tr>
<td>David</td>
<td>Christian</td>
<td>Blank</td>
</tr>
<tr>
<td>Erik</td>
<td>Atheist - Humanist</td>
<td>Blank</td>
</tr>
<tr>
<td>Felicia</td>
<td>Catholic</td>
<td>Blank</td>
</tr>
<tr>
<td>Greg</td>
<td>None</td>
<td>Blank</td>
</tr>
<tr>
<td>Helen</td>
<td>Catholic</td>
<td>Blank</td>
</tr>
<tr>
<td>Isaac</td>
<td>Methodist</td>
<td>Blank</td>
</tr>
<tr>
<td>Julie</td>
<td>None</td>
<td>Blank</td>
</tr>
<tr>
<td>Karen</td>
<td>Christian</td>
<td>Presbyterian</td>
</tr>
<tr>
<td>Louise</td>
<td>Buddhist, Quaker, Theosophy</td>
<td>Blank</td>
</tr>
</tbody>
</table>

Note. BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality Questions from the Religious Preference Domain (Q represents question):
Q37 = What is your current religious preference? If Protestant, which specific denomination is that?
Overall Self-Ranking

The intent of this domain is to measure the degree of one’s perception of his or her religiousness and spirituality. This domain measures the participant’s perceptions of one’s overall religiousness and spirituality using a Likert scale with the following choices for question 38 and question 39 respectively: 1 (very religious), 2 (moderately religious), 3 (slightly religious), and 4 (not religious at all); 1 (very spiritual), 2 (moderately spiritual), 3 (slightly spiritual), and 4 (not spiritual at all). Table 13 represents the participants’ responses to the statements within this domain.

### Table 13
Participants’ Responses to Overall Self-Ranking Domain of the BMMRS

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Q38</th>
<th>Q39</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alicia</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Becky</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Carl</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>David</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Erik</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Felicia</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Greg</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Helen</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Isaac</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Julie</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Karen</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Louise</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note. BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality Questions from the Overall Self-Ranking Domain (Q represents question): Q38 = To what extent do you consider yourself a religious person?; Q39 = To what extent do you consider yourself a spiritual person?*
Summary of BMMRS Findings

Participants’ discussion of the topic varied based upon their personal views and professional training. The inclusion of spirituality in sex offender treatment for some therapists was deemed as an informal aspect of treatment, whereas others considered it a component included only at the client’s request.

Although the definition of spirituality was provided to the participants, they reported a slightly different understanding of the term. Some participants understood spirituality to mean a religious denomination, a practice of some kind (praying, attending church, yoga, and meditation), personal morals and values, and the way a person establishes a connection with others.

Among the different views of spirituality, were five themes that emerged from the study that demonstrated the therapists’ perceptions of the inclusion of spirituality in sex offender treatment. The themes of the study (Theme 1 – Spirituality is an enhancement; Theme 2 – Spirituality is initiated by clients; Theme 3 – Spirituality is not formally included in treatment; Theme 4 – Safe environment; Theme 5 – Spirituality can be a barrier) represent the participants’ views that spirituality is handled based upon the need of the client and goal of treatment. For example, Theme 1 referenced how the inclusion of spirituality supports treatment outcomes and is considered an enhancement (Gall et al., 2011). As for their approach in implementing spirituality in treatment, participants’ involvement ranged from following the client’s lead as to whether the participants wanted to discuss the topic in session to the therapist including certain interventions to begin the discussion or to develop an alliance with the client. Each therapist had a different perspective on the inclusion of spirituality and each therapist referenced his or her
personal beliefs of spirituality, as well as of religiosity, during the interview. Owing to
the participants’ discussion of their personal beliefs, enhancing an understanding of their
views and behaviors related to spirituality is helpful.

The participants were given the BMMRS, which revealed how each therapist
expressed his or her spiritual beliefs. Among the Daily Spiritual Experiences domain,
nine out of 12 participants reported that they feel God’s presence and desire to become
closer to God. All participants reported a feeling of inner peace or harmony, and 10 of
the 12 participants reported that they find strength and comfort in their religion. The
BMMRS revealed that a majority of the participants identified their spiritual experience
as including a relationship with God and that provides them with support in their daily
lives. A majority of the participants (nine out of 12 participants) reported that the events
in their lives are related to a divine or greater plan; and 10 of the 12 participants shared
that they believe God watches over them and that they have a responsibility for
minimizing suffering in the world. These participants deemed themselves as instrumental
in helping to reduce strife in the world and perceived themselves as protected by God. In
addition to identifying God as a factor that provides strength and protection, participants
also endorsed their belief that God forgives them; indicating that their spiritual/religious
beliefs do no support a punitive relationship with God.

The behaviors of religious practice largely included prayer, and meditation; and
all participants reported that they routinely say grace before or after a meal in their home.
In regards to coping behaviors, 11 participants reported that they believe their lives are
linked to a larger spiritual force, and nine out of 12 participants indicate they use religion
to manage stressful situations. These participants use their religious beliefs to manage
daily life stressors, and they attempt to incorporate their beliefs and practices into their lives on a daily basis.

A significant number of the participants reported using spirituality or religion in their lives to support their values and morals and their worldview. They use spirituality as a standard by which they address forgiveness of self and others and use their spiritual/religious beliefs to cope with life issues. Moreover, among this group of participants, variability exists in how they view and use spirituality, yet many of the participants endorsed it as a significant component in their lives. A small group did not describe their spirituality as including a relationship with God or a religion but did endorse using certain practices, such as meditation, saying grace before/after meals, and associating spirituality with the creation. In summary, the participants ranked their spirituality and religiousness as follows:

- Three of the 12 participants identified themselves as slightly religious
- Five of the 12 identified as not religious at all
- Four of the 12 identified as moderately religious

Therapists’ ratings of their level of spirituality, are reflected as follows:

- Eight of the 12 participants identified themselves as moderately spiritual
- One of the 12 identified as very spiritual
- Three of the 12 identified as slightly spiritual
- One of the 12 identified as not spiritual at all.

Based upon their self-rankings more of the participants were able to identify with being spiritual than religious. The participants’ responses to the BMMRS provide information
about how each therapist understands spirituality/religion and the role it fulfills in his or her daily life.

**Semistructured Interviews**

This study was conducted to develop an understanding of the participants’ perceptions of the inclusion of spirituality in sex offender treatment. This section reviews the themes derived from the study as a result of the semistructured interviews conducted with the participants. The four identified themes are the result of the following four interview questions:

1. What are your thoughts about the inclusion of spirituality in sex offender treatment?
2. If you include spirituality in sex offender treatment, how do you do so?
   a. Probe: If not, why?
3. Can you tell me about the treatment of a specific client for which inclusion of spirituality was particularly important?
4. Is there anything I have not asked you related to this topic that you would like to discuss?

**Theme 1: Spirituality Is An Enhancement**

The interviews revealed that therapists spoke of awareness that spirituality could be used to enhance treatment. Others even discussed spirituality as a potential protective factor.

