VOLUME I

RESEARCH COMPONENT

HOW DO THERAPISTS CONTRIBUTE TO THERAPEUTIC CHANGE IN SEX OFFENDER TREATMENT? – A LITERATURE REVIEW

and

WORKING WITH LEARNING DISABLED SEX OFFENDERS: A QUALITATIVE STUDY OF THE EXPERIENCES OF STAFF WORKING ON A TREATMENT PROGRAMME

By

DALJIT KAUR SANDHU

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Abstract

Introduction

This paper explores the experiences of staff working on a sex offender treatment programme for people with a learning disability. This area has not previously been the subject of research.

Method

Semi-structured interviews were carried out with eight participants working on a treatment programme for sex offenders with a learning disability. Interviews were transcribed and analysed using Interpretative Phenomenological Analysis.

Results

Four superordinate themes emerged from the data: rewards and motivation; the challenge of effecting change; the personal impact of work; and ways of managing the impact of work

Conclusions

The results suggest that working on the treatment programme is a complex and challenging experience. Participants both shared and had distinct ways of meeting the challenges of work and this had an impact on the process of effecting change with group members and their own well-being – these issues were reflected in relation to the themes of empathy and humour.

Keywords sex offender treatment, learning disability, staff well-being, therapeutic processes, empathy, humour

DEDICATION

This thesis is dedicated to my father, with love, gratitude, and sadness.

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My thanks go to all the staff that participated in this study, and shared their thoughts and feelings about their experiences. I hope this study will help to highlight the challenges and rewards facing staff who work with people with a learning disability who have sexually offended.

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HOW DO THERAPISTS CONTRIBUTE TO THERAPEUTIC CHANGE IN SEX OFFENDER TREATMENT? – A LITERATURE REVIEW

By

DALJIT KAUR SANDHU

University of Birmingham

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Abstract

Background

Psychotherapy research suggests that therapists contribute to the process of therapeutic change. Research into sex offender treatment has tended to focus on the content rather than the process of therapeutic change. This paper reviews the evidence for the role of therapist characteristics in relation to therapeutic change in sex offender treatment.

Methods

A literature search of a number of electronic databases and additional manual searches identified a total of 15 relevant articles.

Results

Studies were carried out in different treatment contexts and with a variety of methodological approaches. A number of therapist characteristics were identified in relation to the process of therapeutic change in sex offender treatment.

Conclusion

Due to the methodological limitations of the studies no conclusive evidence for the contribution of therapist characteristics to treatment efficacy was found. Nevertheless, the findings may have some clinical utility in relation to improving the therapeutic effectiveness of sex offender treatment.

Keywords sex offender treatment, therapist characteristics, therapeutic change, empathy, attitudes, leadership

1 Introduction

A recent task force sponsored by the American Psychological Association and the North American Society for Psychotherapy Research identified a number of empirically derived principles of therapeutic change that apply across a range of clinical problems including affective, personality and substance use disorders (Castonguay & Beutler, 2006). They identified three sources of therapeutic change: participant characteristics (client and therapist variables); relational factors (such as the therapeutic alliance); and technique factors. The taskforce identified that there were a number of principles of therapeutic change that appeared to be common across conditions, and some that were specific to particular conditions. In relation to therapist characteristics; therapist flexibility, openness, and tolerance were all identified as important principles of therapeutic change. In the context of the therapy relationship; a positive working alliance, or in groups - group cohesiveness, therapist empathy, collaboration, positive regard, and congruence, were all identified as common principles of change. The task force identified a number of common principles in relation to techniques but cautioned that techniques needed to be embedded within a good therapeutic relationship. A recent meta-analysis (Martin et al., 2000) found that the therapeutic alliance is moderately but consistently associated with outcome, and the evidence implied that the results were directly due to the therapeutic alliance rather than any confounding variables. Martin et al. suggest that this may be evidence that the therapeutic alliance of itself can be therapeutic, regardless of the particular psychological intervention that is used. In terms of the relative contribution to the therapeutic alliance and outcome, there is some evidence that therapist variability as well as client variability

predicts outcome, which suggests that therapist characteristics play an important role in therapeutic outcomes (Baldwin et al., 2007).

Research into the effectiveness of interventions with sex offenders has focused on the content of treatment approaches rather than on therapeutic processes. A review of the effect sizes associated with sex offender treatment concluded that there was evidence for the efficacy of sex offender treatment, with a range of variability in effect sizes (Marshall, 2006). The most effective treatments were cognitive behavioural approaches combined with relapse prevention approaches. Relapse prevention by itself appeared to be less effective. There has been some concern that relapse prevention and cognitive behavioural approaches have been adopted by sex offender treatment programmes, without a key feature of these approaches, which is the development and maintenance of a collaborative relationship between therapist and client (Shingler & Mann, 2006). There has also been considerable criticism of the application of the traditional relapse prevention model to sex offender treatment due to a number of empirical, theoretical and clinical deficiencies of the model (Yates, 2003). The self regulation model (Ward & Hudson, 2000) was developed as an alternative sex offender specific theoretical model of sexual offending. This model is reported to have a number of advantages over the traditional relapse prevention model: being empirically derived; more responsive to individual pathways to offending; incorporates a wider range of risk factors; and takes into account offender strengths and skills rather than just focusing on deficits (Yates, 2003).

Marshall et al. (2006) have commented on the relative efficacy of focusing on the criminogenic versus non-criminogenic needs of offenders in relation to sex offender treatment, and identified the need to take more constructive approaches to sex offender treatment. Sexual offenders are reported to have particular difficulties with intimacy and relationships, low self esteem, and difficulties coping with stress and emotional regulation, and it has been suggested that sexual offending may be an inappropriate way of managing these problems (Yates, 2003). It has also been suggested that sex offenders may have particular difficulties with shame and attachment issues, and that the way in which therapists relate to offenders may have an impact on their engagement in treatment (Proeve & Howells, 2006). There has been increasing interest in the role of therapeutic process issues in sex offender treatment (Serran et al., 2003; Yates, 2003; Marshall & Serran, 2004; Harkins & Beech, 2007). Although the role of therapist characteristics have been commented on in previous reviews of sex offender treatment, only a small number of studies looking at the effect of therapist characteristics on treatment outcome were identified and discussed. The primary purpose of this review is to carry out a systematic search of the sex offender empirical literature in order to identify the range of therapist related factors that may have a role in sex offender treatment. Then based on the currently available evidence, discuss and evaluate the role of these factors in relation to therapeutic change in sex offender treatment.

2 Search strategy

A literature search was carried out of a number of databases (PSYCHINFO, EMBASE and MEDLINE) looking for peer reviewed articles relating to therapist characteristics in relation to treatment or therapy with adult male sex offenders, between 1987 and April 2009. Therapist factors included: personality, effectiveness, experiences and attitudes (see Table 1 below).

Table 1. Search strategy for PSYCHINFO

"sex offenders"		**"therapist characteristics"**
"sex$ adj1 offend$" as a keyword in the abstract, title, table of contents or key concept	**AND**	"therapist characteristics" OR "counsellor characteristics" as a keyword in the abstract, title, table of contents or key concept **OR** "therapist characteristics" exploded as a MESH term Scope of term: therapist experience, personality, effectiveness, attitudes **0R** "counselor characteristics" exploded as a MESH term. Scope of term: therapist experience, personality, effectiveness, attitudes
Total no. of articles identified		34
Number excluded		24
Suitable articles		10
Additional articles identified		5
Total number of suitable articles		**15**

Articles were excluded if they were not published, were dissertations, book chapters or reviews, not published in English, related to sexual abuse or sexual offences but not offenders specifically, or if they involved professionals or staff who were not working directly with offenders in the context of treatment or therapy for offenders. Articles were also excluded if they related to therapist client sexual relationships.

3 Results

3.1 Summary of methodological issues

The articles that are the subject of this review are summarised in Table 2 along with details of methodology, numbers of participants in each study, and some of the methodological limitations of the studies. As can be seen from the table a range of methodological approaches were used in these studies.

A number of the articles come under heading of clinical description (Bauman & Kopp, 2006; Ware & Bright, 2008; Tyagi, 2006). There has been considerable debate over the reliability and validity of clinical judgement because of criticism of the subjective and informal methods of data collection. However, it has been argued that clinical description has validity when clinicians have experience of the area under study and that such data can be aggregated to make statistical predictions (Westen & Weinberger, 2004).