Alicia expressed concern regarding understanding how clients’ spirituality is important to them and then understanding the best way to incorporate their practices into their lives to support community reengagement:
There was one guy who had limited English proficiency. And his family was a big source of support for him. And prior to his offense, he went to church every Sunday, every major religious holiday, bible study on Wednesdays, like it was a big activity for him. And he had brought this up that, ‘Well, my wife is going to church tomorrow, and I have to stay home.’ He had brought this up a few times and we asked him, ‘Why don’t you go with her?’ And he said, he ‘didn’t feel comfortable because of his offense and didn’t want to be around children because it’s a stipulation of his parole that he can’t be unsupervised around kids.’ So, we really worked with him on developing a plan . . . reparticipate in these things again but feel comfortable . . . and be safe and not put himself in a situation where he could violate or where, you know, get in trouble.

Becky identified spirituality as something that has the potential to enhance treatment by giving her a means of connecting with the client therapeutically. She reported the following:

Cause a lot of guys will say like ‘pray on it’ and that’s how they get through things or say that how they are not going to do it again. So like if someone brings it up and later are kind of having an issue with something, I might say, ‘You said you’d do this. Does this work for you?’

Becky shared how she would remind clients about the beliefs the client previously stated in treatment were important to act as a form of coping mechanism.

David identified spirituality as a factor that could produce a positive aspect in clients’ lives. He reported, “I think it is a very good thing. And to me it seems like a
strong religious faith is one of the best protective factors that can serve to reduce the risk of an offender reoffending.”

Felicia’s thoughts on the subject indicated that she sees spirituality as a way to incorporate positive activities. She stated, “I think it’s important for them to have something positive they are living up to and living by.”

Greg deemed spirituality as a way to enhance the therapeutic alliance and to create a positive way to connect with the client. He stated, “I think it’s kind of, I think just in general I use it in my work to understand where the client is and who the client is as a person.”

Isaac discussed spirituality as a means of helping clients connect to something outside of themselves:

A lot of times I’ll find or gain knowledge of what their sort of beliefs are and what they really connect with along the way and so whether it’s a few guys and meditation and things like that, or whether it’s outside . . . you know guys are inside a lot but trying to get them connected to something that is alive and things that they want. So some of the more spiritual things would be the meditation sort of that mindfulness that they try to connect with so in individual therapy, there are times when they want to understand more about spirituality as they become comfortable with themselves.

Isaac’s account seems to discuss spirituality as an opportunity for clients to establish a deeper connection with their self-concept and to demonstrate self-awareness.

Julie shared that she perceives spirituality to be a benefit for adult sex offenders in strengthening their coping skills and decreasing likelihood of reoffending:
With the adults, I found it to be beneficial to them. A lot of them, of course after offending and being thrown into jail, found God and found spirituality or religion, and it’s helped motivate them to never offend again or to work on their own issues and find strength.

Karen described spirituality as bringing balance for the clients, with the understanding that the clients are not balanced when they enter treatment:

In terms of clients themselves, I think that every human being needs to be in touch with some aspect of their spirituality, whatever that means for them. I think that’s important to bring balance. Because for whatever reason the client is here, they are not balanced. A lot of them because of their own trauma or just a dearth of limitations in how they were raised haven’t been taught to think about anything beyond them.

The enhancement of spirituality was also identified through the participants’ discussion regarding RP planning. Participants shared that they target the client’s spiritual beliefs and actions that may support nonrecidivism towards the end of treatment when the RP planning begins.

Helen gave account of how spirituality is used as a framework for a client’s values and, in turn, creates a wellness plan (RP plan) that is individualized and meaningful for the client:

By the way that you define it, I think it would be great. I think it’s a great idea. Because it then taps into how each of the clients can come form their own values and beliefs. I think that’s hugely important. And they talk about wellness planning towards the end of their treatment. They are able to identify how
incorporating their family’s values, their cultural values, their religious values . . .

So, I think when they incorporate morals and values, they can grasp meaning, and when they can have their own meaning for something, then it makes it more motivating for them to follow.

Isaac identified spirituality as an important factor during the development of the RP plan because it helps the clients to conceptualize how they want to live their lives post-treatment:

So some of the more spiritual things would be the meditation sort of that mindfulness that they try to connect with so . . . in individual therapy, there are times when they want to understand more about spirituality as they become comfortable with themselves. Along the way, we have this wellness plan. We have them start thinking about not only avoiding things in their life and the things that they shouldn’t be doing but living life in a way that you want to be doing and do the things that are in line with a strength-based perspective and know what you are good at, and there are so many things you can do.

In summary, participants referenced the use of spirituality to support collaborative relationships with other members of the client’s treatment group and increase self-awareness. One therapist discussed using spirituality as a coping intervention for reducing clients’ anxiety. Participants used spirituality to support the client’s interest by formulating an individualized treatment plan. For example, one participant reported using a client’s spirituality to help the person to regain a connection with his church family. A majority of the participants approved of the inclusion of spirituality because it provides the client with an ability to manage life problems. This idea was also related to
the effectiveness of using the RP plan to develop long-term interventions for community management after treatment. In addition, participants reported that the therapeutic alliance was improved when they included the client’s spiritual beliefs. In addition, participants reported that including spirituality provided an opportunity to create individualized treatment plans.

**Theme 2: Spirituality Is Initiated by Clients**

Many of the therapists reported that they do not initiate the discussion of spirituality in treatment and often allow the client to initiate dialogue in treatment. Becky is one of the therapists who endorsed that spirituality comes up when the client brings it in. She stated, “Well, it’s only comes up . . . if a client brings it into treatment.”

David also shared a similar perspective but with additional detail:

Well, it’s one of those things. I don’t try to force guys to pray or do anything like that. But I’m certainly comfortable and will allow clients to discuss issues of spirituality and to consider how their spirituality is relevant to their behavior and how it should guide their morals and decision making; and so I kinda let them go and lead it and address it.

Julie shared that spirituality is brought in only when the client brings it in. She stated, “I don’t necessarily include it. I don’t bring it up. I explore it with my clients. If they talk about it being a big influence in their lives then we will go in that direction.”

Carl also noted that spirituality is presented as much as the client deems necessary. He stated, “I think you can include it as frequently as the patient wants to include it.” Carl gave the impression that the client controls how much and how often the
topic of spirituality is discussed in session and if it is discussed at all. Similar to the other therapists, Carl is willing to follow the lead of the client.

In summary, a number of therapists indicated that they would include spirituality only if initiated by the client. Participants gave the impression that they were more comfortable with using spirituality if clients gave a clear indication that it was important to them and that they wanted to include it. This finding indicates that if clients did not bring up the topic of spirituality, then the topic was not explored as an intervention for treatment. Some of the therapists reported that they encountered few clients who brought up their spiritual backgrounds and wanted to stay focused on their behavior. Participants were careful to respect clients’ beliefs and their right to receive an individualized treatment plan by making spirituality a part of the treatment.

**Theme 3: Spirituality Is Not Formally Included in Treatment**

Some therapists reported that spirituality is not formally part of treatment, which leads to a decreased likelihood of spirituality being included in treatment. Felicia shared that the topic of spirituality was not included in the treatment module and, therefore, was not included in her client sessions. She stated, “I don’t just because from our training we’re not really encouraged to bring it up ourselves. The trainings that we use and the modules that we use here don’t include it. It’s just not part of the curriculum.”

Greg reported a similar perspective to, that of Felicia, stating, “Specifically with sexually offending, we have a very concrete structure, program for addressing their sexual offense. So I kind of stick to that.” Greg gave the impression that the training at his program is not designed to include spirituality, and as an attempt to maintain fidelity, he follows the protocol.
Helen shared also that there is no protocol and discussed how spirituality limits treatment:

Like I said, we do the wellness planning, but with our particular treatment, we don’t necessarily focus heavily on that. So I think it is important that we [outpatient agency] do. Because some of the kids will bring it [spirituality] up and say, ‘This is not how I was raised’ and reference how they are different from the values and morals they were raised with. And then it allows us to have a deeper discussion of it, if that is the case: ‘Then how did this happen?’ ‘What was more important to you at the time?’ and ‘What are we forgetting about?’ But there is no protocol; it’s more about what naturally comes up.”

In summary, although a number of participants revealed their willingness to use spirituality in treatment, they also provided feedback that they do not have a model of treatment that includes spirituality. Therefore, with no model, participants indicated that they were less likely to include spirituality in treatment because they did not know how to do so. Others reported that the treatment curriculum was a very structured program and did not include spirituality as a factor in treatment. Others indicated that spirituality was not a major focus of treatment and that the CBT model was primarily used. Participants reported that there was no protocol and that they did not receive training on how to incorporating spirituality in treatment.

Theme 4: Safe Environment

Alicia discussed the importance of using spirituality in a way that allows a client the opportunity to express his or her individual views without conflict:
One issue that has come in relation to religion and sex offender groups is that there are times when it’s a group therapy session and one member will disclose their offense and another member will have a reaction to that based on their religious beliefs. And so there are times when we have to address that so that everyone is respected and that beliefs are respected without making someone feel uncomfortable.

David discussed the issue of safety as a necessity when dealing with different religious faiths:

“For example, I have in a group a Christian member, a Muslim member, and a Jewish member. I wouldn’t want that to become a conflict where we would have religious debates and things. So I would try to avoid that situation. So if it would be a situational thing, where they are discussing how they think and believe that would be fine, but if they start arguing, then that is the thing I would cut back on.

Becky also discussed how incorporating spirituality in a group requires awareness of its effect on others. She shared, “If in a group setting another member is trying to encourage someone else by saying, ‘You can solve this by praying,’ I kinda cut that off and say, ‘No everyone has their own belief.’

Julie discussed safety in terms of the client feeling comfortable to discuss his sexual practices in spite of his religious beliefs. She expressed her perception of how her client’s thoughts of spirituality in treatment and the discomfort in discussing aspects of treatment:

“So, an important piece of treatment is to explore what are your views, what are your perceptions, how do you express sexuality, what’s normal, what’s not
normal and things like that. I think for this particular client I’m thinking of there was this resistance, like ‘I don’t masturbate.’ And it’s like, I know you do, but I don’t talk about those things and I don’t talk about sexuality.

In summary, therapists communicated the importance of ensuring that the clients had a safe environment in which they could share thoughts and behaviors related to their spiritual as well as religious beliefs. Therapists reported, creating an environment where clients could explore their beliefs without judgment especially in group therapy. The establishment of a safe environment was of interest particularly when clients shared different views of spirituality/religion. Participants expressed the importance of being mindful of the way topics were introduced so that others were not offended or feeling excluded.

Theme 5: Spirituality Can Be a Barrier

Similar to Julie’s remarks in the previous section, the inclusion of spirituality can also lead to therapists meeting a barrier in treatment. She shared that one client was reluctant to discuss his sexual practices openly and truthfully, because of his religious belief, which deemed his practices as deviant. Julie reported, “Well, I address how you talk about your offense with boys; and so there might be some struggle with sexuality there. So it becomes this barrier to kind of work through in order to just talk about sexuality with no judgment.”

Erik discussed the inclusion of spirituality as a barrier to supporting positive treatment outcomes and fostering maladaptive behavior. He shared his perspective using a client example that involved the outpatient agency protecting a community program
(church) from a client whose intentions that were self-serving and not in the best interest of the client or the community:

He had offended multiple adolescent victims, and he was designated as a sexually violent predator. And he got involved with a church (it was through his cousin who had an extensive criminal history too) that was grassroots and he wanted to get started as a deacon there. That was something we [the outpatient agency] went in the other direction and we actively did not want to support. This was somebody who had manipulated that authority, that power inequity with others, and yet after 3 months of treatment, he wanted to get back into that same authority. And that was something we had to go in the opposite direction, and we had to curtail that because it certainly put all those parishioners at potential risk.

Alicia indicated that allowing the discussion of spirituality in treatment may lead to dissension among group members and impede the therapeutic process. She shared one experience as an example:

One issue that has come up in relation to religion and sex offender groups is that there are times when it’s a group therapy session and one member will disclose their offense and another member will have a reaction to that based on their religious beliefs. And so there are times when we have to address that so that everyone is respected and that beliefs are respected without making someone feel uncomfortable and unsafe.

Carl reported concerns about including spirituality in treatment. He reported that spirituality can lead to unfavorable results, which can get in the way of effective collaborative treatment.
The current model, at least in Philadelphia, is to bring it all together and make it inclusive using the Recover model, which is out of Yale. And CBH, who is the public insurance for the mental health and substance abuse side of medical assistance in Philadelphia, they want you to incorporate this model. They want a lot of spirituality, but when we try to bring it into treatment, I’ve seen a lot of backlash, and clients don’t really want it.

Carl also addressed how the use of spirituality may give clients the impression that their behaviors will change only through the inclusion of spirituality. Carl reported that clients have identified spirituality as the way they cope but it results in unchanged behavior and the treatment concern remains unchanged. Carl stated, “Religion and spirituality may be a part of their life but at the same time, people are offending, and religion and spirituality may be part of their life and not really helping them to stop reoffending.”

The notion of spirituality as a barrier was also made relevant by participants’ lack of training and comfort with including spirituality in treatment. Felicia reported that it was not part of the training and that she does not acknowledge it because of that fact: “It [spirituality] is not something that is part of the training. I don’t just because from our training we’re not really encouraged to bring it up.”

In summary, the concern raised by therapists was that spirituality could redirect clients’ attention from treatment-related topics, such as thoughts, feelings, and behaviors. Participants shared that clients may struggle with distorted cognitions related to their sexuality because their faith states that homosexuality is a sin. In addition, they reported that individuals may feel inclined to use certain interventions of other clients, such as
prayer, when those interventions are not part of their belief. Participants also shared that if a client had unfavorable experiences with religion, including spirituality in treatment may be inappropriate and unhelpful. Another important barrier revealed from this study is that the therapists perceived they lacked training to assess clients for spirituality and to include spirituality in treatment.
Chapter 6
Discussion

The purpose of this study was to investigate sex offender therapists’ perceptions about the inclusion of spirituality in sex offender treatment. The investigator used a semistructured interview to understand whether therapists perceived spirituality as a relevant factor in treatment, why it should or should not be included, and in what ways they have incorporated spirituality into treatment. The researcher used the semistructured interview to gain insight into the participants’ perspectives on the topic and to understand the framework from which their viewpoints derived.