A number of studies used qualitative approaches (McCallum, 1997; Scheela, 2001; Polson & McCullom, 1995). These were studies with small samples of participants in particular treatment contexts which may limit the transferability of the findings to other contexts. However, the use of qualitative approaches has some naturalistic validity as they appeared to be useful for understanding complex issues, the subjective aspect of participants' experiences and processes of change.

Table 2 - Summary of articles

AUTHOR	Summary of research	Methodology	Details of sample	Methodological limitations
Bauman & Kopp (2006)	Role of therapist characteristics and humanistic approach in group process and treatment	Clinical description and vignettes	n/a	No systematic study of therapist variables. Findings are anecdotal and not replicable or verifiable
Beech & Fordham (1997)	Therapist and offender perceptions of group process and relation to effectiveness	quantitative study correlations between therapist variables and treatment outcome	n =30 group leaders n=76 offenders n=12 groups	No details of how samples chosen or response rate. No control over treatment settings or group variables
Beech & Hamilton-Giachritsis (2005)	Relationship between therapeutic climate and treatment outcome	quantitative study correlations between therapist variables and treatment outcome	n = 100 offenders 88% response rate 12 treatment groups in 6 prisons	No details of how sample was selected. No therapist details given. Results may not generalise to other treatment contexts.
Drapeau (2005)	Offender perceptions of group treatment	pilot study - mixed qualitative and quantitative design	n = 24 offenders	No details of how sample was selected. No details of methods for authenticating qualitative results

Table 2 – summary of articles contd

Farrenkopf (1992)	Impact on therapists of working with offenders	survey using structured questionnaire	n = 35 response rate - 69%	No details of sampling methods or questionnaire used or methods of analysis.
Hilton et al. (1995)	Effects of childhood sexual abuse on working with sex offenders	mail survey using adapted questionnaire & open ended question	50% response rate n = 150 respondents	Respondents may have been unrepresentative. No details of how responses to open questions analysed
Marshall (2005)	Influence of therapist style on offender change	quantitative study correlations between therapist variables and treatment outcome	n = 6 programmes number of therapists not detailed	Observational methods may have limited validity and be unrepresentative way of assessing therapist variables
Marshall et al. (2003)	Relationship between therapist characteristics on behaviour change in sex offenders	quantitative study correlations between therapist variables and treatment outcome	n = 7 prisons	Observational methods may have limited validity and be unrepresentative way of assessing therapist variables

Table 2 – Summary of articles contd.

Marshall et al. (2002)	Identification of therapist features and influence on behaviour change	quantitative study correlations between therapist variables and treatment outcome	study 1 – n = 6 prisons study 2 – n = 5 prisons	Observational methods may have limited validity and be unrepresentative way of assessing therapist variables
McCallum(1997)	Women as co-facilitators in groups for male sex offenders	qualitative study using constant comparison methods of analysis	n = 5 therapists number of offenders not specified	Findings may be context specific. Sample excluded male therapists. Limited detail of methods used.
Nelson et al. (2002)	Survey of attitudes towards sex offenders	mail survey using standardized measure and questionnaire	n = 437 participants responded 54% response rate	Respondents may have been unrepresentative of wider population. Self report may lead to desirability bias.
Polson & McCullom (1995)	Qualitative case study of therapist caring	qualitative study using content analysis	n = 4 therapists n = 3 offenders	Findings may be context specific. Sample of offenders was purposively chosen and unrepresentative

Table 2 – summary of articles contd.

Scheela (2001)	Therapists' experiences and perceptions of sex offender treatment	qualitative study using constant comparison methods of analysis	n = 19 therapists all available therapists took part in research	Findings may be context specific. Researcher was also member of staff team.
Tyagi (2006)	Relationship between female counsellors and male perpetrators	Clinical description and vignettes	n/a	No systematic study of therapist variables. Findings are anecdotal and not replicable or verifiable
Ware & Bright (2008)	Evolution of a treatment programme for sex offenders	clinical description	n/a	No systematic study of therapist variables. Findings are anecdotal and not replicable or verifiable

Some of the studies used survey methods. These ranged from small scale studies such as (Farrenkopf, 1992) to larger scale studies (Hilton et al., 1995; Nelson et al., 2002). The studies used a variety of measures to gather data. The methodological quality of these studies also varied.

A number of studies used quantitative methods (Beech and colleagues, Marshall and colleagues). In the main these investigated the correlation between a variety of therapist variables and either group process variables or offender related change. The samples included a number of sex offender groups. The majority of these studies were carried out in a prison setting.

One study (Drapeau, 2005) used a combination of qualitative and quantitative methods. However, this was a small scale pilot study and the methods and results were not systematically reported which decreased the quality of the research evidence.

Details of the context in which the studies were carried out are summarised in Table 3. As can be seen from the table, therapists worked in a diverse range of settings and with diverse types of offenders. Although many of the studies were undertaken within the context of groups using a cognitive behavioural approach this was not universal. The professional background of therapists also varied across the studies. Therapists came from a diverse range of professional backgrounds including, counsellors, psychologists, social workers, prison officers, nurses and in one study even a minister. Many of the studies gave some

Table 3 – Summary of treatment contexts

AUTHOR	Therapist details	Treatment format	Treatment approach	Treatment setting	Offender characteristics	Country of research
Bauman & Kopp (2006)	not detailed	open group therapy	humanistic	outpatient / community	low risk male offenders	U.S.A.
Beech & Fordham (1997)	not detailed	short and long term group therapy	cognitive behavioural	residential and probation	majortiy offended against children. Some high risk	U.K.
Beech & Hamilton-Giachritsis (2005)	not detailed	group	cognitive behavioural	prison - medium security	over 80% offended against children. Offence - 'serious'	U.K.
Drapeau (2005)	not detailed	group	cognitive behavioural	prison	not detailed	Canada
Farrenkopf (1992)	mental health therapists	not detailed	not detailed	private and public practice	mandatory	U.S.A.
Hilton et al. (1995)	majority social workers or psychologists	not detailed	not detailed	not detailed	offended against child and/or adults	Canada

Table 3 – Summary of treatment contexts contd

Marshall (2005)	not detailed	group	manualised cognitive behavioural	prison	not detailed	U.K.
Marshall et al. (2003)	psychologists and prison officers	group	manualised cognitive behavioural	prison	not detailed	U.K.
Marshall et al. (2002)	psychologists and prison officers	group	manualised cognitive behavioural	prison	adult males offending against children and adult females	U.K.
McCallum(1997)	volunteers	open ended support groups	exploratory?	community	voluntary and mandatory offenders against women or children	Canada
Nelson, Herlihy & Oeschler (2003)	counsellors	not detailed	not detailed	private practice or community	not detailed	U.S.A.
Polson & McCullom (1995)	Qualitative case study of therapist caring	group mostly	not detailed	community	mostly mandatory and intra-familial offenders	U.S.A.

Table 3 – Summary of treatment contexts

Scheela (2001)	multi- disciplinary team	individual, couple, family and group	therapeutic not punitive'	outpatient mental health centre	majority mandatory male offenders	U.S.A.
Tyagi (2006)	counsellor	group	cognitive behavioural or psychoeucational counselling	not detailed	not detailed	Canada
Ware & Bright (2008)	psychologists and correctional staff	group	cognitive behavioural	prison based residential programme	male offenders against adults and/or children	Australia

level of detail about the professional characteristics of the therapists who participated in their studies, with a number giving details of level of education, training and years of experience working with offenders. A number of studies failed to give any details of professional characteristics. Therapists' level of education, training, experience of working with offenders and caseload also varied across the studies. One of the implications of the diversity of treatment contexts and therapist background, is the limitation this places on the generalisation of findings between different treatment contexts.

This review uses the three categories identified by Castonguay and Beutler (2006) as a framework to review the evidence for the role of therapists in relation to the process of therapeutic change in sex offender treatment.

3.2 Therapist factors

Castonguay and Beutler (2006) identified therapist factors as characteristics that are inherent to the individual and exist both within and outside therapy and include factors such as demographic characteristics, coping and attachment style.

3.2.1 Age

Only four of the studies reported details of the age of therapists involved in sex offender treatment (Farrenkopf, 1992; Hilton et al., 1995; Nelson et al., 2002; Scheela, 2001) these are detailed in Table 4.