Research indicated that therapists perceived spirituality as beneficial to include in treatment (Gall et al., 2011). However, therapists were less likely to assess for it, initiate discussion regarding spirituality or spiritual/religious practices, or extensively utilize in treatment spiritual or religious beliefs or practices they may personally find helpful; some perceived that spirituality could be a treatment barrier especially in group settings. These views seem to stem from the therapists’ lack of comfort with the topic in their professional settings (Frazier & Hansen, 2009) and lack of confidence and perceived limits of training to effectively incorporate spirituality into treatment (Collicutt, 2011).

Comparing their personal views of spirituality (BMMRS) with their perceptions on the professional use of spirituality in sex offender treatment was useful. The researcher observed that there may have been confusion about the term spirituality or particularly how it was different from the term religion. Some participants asked for the definition to be repeated during the interview or for clarification of the meaning. (The researcher did not provide additional information about the term, but did repeat the
definition as provided in the semi-structured interview instructions). However, in responding to the BMMRS, participants were able to respond to religion and spirituality as two separate entities. Based on the participants’ abilities to identify these terms separately on the BMMRS, providing the BMMRS prior to the semistructured interview may have been a better approach.

In keeping with Frazier and Hansen’s (2009) findings, some participants used the terms spirituality and religion to represent the same meaning. In response to, “If you include spirituality in sex offender treatment, how do you do so?,” participant Becky shared that she knows spirituality and religion are not the same thing, but she tends to use both terms to mean the same thing. Becky, who self-identified as Catholic, reported that she does not engage in religious service or other activities at a place of worship. However, for Becky, her religious affiliation likely represents her spiritual beliefs and values and is part of shaping her worldview. The researcher did not prompt the participant to explain why she used religion and spirituality interchangeably and allowed the participant to respond freely during the interview. Similarly, participant Helen, who self-identified as Catholic and attends religious services once or twice a month, also admitted to using the terms religion and spirituality to represent the same meaning. However, for participants Helen and Becky, their religious affiliation and spirituality likely represent the same thing and have the same impact on their spiritual values and worldview. Whereas other participants, such as Alicia, David, Erik, Julie, and Karen, considered spirituality as relating to a religious practice (going to church) or a religious belief (believing in Jesus Christ, believing in God). Although participant Erik did not
self-identify with a religious affiliation, he may have done so in the past and now has an understanding of spirituality that includes religious activities/practices.

Although participants expressed uncertainty with the concept and difficulty with maintaining a clear definition of spirituality, they were able to make a distinction between the two terms when rating their own level of spirituality and religiosity in response to the BMMRS. Possibly, the BMMRS required the participants to respond to items using religion or spirituality as the point of context as they answered each item on the inventory (i.e., I find strength and comfort in my religion; I think about how my life is part of a larger spiritual force), whereas when they discussed these concepts freely in the interview, they perceived aspects of their religion as related to spirituality, thus possibly resulting in participants using both terms interchangeably. Alicia rated herself as slightly religious and moderately spiritual; and David and Karen rated themselves as moderately religious and moderately spiritual. Helen rated herself as moderately religious and slightly spiritual. The way in which they viewed their own spirituality, and how it differed from religiosity, may have influenced the way they viewed this concept for clients. When the participants considered the role of spirituality for their clients, they possibly were more likely to identify with beliefs and practices that were familiar to them. For example, in response to questions about the inclusion of spirituality, some participants responded by giving a brief history of their own spirituality that included discussion about their religious faith and religious practices (i.e., being raised Catholic or referencing another religious denomination, going to church, taking communion).

Although the interview revealed participants’ tendencies to reference spirituality and religion interchangeably, the participants identified practices that were similar to the
practices they incorporated into treatment. Based on participants’ responses about spirituality, they apparently perceived spirituality to be useful for clients. The findings of this study revealed the variables that the participants identified as important associated with the themes of the study.

Within all five themes (Theme 1: Spirituality is an enhancement; Theme 2: Spirituality is initiated by the client; Theme 3: Safe environment; Theme 4: Spirituality is not formally included in treatment; and Theme 5: Spirituality is a barrier), the participants discussed the importance of maintaining boundaries was important in treatment. One participant, Becky, shared that she refrains from talking about her personal views of spirituality with clients because she is concerned with giving clients the impression that her personal beliefs should be a guide or model for them. More specifically, participant Becky was concerned about the influence of her beliefs on the way she facilitated treatment and in creating undue influence on her clients. This finding was supported by Post and Wade (2009), who advised therapists to become more self-aware of their own spiritual beliefs and biases to avoid imposing their beliefs on clients, ignoring the needs of clients, or misappraising of clients’ perceptions of including spiritual interventions (prayer, scripture readings, or attending spiritual/religious services). Participant Becky’s feedback may represent the training needed for therapists to learn how to keep boundaries clear between participants’ personal preferences and professional advisement. Training also could help therapists like Becky feel comfortable supporting the client’s existing opportunities for spiritual/religious support.

The focus of maintaining boundaries was also discussed in relation to clients respecting each other’s viewpoints of spirituality and not judging others, especially in a
group setting. For example, participants informed their clients of the expectation that they are to respect other clients’ rights to discuss their spiritual views and provide an opportunity for clients to share what is spiritually meaningful for them as it relates to treatment (i.e., experiences, beliefs, and practices). In addition, participants shared that boundary setting also included informing clients of their responsibility to share their spiritual beliefs in the group setting in a manner that is respectful of others’ differing beliefs and not to do so to place judgment.

Although boundary setting could be referenced as rule setting, in keeping with the participants’ responses to the interview, the term **boundary/boundary setting** will be used. This concern was raised in relation to Themes 2, 3, and 5, where participants considered important the establishment of boundaries within treatment. Participant Erik stated that failure to have clear boundaries in group treatment could result in clients feeling judged by others (i.e., a client who engaged in a religion that was considered militant and offensive). In reference to Themes 2 and 5, participants Becky, Carl, Alicia, and Erik deemed boundary setting as important because it also allowed clients to feel comfortable initiating spiritual discussion.

Therefore, participants considered the process of boundary setting to be important within treatment sessions to reinforce a safe environment, in which clients can share their thoughts and use spirituality to examine and restructure cognitions. In addition, participants considered boundaries important to structure the way clients discuss or use their spirituality in treatment while respecting the beliefs and rights of others in session. Further, participants considered boundary setting as a way to reinforce treatment success by providing clients autonomy in treatment planning (i.e., attending a spiritually based
support group in addition to sex offender group therapy). Participants identified the importance of setting clear boundaries with clients that included respecting other clients’ rights to discuss their spiritual beliefs and the responsibility of each client to speak about his or her personal spirituality without forcing it on others. As a result, clients could have the freedom to engage in practices and discuss those practices in treatment with the responsibility of respecting others and their right to share openly. These participants’ spiritual/religious preferences varied, yet their approach to treatment was similar in that they considered boundary setting important to provide clients access to a safe environment to explore and develop a spiritually enhanced treatment.

Whereas the participants were clear about the need for boundaries regarding religious/spiritual discussions (their own boundaries and the boundaries needed in the group setting), participants seemed less confident about incorporating spiritual beliefs and practices without crossing the boundaries of the treatment protocols beyond what the clients self-initiated. Within Themes 3 and 5, participants Felicia and Greg reported that their clinical training did not include spirituality in treatment. Owing to their lack of training, they expressed discomfort with deviating from the treatment protocol and were more concerned with maintaining treatment fidelity. This finding is supported by Frazier and Hansen (2009) and Delaney, Miller, and Bisonó (2013), who posited that therapists have concerns about their abilities to address spiritual matters in treatment. Like Felicia and Greg, the participants considered their lack of training a cause of spirituality’s exclusion from treatment. They viewed the exclusion of spirituality as a barrier in treatment as well.
Participants Greg and Felicia also introduced flexibility as related to Themes 3 and 5. Felicia reported that because spirituality was not formally part of the treatment and she was not encouraged by her treating facility to include spirituality in treatment, she did not consider deviating from the mental-health agency’s standard practice as a possibility. As for Greg, he reported that because of his lack of training and the structure of the treatment curriculum, he felt less confident about deviating from treatment protocol. Although Felicia and Greg reported different reasons for the impact of flexibility on the inclusion of spirituality, they both expressed that spirituality was not included in the curriculum. According to Felicia and Greg, their perceived limitation of flexibility or lack of opportunity to deviate from the protocol impacted their opportunity to augment treatment to reflect clients’ needs. As they discussed flexibility in terms of the inclusion of spirituality, they expressed that spirituality not formally included was important and served as a barrier for inclusion.

Research has shown that therapists are instrumental in motivating clients through role modeling and displaying flexibility in treatment (Marshall & Serran, 2004). The implications of Marshall and Serran’s (2004) research support the notion that therapists can model to clients the topics that are appropriate or inappropriate to discuss in treatment, and perhaps modeling the use of spirituality in treatment could be an effective training component. In other words, training in incorporating spirituality as an enhancement to treatment without concern about altering treatment protocol (e.g., training in customizing and being flexible in delivering treatment) could be helpful.

Some participants reported being flexible in facilitating spirituality to meet clients’ needs. Participants Alicia, Becky, Carl, and Karen reported that they used
flexibility to tailor a client’s treatment to include spiritually based interventions that were important to the client, such as reintegrating into a faith community, receiving outside spiritual advisement in conjunction with sex offender treatment, prayer, meditation, and yoga. These participants emphasized the use of spiritually based interventions as positive and motivating for the client. When comparing the group of participants who used flexibility with those who did not, there were some interesting differences emerged, such as race/culture, worldview, and self-identified religiosity. Felicia, who felt she could not deviate from the protocol, and Greg, who felt he could deviate from the protocol minimally, shared some similarities, such as being from minority group. They also reported working in the field for at least 1 year, had a similar worldview (e.g., value in God watching over them and using religion and spirituality to cope), and self-identified religiosity.

Participants Felicia and Greg, who were unwilling to deviate from the curriculum, self-identified as Hispanic and African American, respectively, whereas the group members who were willing to provide flexibility in treatment self-identified as Caucasian. Research indicates possible differences among therapists of different racial/ethnic backgrounds regarding their worldviews (Mahalik, Worthington, & Crump, 1999). Mahalik et al., (1999) found a small statistically significant difference among therapists of different racial/ethnic groups on the Scale to Assess Worldviews, particularly in their value orientation and worldview. Interestingly, according to the BMMRS, the participants who reported using flexibility in treatment, except Carl, indicated that they think about their lives as part of a larger spiritual force, and two participants (Alicia and Karen) reported using their religion to cope with stressful
situations. However, Felicia and Greg, who did not report using flexibility in facilitating treatment options for clients, also reported that they think of their lives as part of a larger spiritual force and both reported using their religion to deal with stressful situations. Mahalik et al.’s (1999) study showed that people of different ethnicity/cultures can hold different worldviews seemingly related to spiritual and existential beliefs such as harmony with nature, expressions of being, and doing. This raises a question that although Felicia and Greg self-identified with similar religious affiliations similar to those of other participants, their racial identification may indicate a difference in spiritual values and beliefs, as indicated by Mahalik et al.’s (1999) study. Although one cannot state with certainty that race/ethnicity was a factor related to Felicia and Greg’s view of flexibility, this possibly is important to consider based on research that purports the existence of differences among racial/ethnic groups.

Another common factor among the participants who were willing to demonstrate flexibility within treatment was their response to the BMMRS reporting a deep sense of responsibility for reducing pain and suffering in the world. This spiritual reflection about their values may underscore their treatment approach in supporting clients’ rights to tailored treatment.

The importance of delivering client-centered treatment was discussed within Themes 1, 2, and 4. The theme of waiting for clients to initiate spirituality was an important factor that aided participants in providing a client-centered treatment. Participants Becky, David, Carl, Helen, Isaac, Julie, and Louise considered a client-centered approach to be a treatment enhancer that reinforced a safe environment within which clients could discuss their spirituality in session and be allowed the freedom to
initiate discussions based on when during treatment doing so was important for them. These participants reported that they facilitated client-centered treatment by including interventions in treatment and in the RP plan (posttreatment plan), such as meditation, yoga and prayer, as initiated by and seemingly helpful to their clients.

Duwe and King (2013), who indicated the importance of clients establishing a solid framework of social skills and interventions that will reinforce non-recidivism as they re-integrate into the community, supported this approach to posttreatment. Participant Julie expressed comfort in using spiritually based treatment support activities if the client indicated that these activities would provide a source of strength and motivation. Participant David shared that he was agreeable to facilitating discussion about spirituality to help clients with issues of shame, guilt, and forgiveness if the clients reported such discussions were congruent with their spiritual convictions and values. Although participant Carl reported that spirituality did not need to be a part of sex offender treatment, he expressed that he would use spirituality in treatment if spirituality was revealed by the client as helpful in meeting his needs. Although these participants reported to engaging in a discussion of spirituality only when the topic was initiated by their clients, they were more inclined to use it to develop a client-centered treatment plan if clients expressed that it was helpful to them. Participants considered important the opportunity for clients to discuss matters that may affect their spiritual beliefs without judgment from others (e.g., engaging in sexual practices, such as masturbation and homosexual activities, that may interfere with others’ spiritual beliefs; clients in group encouraging other group members to pray without understanding if this option is welcome; and avoiding conflict among clients who may share different spiritual beliefs).
Again, in this study, presenting as being religious or spiritual did not determine whether the therapist would or would not use spirituality as a treatment enhancer, especially if the client initiated a discussion about it and the client also indicated that such a discussion would be helpful. Regardless of the participants’ personal perspectives about spirituality, they demonstrated sensitivity in showing respect for clients’ individualistic beliefs, expressions, and behaviors that represent their spiritual perspectives. For example, participant Carl reported that he did not believe spirituality could enhance treatment, but he gave an example of a client who used prayer to regulate his mood to reinforce rational thinking; therefore, Carl identified this spiritually focused intervention as useful for the client and incorporated it into his treatment plan and followed up with the client’s progress. Although, prayer may not have been an activity participant Carl would have engaged in personally and although he did not believe prayer would help clients in treatment, he respected the client’s choice to use an intervention that was spiritually meaningful.