Table 4. Age and gender characteristics of therapists

Study	Gender - m : f (%)	Mean age	Age range
Farrenkopf (1992)	83:17	48	30 – 60
Hilton et al. (1995)	44 : 56	38	No details
Nelson et al. (2002)	33 : 67	49	No details
Scheela (2001)	47 : 53	47	32 - 54

Only one study (Nelson et al., 2002) investigated the role of therapist age in sex offender treatment. The study surveyed the attitudes of counsellors towards sex offenders and found that there was no relationship between age and attitude to sex offenders. The study used the Attitudes Towards Sex Offenders Scale (Hogue, 1993) which is a standardised self report measure with good psychometric properties, and a researcher constructed questionnaire to collect personal and professional data. Participants were systematically selected from two professional organisations and then 400 from each organisation were randomly selected and contacted by post to take part in the survey. Although the methods of sampling were quite rigorous there were other methodological limitations (see Table 2). An additional limitation of the study was that a number of correlational analyses were carried out on the data without adjustment to the level of significance, which increases the chance of a number of false positive results.

3.2.2 Gender

Only four studies detailed the gender profile of therapists that participated in the studies. These are detailed in Table 4. As can be see from the table, three of the studies had roughly equal numbers of male and female therapists, with the remaining two studies reporting a majority of one gender or the other.

Two articles gave anecdotal reports of the role of therapist gender in sex offender treatment in relation to group processes and offender dynamics. Bauman and Kopp (2006) in their report on humanistic approaches to sex offender treatment, state that therapist gender may play a part in the group process. They report that offenders may use therapists as objects of transference in order to work through their offending dynamics; however the article does not give any further details or description of the process which limits both clinical application and further research investigation. Tyagi (2006) gives a clinical description based on clinical experience and observations, of the ways in which female therapists may become the target of negative male reactions solely as a basis of their gender and how this may have an impact on the therapeutic alliance.

McCallum (1997) and Polson & McCullom (1995) both used qualitative methods to study both therapist and offender perceptions of therapists. Mc Callum (1997) explored both offender and therapist perceptions of the role of women as co-facilitators on groups for male sex offenders. Both offenders and therapists identified that female therapists had a role in changing offenders' perceptions and attitudes towards women. Offenders also reported valuing a female perspective

as it gave them an insight into how their victims might feel. They also identified that the presence of a female therapist gave them an opportunity to behave in more socially appropriate ways and to relate and communicate better with women in general. Although the study design included methods of triangulation by including the perspectives of offenders and therapists, no male therapists participated in the study. Their perspective would have improved the validity of the findings. Polson and McCallum (1995) explored perceptions of therapist caring in their study. Both offenders and therapists identified that offenders' power and control dynamics with women could re-occur in the group and therapists needed awareness and ability to deal appropriately with these issues. The study gave greater detail about the methods of analysis than the previous study, however again no male therapists participated in the study. One of the researchers was also a member of the team of therapists but the effect of this on the research process was not reflected on. Offenders who took part in the research were chosen on the basis of success on the treatment programme, so the findings may not have reflected the experiences of less successful offenders.

3.2.3 Marital and parental status

Only Nelson et al (2002) reported on the marital and child status of participants. They found no relationship between these variables and counsellor self reported attitudes towards offenders.

3.2.4 Experience of sexual abuse

Hilton et al. (1995) surveyed the prevalence and self reported effects of childhood sexual abuse in therapists working on sex offender programmes. The survey reported that two thirds of females

and a third of the male therapists participating in the study reported experiencing childhood sexual abuse (CSA). They did not investigate whether gender had an effect on the process of sex offender treatment. The study used an adapted questionnaire to investigate the prevalence and nature of childhood sexual abuse and an open ended question to explore the effects of abuse on work with sex offenders. The study found that most acts of abuse that were reported were relatively minor and that those therapists that had experienced CSA generally rated the lasting physical and emotional effects as being very low, although most (70%) viewed the acts in a negative light. The study also found that just under 40% of therapists who had experienced childhood sexual abuse reported that it had a positive impact on their motivation to work with offenders, and around a half reported that it had a positive impact on their ability to work with offenders. A third disclosed the abuse to colleagues and a minority (14.8%) to their clients. In terms of attitudes towards victims of abuse working with offenders, just over half of both victims and non-victims reported it being acceptable for therapist who had experienced CSA to work with sex offenders if they had come to terms with their experience or were able to control their emotions. There were a number of methodological limitations to the study which limit the generalisation or reliability of the results. In addition, there are questions over the validity of self report to evaluate the effect of CSA on therapists' ability to work with sex offenders.

One other study reported on therapists experiences of sexual abuse. Nelson et al. (2002) used slightly wider criteria to Hilton, including therapists' personally knowing somebody who had been the victim of sexual abuse. Their study found that therapists who personally knew somebody who had been the victim sexual abuse had more positive attitudes to offenders than

those who did not. However, these findings have limited reliability due to methodological limitations of the study.

3.2.5 Therapist personal impact and coping strategies

Farrenkopf (1992) used a structured questionnaire to survey therapists working with sex offenders about the personal impact of work, perceived phases of impact and coping strategies. Participants in this study reported the greatest length of time working with offenders out of all the studies that reported this information. Their experience of working with offenders ranged from ten to thirty years. The study reported that therapists went through a number of phases of reaction to work with sex offenders. A quarter of therapists studied reported burnout, while a fifth ceased to work with offenders. The remainder were reported to have made psychological adaptation in order to continue working with this client group. A number of coping strategies were identified for maintaining mental health and avoiding burnout, including work diversification, decreasing or terminating offender work and attitude adjustment. The study also reported gender differences in relation to the impact of work. Female therapists reported greater negative emotional and social impact and spent less time working with offenders than male therapists. Whereas some male therapists reported gender related guilt about abusive behaviour. The study had a number of serious methodological limitations which limit the generalisation and the reliability of the results.

3.3 Therapist relational factors

Castonguay and Beutler (2006) identified a number of therapist related qualities or skills that contribute to the quality of the interaction between therapists and clients and included such factors as empathy, positive regard, genuineness and the management of countertransference. In relation to sex offender treatment three key therapist characteristics were identified in the articles.

3.3.1 Therapist empathy

A number of articles discussed the role of therapist empathy in sex offender treatment. In most studies this concept was not clearly defined.

Some articles provide anecdotal or clinical descriptions of the role of therapist empathy in sex offender treatment. Therapist empathy and warmth were identified as important characteristics by Ware and Bright (2008) and reported to have contributed to improved treatment attrition and positive offender related changes. Bauman and Kopp (2006) also identify empathy as a key feature of a humanistic approach to sex offender treatment along with trust, respect and caring. They describes how these therapist characteristics play a role in helping offenders develop empathy and take responsibility for offending. Although the study reports that the primary goal of the sex offender groups is to reduce recidivism, they report that this is achieved through the exploratory and humanistic approach of the therapy and therapists. The authors report that to their knowledge there have been no cases of recidivism over the five years which the group has been running. The authors seem to suggest that this is linked to the humanistic approach of its

therapists. Based on her own clinical experience and observations, Tyagi (2006) identifies that therapist empathy can be compromised by countertransference reactions to offenders. She also suggests that racial differences between therapist and offenders may affect the formation of a therapeutic relationship due to offenders' cultural experiences and expectations, and that therapists need to be aware of and skilled in dealing with these issues.

Farrenkopf's (1992) small scale survey of the personal impact of working with sex offenders reported that therapist empathy was not a static attribute. Therapists who participated in the study reported going through a number of phases in relation to their work. In the early phases of work, between one to five years of working with sex offenders, therapists reported having empathy for offenders, but as time went on their empathy for offenders decreased. The study reported using a structured questionnaire to collect data but did not give any detail of the content of the questionnaire or how data was analysed so it is difficult to evaluate the reliability of these findings. In addition, a number of methodological issues limit the generalisation of these findings.

Polson & McCullom (1995) looked at the role of therapist caring in the treatment of sexual offenders using a qualitative approach to explore the perspectives of both offenders and therapists. Therapists reported that having empathy for offenders as victims and people enabled them to maintain positive and caring attitudes towards offenders. Both therapists and offenders reported a similar process whereby therapist empathy for the offender was seen as enabling the offender to empathise with himself and then with victims.

A number of related studies by Marshall and colleagues (Marshall, 2005; Marshall et al., 2003; Marshall et al., 2002) looked at the role of a range of therapist characteristics in sex offender treatment. In these studies therapist characteristics or features as they were termed in one of the studies, were defined as behaviours that were observed in group sessions and could be categorised by external observers. They included a wide range of therapist characteristics including empathy, sincerity, warmth and respect. Marshall et al. (2003) was a pilot study looking at the reliable identification of a number of these therapist features and their relationship to change in offenders. Marshall et al. (2002) and Marshall (2005) looked at similar areas but with slightly different samples and methodological rigour. All the studies sampled therapists from a number of prisons running the same manualised treatment programme and used observation methods to identify the presence of a range of therapist behaviours. Two trained observers were used to independently identify these therapist behaviours and correlational methods were used to assess the reliability of identification. In the second stage of the studies, selected samples of group sessions were studied to investigate whether there was a relationship between a number of identified therapist behaviours and a number of measures of offender change. A regression analysis of the data found that therapist empathy and warmth were the best predictors of a reduction in offender minimisation and denial of responsibility (Marshall et al., 2002; Marshall et al., 2003). Empathy was also significantly correlated with positive change in offenders' relationships (Marshall, 2002). The studies reported drawing their samples from across all the prisons that run the Sex Offender Treatment Programme (SOTP). Methods of sampling varied in the studies, from being independently selected (Marshall et al., 2002) to being randomly selected (Marshall et al., 2003). Although the studies controlled for treatment content across the programmes, there were other methodological limitations. There are some questions about the

validity of their identification of therapist characteristics as both observers received the same training and there was no detail of the external validity of the method. In addition, there was a question of how representative these therapist behaviours were across the whole treatment programme as the studies sampled a very small proportion of treatment sessions. The studies report using a large number of measures of offender change, however these are not detailed so it is difficult to assess the validity and reliability of these measures. Although the study carried out many statistical analyses on the data, they reported that adjusting the significance level to minimise the chance of false positives in Marshall et al. (2002).

3.3.2 Therapist attitudes

A number of articles reported on the role of therapist attitude in sex offender treatment. In many of the studies the concept of therapist attitudes was not clearly defined.

Based on their clinical experience, Bauman and Kopp (2006) suggest that therapists' non-judgemental attitude has a positive impact on treatment attrition, inter-personal issues and in offending recidivism. However, these findings have limited value as these variables were not systematically studied.

A number of qualitative studies reported on the role of therapist attitudes in sex offender treatment. In these studies therapist attitude was based on participants' reports of their subjective experiences. Offenders in a number of studies identified the importance of therapists having a non-judgemental attitude (Drapeau, 2005; Polson & McCullom, 1995; McCallum, 1997).

Offenders reported a number of ways in which a therapists' attitude could be helpful. A caring attitude from therapists was seen to help offenders feel like people rather than just offenders (Polson & McCullom, 1995). Offenders also reported that a non-judgemental attitude played an important part in engagement, the change process and in creating a therapeutic environment (McCallum, 1997). Therapists in Polson and McCullom's (1995) study identified the difficulties of maintaining a caring attitude towards offenders due to offenders' attitudes and behaviour, and that a positive attitude was not a static attribute, but one that required a process of maintenance. Therapists in Scheela's (2001) study of therapists' experiences and perceptions of sex offender work described how they maintained positive attitudes to offenders by shifting their perspective from the offence to the person, and how humanistic values and approach helped them maintain a positive attitude.

The changing nature of attitudes towards sex offenders was also reported by therapists who participated in Farrenkopf's (1992) small scale survey. The study reported that some therapists adapted to long term work with sex offenders by taking a more detached attitude to work and concern for offenders. It was not clear exactly how data about attitudes was collected or analysed in order to come to these conclusions.

Nelson et al. (2002) was the only study that focused on therapist attitudes to sex offenders. The study used a standardised questionnaire (The Attitude Towards Offenders Scale, ATS; Hogue, 1993) to survey the attitudes of a sample of counsellors who worked with sex offenders. The data was analysed to compare attitudes with other professionals. The study found that counsellors in their study had significantly more positive attitudes towards offenders than a range of other

professionals groups such as police officers, prison officers, psychologists, and probation officers. As a group, counsellors also had more positive attitudes than other groups of professionals that had experience and training of working with sex offenders. The study also looked at the relationship between attitude and a range of personal and professional characteristics. The study found a significant and positive relationship between attitudes to sex offenders, and offender experience and caseload. In relation to training and attitudes, there was no relationship between training and attitudes per se, but there was between feeling prepared by training and attitudes. The study found no correlation between attitudes and level of education. As already discussed one of the limitations of the study was the statistical analysis and the increased chance of false positive findings. The use of self report measures may have also introduced a desirability bias which may limit the validity of the results.

Drapeau's (2005) small pilot study of offender perceptions of group treatment stated that offenders reported that therapists were the most significant factor in treatment. Offenders identified a range of therapist qualities such as honesty, respect and a caring and valuing nature as being important. Although the study did not use the term attitudes, some of the findings seem to suggest that offenders value therapists having a positive attitude towards them.

3.3.3 Therapist management of emotional reactions and countertransference

A number of articles discussed how therapists' emotional reactions could have an impact on the group process.

Tyagi (2006) comments on the role of therapist management of countertransference in sex offender treatment, based on her observations and clinical experience. She describes how therapists' responses to countertransference reactions can have an impact on treatment processes, including: therapists' being avoidant or superficially engaging; being inappropriately emotionally reactive; being over-boundaried or inappropriately self disclosing, and losing hope of change in offenders. She identifies these issues as having the potential for a negative impact on the group process.

Both offenders and therapists in McCallum's (1997) qualitative study of the role of female therapists in sex offender groups identified the importance of female therapists controlling their emotional reactions in the group. Offenders identified some initial anxiety about how female therapists would react to hearing accounts of their offences, and identified that female therapists needed to be emotionally strong characters. Female therapists reported that at times it was difficult to control their emotional reactions when hearing offence accounts.

3.4 Therapist technique factors

Castonguay and Beutler (2006) identify therapists' ability to provide direction in therapy as a technique factor. Articles looked at a variety of factors that appear to come under this category, including: therapist role; style; and leadership.

A number of articles provide an anecdotal account of the role of therapist leadership in sex offender treatment. Bauman and Kopp (2006) identify the importance of therapist leadership and

style in relation to group processes, offender relationships, treatment attrition and recidivism. They provide some limited clinical vignettes of the positive impact of non-confrontational approach with individual cases. Tyagi (2006) describes how the leadership dynamic between male and female therapists, and between therapists and offenders, can act as a model for relationships for offenders. Ware and Bright (2008) also provide anecdotal reports of how elimination of therapists' use of a confrontational style and use of appropriate directiveness contributed to improved treatment attrition and offender change. Offenders in Drapeau's (2005) pilot study of offender perceptions of group treatment reported valuing therapists who had leadership qualities. Although these articles mention the role of therapist leadership, the concept is not described in any detail or systematically studied, which limits the usefulness and validity of the points they make in the articles.

Two qualitative studies reported on the issue of therapist leadership. Therapists in McCallum's (1997) study of the role of female therapists, identified the tension between being a strong leader, and modelling stereotypically feminine attributes and being perceived in a traditional gender role. A study of therapists' perceptions and experiences of sex offender treatment stated that therapists reported that they became more directive the longer they worked with offenders (Scheela, 2001) which implies that therapists leadership style may change in response to working with sex offenders. Both these studies report therapist subjective perceptions of leadership style.

Marshall and colleagues in their studies with prison sex offender groups also investigated the role of leadership style on offender change. They define a confrontational style as one that is harsh and denigrating, whereas a non-confrontational style is characterised as one that is firm but

supportive (Marshall, 2005). They report that a confrontational style was associated with a negative impact on offender change, whereas therapist behaviours that encouraged participation and dealt effectively with problems were associated with greater perspective-taking by offenders (Marshall et al., 2003). In a subsequent study (Marshall et al., 2002), changes were reported to have been made to therapists' training so that confrontational approaches were minimised, which the authors explained was why there was little variability in this therapist characteristic, and hence no significant relationship found with offender change. The same study reported that directive and rewarding behaviour by therapists made the greatest contribution to the reduction in offender victim-blaming in a regression analysis of the data.