According to the results of this study, the participants may have perceived spirituality, from a client-centered perspective, as a protective factor in minimizing the risk of reoffending (Mandeville-Norden & Beech, 2004). The utilization of individual characteristics to tailor treatment interventions was identified as helpful in improving such outcomes as reducing rate of recidivism, improving interpersonal skills, and increasing victim empathy through self-examination of the way the offenders’ actions (offense) have consequences (or affected the victim).
Theoretical Implications

Spirituality and CBT

The study's data revealed that participants apparently addressed spirituality as an intervention that they incorporated into sex offender treatment to enhance treatment outcomes. Note that the use of CBT interventions can inherently support the use of spirituality. The approach of client-centered treatment using a mind, body, and soul approach can be addressed in a CBT framework. For instance, participants in this study shared how they were willing to work with clients to include interventions that addressed their thoughts, feelings, and behaviors. As purported by Koszycki, Raab, Aldosary, and Bradwejn (2010), spiritually focused CBT can be useful in providing a framework that is personal and unique to the offender to incorporate interventions, such as the following:

1. Learning to forgive self and others, accepting one’s status as a sexual offender, applying spiritual beliefs and values to reconciling wrongful behavior, addressing minimization/denial, understanding the influential and schematic factors associated with offending behavior (cognitive domain).

2. Building a support network in the community; engaging in self-care activities, such as like meditation and exercise; engaging in service to others (behavior domain).

3. Identifying and understanding internal and external triggers for unstable emotions and implementing ways to regulate emotions (affect domain).

Interestingly, the participants of this study did not identify spirituality as a component of their CBT treatment model; however, participants possibly were engaging in these similar
practices without the complete understanding of the use of spirituality in CBT and spirituality.

**CBT Supervision**

The participants’ limited knowledge of the use of spirituality in treatment using the CBT model can be reflective of the supervision relationship. Discussing matters that are relevant to the client conceptualization is important, particularly for therapists of advanced training. As purported by Watkins (1997), supervision is where the therapist has the opportunity to conceptualize the clinical and to report on what is working or not working in treatment. Supervision is also where the supervisor can address the supervisee’s need for training in specific areas. For example, the therapist may report or display difficulty in facilitating structured treatment, the therapist may feel uncomfortable discussing personal views in treatment for fear of causing undue influence on clients; or the therapist may hold a stigma and view sex offenders as qualitatively different from others in the general population (Collins & Nee, 2010). Moulden and Firestone (2010) reported that therapists working with the sex offender population are likely to suffer from burnout and other negative emotions such as emotional hardening, anger, and frustration.

Whether any of these factors were relevant in this study is not clear; however, participants’ views of their clients may have influenced their perceptions regarding the inclusion of spirituality in sex offender treatment. The negative emotions that therapists may experience when delivering sex offender treatment can be addressed in supervision. As a result, supervision can be a protective factor that supports the therapist and supports the client. If therapists are not addressing these concerns in supervision, the concerns likely will influence treatment. With the understanding that a parallel process exists
between the supervision session and the therapy session, therapists must discuss ways to address their difficulties in treatment so they can enhance their effectiveness as sex offender therapists.

Thus, therapists’ effectiveness in including spirituality in treatment may be influenced by the quality of supervision. For example, if therapists are not discussing the use of faith-based practices as a protective factor, then the therapist is less likely to incorporate such practices or to feel confident in discussing the topic in therapy. Supervision may be useful for the therapist to learn and utilize specific skills. Therefore, the use of supervision can be beneficial in supporting clinicians of advanced training who deliver intensive treatment services

**Limitations of Study**

Several limitations of this study affect the generalizability of the findings. The barriers to transferability to populations beyond this sample include diversity of the participants’ clinical experience (different levels of graduate training, experience working in different settings), sampling bias, researcher bias, participant bias, and limited prior research.

The diversity of clinical experience is a limitation of this study because the sample group consisted of individuals who worked with different subgroups of the sex offender population. For example, participants worked with adult sex offenders, juvenile sex offenders, in outpatient settings, and in residential settings. Whether therapists perceive the inclusion of spirituality as different based upon the treatment setting or based upon the type of sex offender would be interesting to know. Though not specifically explored, sex offender treatment is largely administered in group therapy
settings (Serran & Marshall, 2010), which is linked to participants’ expressed concerns that clients feel respected and not engage in debates or emotionally evoking discussions about spiritual/religious differences. Therefore, the inclusion of spirituality may look different based upon the setting in which treatment is delivered. For example, participants in this study largely had experience in delivering sex offender treatment in a group setting versus an individual setting. With that said, the participants’ perceptions of delivering spirituality may differ with a group setting versus an individual setting. In this study, participants shared concerns about providing structure for handling the topic of spirituality to ensure that clients were respected for their individual views and were able to share their views without judgment in the group setting. However, in an individual therapy setting, the focus is on the therapeutic alliance between the therapist and the client, and the concern for structure/rules of sharing spiritual worldviews may receive less attention. In the individual therapy setting, risk of outside interference from others is limited. Thus, the participants’ perceptions of including spirituality in treatment may have been influenced by their consideration of the therapeutic setting and the topics they deemed important for the client to share regarding spiritual viewpoints.

The sample selection was derived from treatment facilities for sex offenders in the northeastern region of the U.S. As a result, a random sampling of the population of sex offender therapists from this geographical area decreased the likelihood of other eligible therapists from being included in the study. This selection process limits the generalizability of the sample. Therefore, therapists working with clients in different areas, with different groups of cultures, ethnicities, and different dominant religions, are
likely to demonstrate different perspectives about the inclusion of spirituality in sex offender treatment.

Delaney, et al. (2013) reported that although training is an issue, improving the understanding of therapists’ perspectives of spirituality in treatment is imperative in efforts to make future clinical training effective. The participant inclusion criteria required participants to be master’s-level practitioners; however, variability in the level of training existed among the participants. Among the 12 participants, seven were not licensed, one was a licensed psychologist, two were licensed marriage and family therapists, one was a licensed professional counselor, and one was a licensed clinical social worker. Therefore, with this level of variability, the findings of this study may have been explained by the participants’ backgrounds in training and years of experience. For example, the participants who felt less confident in facilitating the discussion of religion in session likely felt that way because of their limited opportunity in addressing spirituality in therapy or possibly their limited supervised training. Research demonstrates that treatment outcome is associated with the therapist’s level of training (Stein & Lambert, 1995). Stein and Lambert (1995) revealed that therapists with more training experienced lower less dropout rates than those of therapists with less training (i.e., bachelor’s-level therapists versus master’s-level sex offender therapists).

The researcher had an existing perception that including spirituality in sex offender treatment would be of advantage to clients; therefore, the researcher’s impression of the topic may have influenced participants’ perspectives indirectly through such variables as body language or inflection of tone. During the interview process, the researcher expected more variability in the way participants discussed their use of
spirituality. More specifically, the researcher expected clear and direct feedback about how the participants perceived spirituality in sex offender treatment. Surprisingly, each participant appeared initially to find the topic a novel concept for sex offender treatment, but they were able to share how they have used spirituality in treatment. In addition, they were able to share their thoughts on their personal spiritual beliefs, and they were attentive to the potential influence on their clients.