Beech and colleagues (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005) also carried out a number of large scale studies looking at the role of therapist leadership on the group process and offender outcomes using the Group Environment Scale (Moos, 1986). This is a standardised measure that has been used to assess and compare the climate of different groups. It contains a number of sub-scales which measure group cohesion and a variety of group leadership styles. Beech & Fordham (1997) sampled a number of mainly probation service sex offender groups and found significant differences in offender and therapist reports of therapist leadership across the treatment groups. Therapists rated themselves higher than offenders on all the leadership sub-scales. The study also found significant correlation between a supportive leadership style and a number of group processes, such as cohesion, orientation to task and organisation of group when they looked at just the responses of group members. Supportive leadership was defined as the help and friendship shown by group leaders. The study found no significant relationship between leader control, which related to direction and enforcement of

rules, and group processes when looking across treatment groups. When the study compared treatment groups they found an association between high levels of leadership control and low levels of group cohesiveness. One of the limitations of the study was the correlational design and lack of control of confounding variables which makes it impossible to draw any causal conclusions about the relationship between therapists leadership style and group climate.

Beech and Hamilton-Giachritsis (2005) used similar methods with greater control over treatment variables to investigate the relationship between treatment outcome and group processes, this time with a number of prison sex offender groups. The study again found significant differences in therapist and offender perception of therapist leadership. The study reported a significant positive correlation between treatment outcome and group cohesiveness and expressiveness. Of the therapist related variables, only one - leader support, was significantly and positively correlated with both group cohesion and expressiveness. However, there was no direct correlation between leader support and treatment outcome. Although there was greater control over treatment variables in this study the relationship between therapist variables and group climate is correlational, which does not allow causal relationship to be made between variables. In addition there were some methodological limitations in relation to sampling methods and the population studied, which limit the generalisation of these results to other treatment contexts.

4 Discussion

This review has found a number of articles that have reported on a diverse range of therapist characteristics. Some of these characteristics have not previously been the subject of review in the context of sex offender treatment. Although all the studies had methodological limitations, there appear to be some interesting findings about the role of therapist characteristics in relation to the process of therapeutic change in sex offender treatment.

The role of therapist personal characteristics has not been widely or systematically studied in relation to sex offender treatment. The limited evidence available suggests that therapist gender may have some impact on the process of therapy with offenders. Offenders' relationships with female therapists within the context of treatment, appear to have the potential to change offender perceptions, attitudes and relationships with women in general. There is also some evidence that female therapists may face particular challenges in working with sex offenders which may have an impact on the therapeutic process. In the main this evidence has come from small scale qualitative studies or reports based on clinical experience. Although these studies generally take a subjective approach and employed small samples of participants, they may have some clinical utility as they offer an insight into a number of micro group processes, and the complexity of interpersonal processes in sex offender treatment. These studies have taken account of both offender and therapist perceptions of the group process. Further research is needed to investigate whether these findings generalise to other treatment contexts, and different methods could be used to corroborate the suggestion that a therapeutic relationship within the context of sex offender treatment is associated with more general changes in offender relationships and intimacy

difficulties. Future research in this area could also look at the role of male therapists, and the interaction between therapist gender and offender characteristics.

There is some evidence for the role of therapist empathy in the process and outcome of sex offender treatment. This evidence comes from studies that employ both objective and subjective approaches to the concept and across different treatment contexts and using different methodological approaches. There is evidence that therapist empathy may be associated with positive changes in offenders' attitude towards their sexual offending behaviour. It has been suggested that there is a parallel process between therapist empathy for offenders, and offender empathy for themselves and then their victims. Research from a number of small scale studies suggest that therapist empathy is not static but may be challenged both by the nature of an offender client group and by longer term experience of working with offenders. There is anecdotal and research evidence to suggest that certain treatment approaches, such as a humanistic approach, and certain therapist backgrounds, such as counselling, may facilitate and support therapists to empathise with offenders. Although there is evidence that even within the context of manualised treatment approaches, therapist empathy is associated with offender change. One of the limitations of the evidence from these studies is that the concept of empathy is not clearly defined and so may vary from study to study. There is a need for this potentially important therapist characteristic to be clarified and to be the focus of study in future research.

Therapist attitudes also appear to have a role in the treatment process and offender change. The evidence for the importance of this characteristic is less robust from a methodological perspective coming as it does mainly from a couple of small scale qualitative studies. There is some evidence

that therapists' attitudes towards offenders and offenders' perceptions of these attitudes may have a role in engaging offenders in treatment and the process of change. The conceptualisation of therapist attitudes in these studies appears to encompass therapist cognitions, affect and behaviour towards offenders. Despite some methodological limitations one large scale study suggests that therapists with a counselling background have more positive attitudes to sex offenders than a number of other professionals groups working with sex offenders. There is some limited evidence that attitudes to sex offenders are not static but may be affected by exposure to work with sex offenders. There is a need for further research to investigate the association between therapist self reported attitudes, the therapeutic relationship with offenders, and treatment outcomes, using different methodological approaches and across a wider variety of treatment contexts.

Research looking at therapist technique factors suggests that leadership style and direction may have a role in the process of therapeutic change in sex offender treatment. There is some evidence from a number of large scale studies that a supportive style of leadership is associated with greater group cohesiveness and positive offender change. However the majority of these studies were within the setting of prison service sex offender groups. Differences in offender and therapist perception of therapist leadership style have been highlighted by the studies of Beech and colleagues. There is some evidence from both anecdotal and large scale studies that a confrontational therapist style may have a negative impact on offender change. A number of articles suggest that the relationship between therapist leadership style and therapist gender may be a complex issue in sex offender treatment. The evidence for the role of therapist directiveness appears unclear. Studies carried out within the same treatment context reached different

conclusion about the role of therapist direction in sex offender treatment. Marshall et al. (2002) found the therapist directiveness was associated with some positive offender changes, while Beech and Ford (1997) found that high levels of control were associated with lower levels of group cohesiveness. The difficulty in making sense of these findings comes from differences in methodological approach and rigour in relation to the concept of therapist direction. Further research is needed in this area in order to clarify the role of therapist direction in sex offender treatment.

A number of therapist characteristics have been less well reported and investigated, or evidence is less convincing for their role in sex offender treatment. These include therapist age, experience of sexual abuse, coping strategies and management of countertransference reactions. These last two factors may be particularly important in relation to the process of therapeutic change in sex offender treatment. A 'consumers report' into sex offender treatment has consistently found that catharsis was highly rated by offenders (Reimer & Mathieu, 2006; Reddon et al., 1999). Hence, therapist awareness, understanding and processing, of both their own and offenders' emotional responses, may be particularly important skills in relation to therapeutic change in sex offender treatment. Research from the general psychotherapy literature suggests therapist attachment style may play a role in this aspect of therapeutic work (Berry et al., 2008). This is an area for future research in relation to sex offender treatment. The research also suggests that some therapist characteristics, such as emotional reactions, empathy and attitudes, may not be static factors. These characteristics appear to be stable but changeable factors that are challenged both by the nature of and prolonged exposure to work with sex offenders. Further systematic study of this area may be particularly helpful both in terms of maintaining the effectiveness of treatment and

also in supporting therapists who work in this area. It would also be interesting for research to look at the relationship between different therapist characteristics to investigate whether there are correlations between different therapist characteristics.

Although there is some research evidence to suggest that a number of therapist characteristics may have an impact on the process and outcome of sex offender treatment, the evidence is not robust due to studies being carried out with diverse offender populations, treatment contexts, therapist background and methodological approaches. Due to methodological limitations, few definitive conclusions can be made about the contribution of therapist characteristics to the efficacy of sex offender treatment. In order to improve the quality of the research evidence in relation to treatment efficacy there is a need for longer term and better controlled studies to follow up some of the promising results reported in the studies that have been reviewed here. There may be a number of reasons why this may be difficult. Treatment appears to be carried out in a variety of different contexts making it difficult to control for extraneous variables. In addition, it may be difficult and unethical to control variables such as therapist empathy. There is also the argument that evidence of efficacy does not necessarily translate into effectiveness in clinical practice. So despite the limitations of the research evidence the findings of these studies may still have some clinical utility in highlighting factors which may have an impact on the effectiveness of sex treatment and the process of therapeutic change in sex offender treatment. This review has identified areas where further research would be helpful in order to strengthen the quality of the evidence base and contribute to improving the effectiveness of interventions with sex offenders.