In effort to elicit responses free of influence, the researcher did not share thoughts on the topic of religion and spirituality with the participants. Limited research exists on the inclusion of spirituality in sex offender treatment. As a result, of this limitation, the opportunity to compare findings with prior studies and to determine the best approach for further research is lessened. However, because of this limitation, further research is recommended to enhance the understanding of the topic of this study.

**Conclusion**

Although there are noteworthy limitations, the results of this study provided valuable insights from the perspective of therapists about the use of spirituality with the sex offender population. The findings revealed that potential concerns, such as varying understanding of spirituality versus religion, lack of training in providing spiritually focused treatment/interventions for the sex offender population, and limited execution of flexibility in facilitation of spiritually focused treatment, regarding the inclusion of spirituality with this population can be further investigated in future study.

Most participants were able to identify spirituality as a protective factor that enhanced treatment outcomes by aiding client-centered work towards reducing clients’ likelihood of recidivism, developing effective coping skills to regulate mood (prayer,
meditation, and yoga), and establishing positive and effective means to reintegrate into society (church and spiritual community fellowship). Most participants expressed comfort with allowing the client to initiate the discussion of spirituality because they wanted to respect clients’ choice of initiating the topic if or when it was appropriate for them. Although 11 of 12 participants identified themselves as spiritual and a majority of the sample perceived spirituality as helpful in reaching treatment goals, participants did not make assumptions about understanding their clients’ views of spirituality, and instead allowed clients to navigate their course toward creating client-centered treatment plans.

Additionally, participants repeatedly endorsed that they did not have experience with a formal model for incorporating spirituality. However, they expressed their use of flexibility when incorporating spirituality in the treatment protocol, especially as they used a client-centered approach to treatment. A couple of participants reported a preference to follow the structured curriculum rather than incorporate change to the curriculum to accommodate client needs. More importantly, participants discussed the need for clients to feel comfortable and respected when discussing their spiritual views.

**Future Directions**

In an effort to improve understanding of the topic of this study, replicating this study with the sex offender population of an identified gender and offender type would be helpful. Participants in this study reported working with male sex offenders; therefore, understanding if therapists’ perspectives are different when working with the female population would be helpful. For example, investigating if therapists’ expectations for treatment planning are different when working with female offenders and whether their ability to facilitate spiritually focused treatment is impacted would be helpful. Research
shows that forensic professionals, such as sex offender therapists, may view female sex offenders more favorably than male offenders (Gakhal & Brown, 2011).

This study did not stipulate that therapists work with a specific type of sexual offender, for example, specific categories, such as rapist, child molester, and exhibitionist. Examining therapists’ perspectives regarding the inclusion of spirituality for clients who fall within these categories would be interesting, as would studying therapists’ perspectives in regards to sex offenders who fall within the category of low, moderate, or high risk. In addition to these categories of offenders is the highly recognized group of clerical sex offenders (Songy, 2003). According to Songy (2003), treatment factors, such as acceptance of the status of the sex offender, community reintegration into religious fellowship with limitations, and the integration of human and spiritual healing, are important when working with clerical sex offenders. Songy (2003) reported that a close working alliance between the religious institution and the mental-health provider is needed for a successful outcome, whereas Blanchard (1991) identified a psychodynamic approach as effective in treating clergymen convicted of sex offending. Consequently, future study would be useful to investigate if clerical sex offenders have experienced successful or unsuccessful outcomes in sex offender treatment and what has attributed to those outcomes. This information could be helpful in analyzing the component of spirituality in sex offender treatment from a slightly different perspective.

Although there is more to know about the use of spirituality in sex offender treatment with a heterogeneous population, one of the significant findings of this study revealed a possible need for additional training on assessment of clients’ spiritual/religious needs and wants in treatment and, more importantly, incorporating
those aspects into the client’s treatment plan. In addition, examination of the use of clinical supervision to reinforce training needs may be helpful. Therefore, future study can target the integration of training for sex offender therapists on spiritually focused interventions and the treatment outcomes identified as a result of such integration.

Although 10 of the 12 participants identified their therapeutic orientation as CBT, four of the 12 listed other orientations that they perceived as important. This study was not designed to control for this variable; however, understanding of whether a therapist’s orientation was related to his or her perception of the role of spirituality in treatment and of the way that perception affected his or her ability to engage clients on the topic would be helpful. According to a study completed by Larsson, Kaldo, and Broberg (2009), therapists’ orientation may demonstrate differences in the way they approach treatment and some therapeutic interventions may be more useful than others (e.g., activation, homework, making a connection between present situation and childhood circumstances). Thus, a better understanding of whether therapeutic orientation affects a therapist’s ability to include spirituality in treatment would be helpful.

With the understanding that the participants expressed variability in their spiritual/religious views and practices, this factor possibly had some influence on the results of this study. Future study on clients’ personal views of spirituality and how they relate to the inclusion of spirituality in sex offender treatment would be a useful examination and contribution.
References


Appendix A
Demographic Questionnaire

Please complete each question by providing some brief demographic information. Check all items that apply. You may decline to answer any of the questions if you choose.

1. Age:

2. Sex:
   □ Male
   □ Female

3. Race:
   □ Caucasian
   □ African American
   □ Hispanic or Latino
   □ Asian
   □ American Indian and Alaska Native
   □ Native Hawaiian and Other Pacific Islander
   □ Other ____________________________

4. Religious affiliation:
   □ Christianity
   □ Judaism
   □ Buddhism
   □ Islam
   □ Hinduism
   □ Unitarian
   □ No religion
   □ Other ____________________________

5. Marital status:
   □ Never married
   □ Married
   □ Partnered
   □ Separated
   □ Divorced
   □ Widowed

6. Educational level:
7. Occupation:

8. Total number of years working with sex offender population:

9. Licensure: □ Yes or □ No  Type:

10. Therapeutic orientation:

11. Professional affiliation(s):
Appendix B
Brief Multidimensional Measure of Religiousness/Spirituality: 1999

Daily Spiritual Experiences: The following questions deal with possible spiritual experiences. To what extent can you say you experience the following:

1. I feel God’s presence.
   1- Many times a day
   2- Every day
   3- Most days
   4- Some days
   5- Once in a while
   6- Never or almost never

2. I find strength and comfort in my religion
   1- Many times a day
   2- Every day
   3- Most days
   4- Some days
   5- Once in a while
   6- Never or almost never

3. I feel deep inner peace or harmony.
   1- Many times a day
   2- Every day
   3- Most days
   4- Some days
   5- Once in a while
   6- Never or almost never

4. I desire to be closer to or in union with God.
   1- Many times a day
   2- Every day
   3- Most days
   4- Some days
5. I feel God’s love for me, directly or through others.
   1- Many times a day
   2- Every day
   3- Most days
   4- Some days
   5- Once in a while
   6- Never or almost never

6. I am spiritually touched by the beauty of creation.
   1- Many times a day
   2- Every day
   3- Most days
   4- Some days
   5- Once in a while
   6- Never or almost never

**Meaning**

7. The events in my life unfold according to a divine or greater plan.
   1- Strongly agree
   2- Agree
   3- Disagree
   4- Strongly disagree