This review has focused on identifying a range of therapist related factors and the role they may play in relation to therapeutic change in sex offender treatment. These aims have been used to structure the review. One of the limitations of this approach is that the strengths and weaknesses of individual studies have not been systematically reviewed, which in turn makes it difficult to weight the evidence for the contribution of different therapist related factors to the effectiveness of sex offender treatment. Hopefully, this review has highlighted areas for future research and as research in this area grows the evidence for the role of different therapist related factors will accumulate and can be reviewed more systematically, and in turn applied with greater confidence to clinical practice.

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WORKING WITH LEARNING DISABLED SEX OFFENDERS: A QUALITATIVE STUDY OF THE EXPERIENCES OF STAFF WORKING ON A TREATMENT PROGRAMME

By

DALJIT KAUR SANDHU

University of Birmingham

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Abstract

Introduction

This paper explores the experiences of staff working on a sex offender treatment programme for people with a learning disability. This area has not previously been the subject of research.

Method

Semi-structured interviews were carried out with eight participants working on a treatment programme for sex offenders with a learning disability. Interviews were transcribed and analysed using Interpretative Phenomenological Analysis.

Results

Four superordinate themes emerged from the data: rewards and motivation; the challenge of effecting change; the personal impact of work; and ways of managing the impact of work

Conclusions

The results suggest that working on the treatment programme is a complex and challenging experience. Participants both shared and had distinct ways of meeting the challenges of work and this had an impact on the process of effecting change with group members and their own well-being – these issues were reflected in relation to the themes of empathy and humour.

Keywords sex offender treatment, learning disability, staff well-being, therapeutic processes, empathy, humour

1. Introduction

A review of treatment for sex offenders with a learning disability identified that a wide range of interventions are being used with this population without good evidence for the efficacy of interventions (Keeling et al., 2008). In contrast, within mainstream sex offender treatment approaches, there is some emerging evidence for the efficacy of cognitive behavioural approaches in particular (Marshall, 2006). Although some of these mainstream approaches have been applied to treatment with offenders with a learning disability, it has been suggested that sex offender interventions need to be responsive to the particular needs of offender populations (Harkins & Beech, 2007). There is some evidence that the needs of offenders with a learning disability may differ from those of mainstream offenders. For instance, this population may have special difficulties with cognitive approaches in particular (Oathamshaw & Haddock, 2006), that require specialist assessment (Dagnan et al., 2000) and adaptations in approach (Willner, 2006). A number of researchers have also investigated whether mainstream approaches such as the self-regulation model are applicable to this population (Ford et al., 2009; Langdon et al., 2007). Courtney et al., (2006) used qualitative methods to investigate the offence process of sex offenders with a learning disability and found considerable variation within and between offences. Recently there has been an increasing interest in the role of process issues in the treatment of mainstream sex offenders (Marshall & Serran, 2004; Serran et al., 2003). There is emerging evidence of the key role that therapists play in group processes and sex offender treatment outcome (Beech & Hamilton-Giachritsis, 2005; Drapeau, 2005; Marshall, 2005). At present there is a lack of research into process issues and the role of therapists in sex offender

treatment with individuals with a learning disability. The need for such research has been identified by Lindsay et al. (2007) who have suggested that staff well-being may potentially have an impact on therapeutic interventions with this population.

Working with clients who have a learning disability and who are sexual offenders has been characterised as a challenge to both staff and services (Clare & Murphy, 1998). A number of studies have found that working with service users with a learning disability was associated with a range of negative effects including stress (Instraad et al. 2002) and burnout (Robertson et al., 2005; Rose et al., 2004). However, a recent review of research in this area by Skirrow et al. (2007), suggests that staff working with this client group may not be as negatively affected as is commonly assumed. Therapists working with mainstream sex offenders also reported a range of negative effects, including negative emotional reactions, burnout and vicarious traumatisation (Farrenkopf, 1992; Mitchell & Melikian, 1995; Moulden & Firestone, 2007). However some therapists also reported a range of positive experiences in relation to their work with sex offenders (Scheela, 2001; Kadambi & Truscott, 2006). A small number of studies have looked at the experiences of staff working with sex offenders with a learning disability. Thompson et al., (1997) looked at the 'special relationship' between female direct care staff and service users with sexually inappropriate behaviour using qualitative methods and found that experiences were complex and that a range of personal, relational and systemic issues had an impact on female staff. Staff faced contradictory expectations that put them in a 'double bind' with regard to their relationships with service users. Research has also looked at the attitudes and job satisfaction of health and social care staff working with this client group (McKenzie et al., 2001) and found differences between these staff groups. Yool, Langdon & Gardner (2003) used qualitative

methods to explore the attitudes of staff working on a medium secure unit towards the sexuality of clients with learning disabilities and found commonalities and differences between individuals in relation to different aspects of service users' sexuality. Staff were liberal about some aspects of service users' sexuality but not others. Female staff were reported to have more negative attitudes towards the sexuality of service users who had sexually offended.

To date there does not appear to have been any research looking at the experiences of staff who work directly with sex offenders with a learning disability in the context of a treatment programme. Other areas of related research suggest that staff have an important role in the process of treatment, and that the relationship between staff experiences and well-being may be complex. Qualitative methods are particularly useful for exploring new areas, complex issues and for understanding the processes by which individuals make sense of their experiences (Smith et al., 2002). This study uses qualitative methods to explore the experiences of staff working with sex offenders with a learning disability and their role in the process of treatment.

2. Method

2.1. Choice of method

The qualitative method used in this study was Interpretative Phenomenological Analysis (IPA). This is an approach that has developed within the field of psychology and has been used to explore how individuals make sense of their experiences and the psychological meaning this may have for the individual and more generally (Smith et al., 1999). This method can also be used to examine similarities and differences between individual experiences of a particular situation if samples are fairly homogenous. IPA also recognises the position of the researcher in the interpretation of the experiences of others.

IPA was chosen for this study because the researcher was interested in the psychological processes by which individuals working in a sex offender treatment programme made sense of their experiences, the similarities and differences between individuals, and the impact this may have had on them and the treatment process. In addition, the researcher was interested in the reflecting on the role of the researcher in ascribing meaning to an experience due to her own personal interest in this area, and the impact this may have had on the research process.

2.2. Context of research

The research was carried out within a large forensic service for clients with a learning disability. The service has been running specially adapted sex offender treatment programmes for over ten

years. The programme is broadly cognitive behavioural in approach and takes place within the context of a closed group for male sex offenders with a learning disability. Group members are drawn from in-patient units within the service, and from the community. The treatment programmes are managed by nursing staff qualified in working with clients with a learning disability, and also have some supervisory input from clinical psychologists within the service. The groups are run by two to three tutors, the majority of who are health care assistants who have received training in sex offender treatment.

At the time the research was carried out, I was a Trainee Clinical Psychologist. A number of years prior to this, I had worked within the service and with clients with a learning disability as a care assistant, qualified nurse, and also briefly as a tutor on a sex offender treatment programme. I remember finding the experience of working on the programme an interesting process, particularly with regard to changes in my perceptions and emotional responses to group members. Following the research, I returned to the service on placement, mainly working with individual clients, none of whom had sexually offended.

2.3. Participants

Eight participants took part in the research. They were all staff who were or had been tutors running sex offender treatment groups. Of the eight participants, three were female and five male. Seven of the participants also worked as health care assistants on a number of different units, and spent half their time working as health care assistants and half as tutors on the treatment programme. One of the participants was a psychological therapist. Participant demographic

information and details of work experience are summarised in Table 1. Participants have been given pseudonyms to maintain their confidentiality.

Table 1 - Participant demographic information

Participant	*Gender*	*Age range / years*	*Living arrangements*	*Dependent children at home*	*Years working with learning disability*	*Years as tutor*
1 Alan	male	30 - 40	with other	yes	5 -10	3 - 5
2 Brit	female	20 - 30	with other	yes	3 - 5	1 - 2
3 Carol	female	30 - 40	on own	no	3 - 5	1 - 2
4 Dave	male	40 - 50	with other	no	> 10	> 10
5 Eric	male	40 - 50	on own	no	> 10	> 10
6 Frank	male	50+	on own	no	> 10	5 - 10
7 Gerry	male	50+	with other	no	> 10	5 - 10
8 Hazel	female	20 - 30	with other	no	3 - 5	3 - 5

3. Procedure

Ethical approval for the study was sought and granted by a local NHS Research Ethics Service (See Appendix 1)

3.1. Participant recruitment

Participants were recruited via contact with the managers of the treatment programme. The researcher met with potential participants and gave them verbal and written information about the details of the research (see Appendix 2). Participants were given an opportunity to ask questions about the research and given a period of time to consider whether they wished to take part in the research before being asked to give their written consent to participation (see Appendix 3).