8. I have a sense of mission or calling in my own life.
   1- Strongly agree
   2- Agree
   3- Disagree
   4- Strongly disagree

**Values/Beliefs**

9. I believe in a God who watches over me.
   1- Strongly agree
2- Agree
3- Disagree
4- Strongly disagree

10. I feel a deep sense of responsibility for reducing pain and suffering in the world.
   1- Strongly agree
   2- Agree
   3- Disagree
   4- Strongly disagree

Forgiveness: Because of my religious or spiritual beliefs:
11. I have forgiven myself for things that I have done wrong.
    1- Always or almost always
    2- Often
    3- Seldom
    4- Never
12. I have forgiven those who hurt me.
    1- Always or almost always
    2- Often
    3- Seldom
    4- Never
13. I know that God forgives me.
    1- Always or almost always
    2- Often
    3- Seldom
    4- Never

Private Religious Practices
14. How often do you pray privately in places other than at church or synagogue?
    1- More than once a day
    2- Once a day
    3- A few times a week
    4- Once a week
5- A few times a month
6- Once a month
7- Less than once a month
8- Never

15. Within your religious or spiritual tradition, how often do you meditate?
   1- More than once a day
   2- Once a day
   3- A few times a week
   4- Once a week
   5- A few times a month
   6- Once a month
   7- Less than once a month
   8- Never

16. How often do you watch or listen to religious programs on TV or radio?
   1- More than once a day
   2- Once a day
   3- A few times a week
   4- Once a week
   5- A few times a month
   6- Once a month
   7- Less than once a month
   8- Never

17. How often do you read the Bible or other religious literature?
   1- More than once a day
   2- Once a day
   3- A few times a week
   4- Once a week
   5- A few times a month
   6- Once a month
7- Less than once a month
8- Never

18. How often are prayers or grace said before or after meals in your home?
1- At all meals
2- Once a day
3- At least once a week
4- Only on special occasions
5- Never

**Religious and Spiritual Coping:** Think about how you try to understand and deal with major problems in your life. To what extent is each of the following involved in the way you cope?

19. I think about how my life is part of a larger spiritual force.
   1- A great deal
   2- Quite a bit
   3- Somewhat
   4- Not at all

20. I work together with God as partners.
   1- A great deal
   2- Quite a bit
   3- Somewhat
   4- Not at all

21. I look to God for strength, support, and guidance.
   1- A great deal
   2- Quite a bit
   3- Somewhat
   4- Not at all

22. I feel God is punishing me for my sins or lack of spirituality.
   1- A great deal
   2- Quite a bit
   3- Somewhat
23. I wonder whether God has abandoned me.
   1- A great deal
   2- Quite a bit
   3- Somewhat
   4- Not at all

24. I try to make sense of the situation and decide what to do without relying on God.
   1- A great deal
   2- Quite a bit
   3- Somewhat
   4- Not at all

25. To what extent is your religion involved in understanding or dealing with stressful situations?
   1- Very involved
   2- Somewhat involved
   3- Not very involved
   4- Not involved at all

**Religious Support:** These questions are designed to find out how much help the people in your congregation would provide if you need it in the future.

26. If you were ill, how much would the people in your congregation help you out?
   1- A great deal
   2- Some
   3- A little
   4- None

27. If you had a problem or were faced with a difficult situation, how much comfort would the people in your congregation be willing to give you?
   1- A great deal
   2- Some
   3- A little
   4- None

28. How often do the people in your congregation make too many demands on you?
1- Very often
2- Fairly often
3- Once in a while
4- Never

29. How often are the people in your congregation critical of you and the things you do?
   1- Very often
   2- Fairly often
   3- Once in a while
   4- Never

**Religious/Spiritual History**

30. Did you ever have a religious or spiritual experience that changed your life?
   _____No       _____Yes
   IF YES: How old were you when this experience occurred? _____

31. Have you ever had a significant gain in your faith?
   _____No       _____Yes
   IF YES: How old were you when this occurred? _____

32. Have you ever had a significant loss in your faith?
   _____No       _____Yes
   IF YES: How old were you when this occurred? _____

**Commitment**

33. I try hard to carry my religious beliefs over into all my other dealings in life.
   1- Strongly agree
   2- Agree
   3- Disagree
   4- Strongly disagree

34. In an average week, how many hours do you spend in activities on behalf of your church or activities that you do for religious or spiritual reasons? _____________
Organizational Religiousness

35. How often do you go to religious services?
   1- More than once a week  
   2- Every week or more often  
   3- Once or twice a month  
   4- Every month or so  
   5- Once or twice a year  
   6- Never

36. Besides religious services, how often do you take part in other activities at a place of worship?
   1- More than once a week  
   2- Every week or more often  
   3- Once or twice a month  
   4- Every month or so  
   5- Once or twice a year  
   6- Never

Religious Preference

37. What is your current religious preference? ____________________

   If Protestant, which specific denomination is that? ____________________
Overall Self-Ranking

38. To what extent do you consider yourself a religious person?
   1- Very religious
   2- Moderately religious
   3- Slightly religious
   4- Not religious at all

39. To what extent do you consider yourself a spiritual person?
   1- Very spiritual
   2- Moderately spiritual
   3- Slightly spiritual
   4- Not spiritual at all

Fetzer Institute, 1999
Appendix C
Semistructured Interview

This interview will be constructed in an attempt to elicit various cognitions, affects, and behaviors associated with the use of spirituality in treating the sex offender population. The interview, which will be audio taped, consists of four open-ended questions posed to gather a subjective narrative of each participant’s experience. The interview will begin once the participant willfully endorses consent to be involved in the study. After the interview, the participant will complete the Demographic Questionnaire and Brief Multidimensional Measure of Religiousness/Spirituality inventory.

“I want to start today’s interview by expressing appreciation towards your participation in this study. As you have previously been informed, today I am going to ask you several open-ended questions during the next hour and a half. These inquiries are going to be about your perceptions of spirituality in sex offender treatment. For the purpose of this interview, spirituality is defined as beliefs, values, and activities that support and represent your efforts to achieve inner strength, peace, and balance. It is my belief that the information gathered from this interview will improve psychological understanding of treatment interventions for the sex offender population. Furthermore, a review of the gathered information may contribute to the improvement of current treatment protocols. Please answer each question as completely as possible or ask questions if you are not sure what is being asked. Your involvement in this interview will assist me in accessing important information about therapists’ perceptions of the inclusion of spirituality in sex offender treatment. Please answer each question as truthfully as possible because your responses will provide a strong foundation for understanding the experiences of therapists who work with this population.
Please keep in mind that I will be audio taping this interview so that I can transcribe the interview at a later date. This will help me to understand your thoughts, feelings, opinions, and experiences as much as possible. Do you have any questions or concerns that I can answer for you before we get started? Okay, let’s begin.”

1. What are your thoughts about the inclusion of spirituality in sex offender treatment?

2. If you include spirituality in sex offender treatment, how do you do so?
   a. Probe: If not, why?

3. Can you tell me about the treatment of a specific client for which inclusion of spirituality was particularly important?

4. Is there anything I have not asked you related to this topic that you would like to discuss?