3.2. Interviews

Prior to the interview, participants were asked to complete a demographic and work experience form (see Appendix 4). A semi-structured interview was carried out with the participants (see Appendix 5 for Interview Schedule). The interview questions were open-ended and covered a number of broad areas including; experiences of a typical day at work; thoughts and feelings about sexual offending and learning disability; and positive and negative aspects of work. Prompts were used to encourage participants to expand on these areas of interest. An open and flexible approach was taken to interviewing in order to allow participants to come up with and expand on areas that were of interest to them. Interviews were carried out individually at the

participants' area of work and at a time of their convenience. Interviews were taped with a digital recorder and participants were asked to contact the researcher within a week if they wished to withdraw from the research.

3.3. Data storage

Interviews were transcribed and stored on a computer, and line numbers were added to the transcripts to aid with the identification of extracted data. Any information that could be used to identify individuals or services was removed or obscured and each transcript given a number. Information kept on computer was kept in password protected files. Written information was kept in secure storage. The audio recordings were also stored as computer files on a password protected computer.

3.4. Data analysis

Interpretative Phenomenological Analysis (IPA) was used to analyse the data following the stages of analysis detailed by Smith et al. (2003). Details of the stages of analysis that were carried out in this study are given below.

Table 2. Stages of analysis

Stage of analysis	Description
Stage 1	The first stage of the analysis was to become familiar with the account by reading and re-reading and writing down initial thoughts and responses to the transcript, and noting participants' claims and concerns in the left hand margin.
Stage 2	In the second stage of the analysis, themes were abstracted from the claims and concerns and noted in the right hand margin. This was the first order of abstraction. (See Appendix 6 for example of stages 1 and 2 of analysis)
Stage 3	In the third stage of the analysis, a list of themes was generated and themes were grouped into hierarchical clusters (see Appendix 7 for example of Stage 3 of analysis). Steps 1 - 3 were repeated for each participant. Themes from earlier interviews were kept in mind when analysing subsequent interviews so repeating themes could be identified. As new themes emerged, previously coded interviews were checked again for evidence of the new theme.
Stage 4	Themes from across the transcripts were listed along with details of how many and which participants had spoken about that the theme (See Appendix 8 for example). Themes were clustered together into groups under super-ordinate themes. These super-ordinate themes were given labels which attempted to reflect some sense of the themes they incorporated.
Stage 5	At this stage there was a pruning and discarding of themes that did not seem to fit into the higher order themes or were not rich in explanation.
Stage 6	In the final stage of the analysis, the higher order themes were presented diagrammatically (see Figure 1) and a narrative account presented of these higher order themes.

3.5. Authenticity

A number of methods were used to check the authenticity of the analysis. The researcher used an iterative process of analysis, so that at each stage of the analysis the emerging themes and interpretations could be linked directly back to the accounts given by the participants. Details of the stages of analysis were also documented and examples provided as illustration, so that there was transparency and an audit trail from the transcripts to the final analysis.

In addition, each stage of the analysis was discussed with both the researcher's supervisors who each had extensive research knowledge and experience. Each had particular areas of expertise, one in relation to the area of research and the other in relation to the use of qualitative methodology. The researcher was also a member of an IPA peer support group who were used to check the credibility of claims directly from the transcripts, again at various stages of the analysis. On occasions, there were some areas where the researcher had a different interpretation of the account due to her knowledge of the context of the research and this was used as a point for reflection. Some of the points made by others were incorporated into the analysis. For instance, the use of language by participants was initially relatively neglected by the researcher, perhaps due to her previous insider position, and by taking more of an outsider position, the researcher was able to go back to the transcripts and reconsider the meaning and relevance of this area.

4. Results

4.1. Higher order themes

A number of superordinate themes emerged from the analysis related to the experience of working with sex offenders with a learning disability on a treatment programme. Superordinate themes and lower order themes are presented diagrammatically in Figure 1.

These were:

(i) Rewards and motivation for working on the treatment programme

(ii) The *'mission'* – the challenge of effecting change in group members

(iii) The personal impact of working with sex offenders

(iv) Meeting the challenge – ways of managing the impact of work on the treatment programme

Each of these super-ordinate themes will be discussed in turn in relation to the commonalities and differences in participants' experiences in these areas and illustrated with quotes from the transcripts of participants.

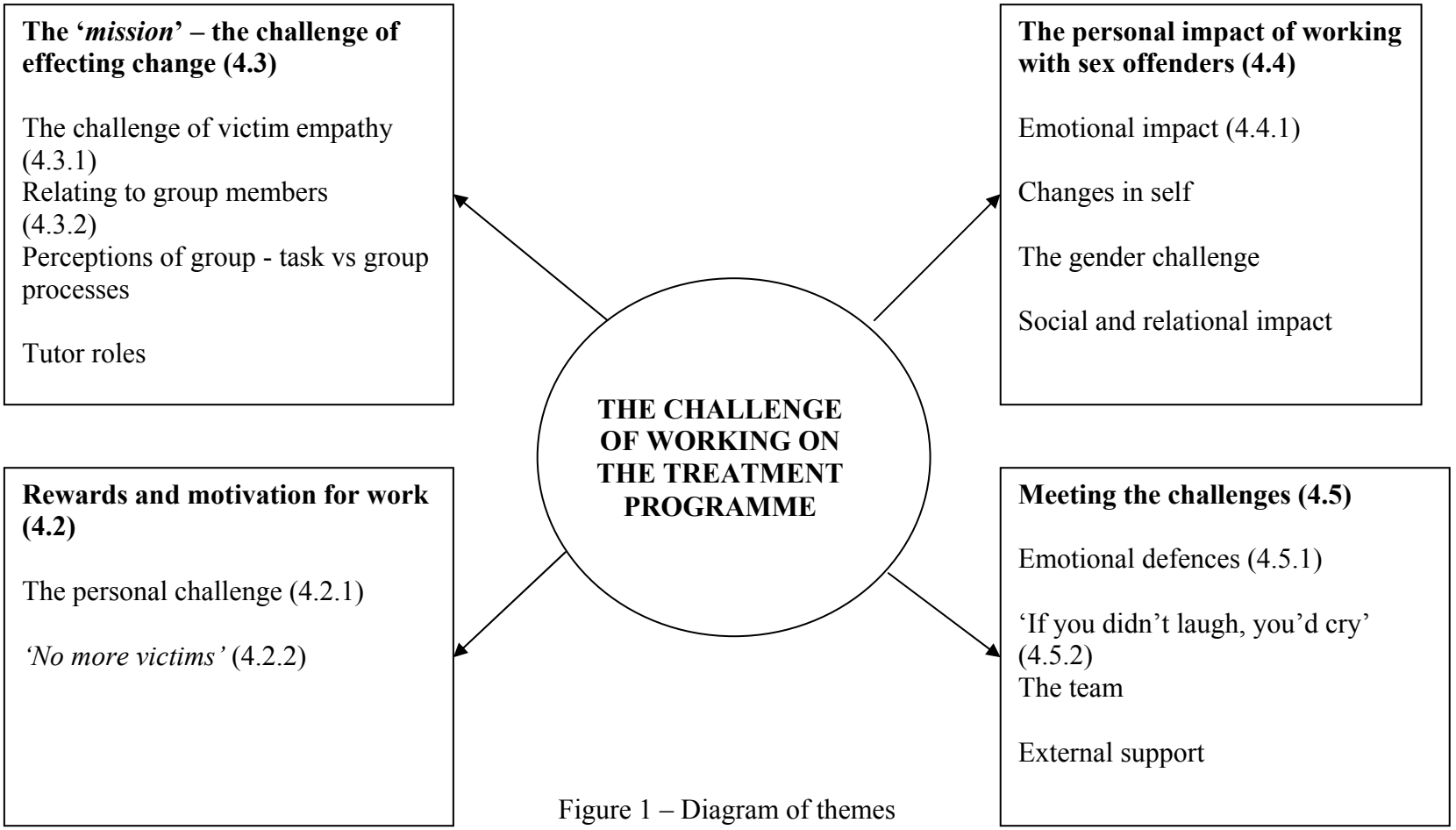

Figure 1 – Diagram of themes

4.2. The rewards and motivation for working on the treatment programme

There were two major themes linked to rewards and motivation identified by the participants in this study.

4.2.1. The personal challenge

There was a common theme amongst the tutors that working on the treatment programme was a challenging but rewarding experience and this reflected in the following quote.

> *'It's just that I really, really do enjoy working here actually. It's been a different experience from all the other experiences that I've had and…although it's a challenge'*
>
> Hazel, lines 979-981

Some of the rewards that were identified were distinct to particular participants which reflected the personal meaning of work.

A number of the participants particularly valued being intellectually challenged and stimulated, and working in the groups appeared to be motivated by either by a personal and/or a professional interest in psychology. Working on the treatment programme was seen to contribute to the development of psychological understanding as in the following extract.

> *''But, I was interested in counselling, and I was always interested in psychology from an early age anyway. And, I thought, okay, this is what I'm going to do, and then, and…I think, the experience I'm getting here…will help me become a better psychologist in the future anyway… it interests me… and I'm a book freak, so I like to learn, you know. Every week's different. You learn something new every week. It's never the same…you grow more, and understand more. Each week it comes through. It just, it doesn't bore me. I hate being bored.'*
>
> Brit, lines 552-570

In the cases of some of the younger participants such as Brit, working on the group appeared to be seen as a stepping stone to a professional career.

A number of the participants identified the reward of seeing group members' change as they progressed through the treatment programme.

> *'I like the progression of the group from where they first come in and they, you know, they're not going to know what's going on, what to do. I like to watch the change in the clients…well, basically, it's work I've put in. And, it's seeing some feedback from the work that I've put in, you know…for example…helping them to…recognise their distortions. And once they start coming out with them without being prompted in any way, you know that you've actually, made some progress with that person, and you get something back from him. That's a reward for me.'*
>
> Gerry, lines 250-264

In the above extract there is a sense that the working on the treatment programme is associated with a sense of personal and professional worth and efficacy. There is also a sense of tutors and group members growing and developing together. These rewards seemed to contrast with working on the units for many of the participants. The following extract reflects the differences in relation to work with clients.

> *'whereas on the unit sometimes, I do still feel a bit like a baby-sitter…because everything is done for the clients, or to the clients.'*
>
> Dave, lines 71-73

The term 'baby-sitter' was used by a number of the participants to characterize their role on the units and seemed to suggest that being on the unit is associated with a lack of opportunity for growth and development for both staff and clients.

The relative rewards of unit and group work are also reflected in the following extract where a participant expresses a wish to work full time on the treatment programme.

> *'I mean, we just admitted today…we'd all say this, that we'd like to do this full time because I think over the years, I think everybody would say that they get a knowledge base, that they grow and… you could actually run with it perhaps. Unfortunately, that isn't the nature of the beast and we have to do it on a half time basis, and that's what we've all got used to'*
>
> Frank, lines 38-40

The above extract also appeared to indicate that working as a tutor on the treatment programmes seemed to be particularly valued by some of the older participants for providing them with a sense of personal and professional worth that might not be available elsewhere. These personal rewards appear to provide these tutors with the motivation to continue in this role on a long term basis.

Although the theme of personal rewards and motivation were quite prominent in the accounts of the participants, there was also a strong theme related to the wider social value of working with offenders on a treatment programme which is discussed in the following section.

4.2.2. *'No more victims'* - The social value of group work

Many of the participants identified that their work on the treatment programme had a role in protecting the public from being the victims of sexual offending. This is illustrated in the following extract:

> *'You make sure there's not a victim. You make sure their lives are going to be better as well. So, that's how you've got to think. That's my core thought and belief in this. And*

we've all got our different ones, we're all going to have our different ones. But, that's mine, make sure there's no more victims. Let's make sure nobody gets hurt'

Frank, lines 329-334

In the above extract there is a strong sense of personal responsibility for the task of preventing further victimisation. Although concern for group members' needs is also expressed, the goal of public protection appears to have primary importance. The following extract illustrates how therapeutic and treatment goals may conflict and how one tutor makes sense of this challenge.

'When a group member grasps a concept that we never thought they'd get, it's like 'brilliant, we did really well today, can't believe we did that.' So that's quite rewarding. Or if, we use the saying, 'they put a nail in their coffin'. And, opened up to the fact that actually they're a bigger risk than they actually presented as. But, now we know, we can deal with it. It's sort of negative, but it's positive in the fact that, now that we're aware, we can deal with it.'

Brit, lines 692-698

The extract illustrates some of the complexities of the experiences of reward and motivation. The rewards of contributing to changes in a group member's understanding seem clear, perhaps because these are concrete and immediate. However, finding out that group members pose a risk of offending appears to be a challenging issue. At first this knowledge is evaluated negatively perhaps because there is a sense that the group and by extension, tutors have in some sense failed to do their job. However, if tutors focus on the goal of public protection then the knowledge of a group member's risk can be re-evaluated in a positive light. For this participant this process may enable her to re-take a pro-active position which maintains her sense of efficacy.

For the participants in this study, working on the sex offender treatment programme appeared to be motivated by a number of personal, professional and social factors. Some of which were shared by the group of tutors, and some of which were distinct to individuals within the team.

4.3. The *'mission'* – the challenge of effecting change

There were several themes within this cluster which related to issues concerning the content and process of therapeutic change in relation to the treatment programme. It is not possible to discuss all of them due to limitations of space. Two have been chosen for detailed discussion because they reflected the complexity of the issues faced by the participants.

4.3.1. The challenge of victim empathy

The theme of victim empathy seemed to be particularly rich and complex in participants accounts. As already discussed, victim protection appeared to be have been identified as an important motivator and treatment goal for many of the tutors. For a number of the participants, victims appeared to have a greater and more personal prominence in their accounts. Here Brit talks about her personal experiences of sexual victimisation:

> *'But, I had an extra reason, because I knew people that had been victims of it, and thought, okay, don't just sit back, do something about it. But, it was only part of it.'*
>
> Brit, lines 559-562

She identifies that personal experience of offending partly motivated her to become involved in the treatment programme. Working on the treatment programme appears to be a way of taking a pro-active position to prevent further victimisation.

For some participants, the group members' apparent lack of empathy for their victims seemed to present an emotional challenge.

'Reading the case notes or speaking to the guys and actually hearing what they're saying and how they've actually offended against a child or how they've managed to manipulate and rape a victim or just hearing those is quite distressing and quite upsetting. But, you know you're there to do a job and, and to help rehabilitate them so there are no more victims, that's important.'

Hazel, lines 447-451

In this account, the tutor identifies her distress and empathy for the victims of group members sexual offending, and appears to manage this distress by focusing on the social value and therapeutic aspects of the treatment programme.

The following extract reflects the differences in participants' experiences. One of the participants reported an idiosyncratic way of dealing with the challenges of empathy for the victims of sexual offending.

'So I deal with it in that way. I never, ever think about the victim. I don't ever think about the victim. I've got/I can't/I suffer empathically when it comes to victims. If I do think about victims, I'm going down. I can't cope with it. I don't even watch adverts on the telly with, you know, little George is crying and nobody ever comes…I can't cope with watching them, it just cracks me up. Don't read about it in the paper. No victim issues at all. I can't deal with. But I can deal with listening to offence accounts because I'm separating that offence account from the actual victim.'

Gerry, lines 147-156

In the above extract the participant appears to indicate that empathising with experiences of victimisation is an emotionally overwhelming experience which he tries to avoid due to his difficulty with containing and managing his distress. He claims that he is able to separate the offence from the victim of the offence. Further detail about this process is provided in the following extract where he talks about his relationship with group members:

'They are people as well as offenders. And I tend to look on it that way… I can see their offending behaviours…and put that to one side and deal with the personality separately. And it doesn't really matter to me, how horrendous the offence is or

> *anything like that. I've got to one side. That's in a different little compartment, if you like. And I deal with that as a separate issue.'*
>
> Gerry, lines 103-109

In this extract the participant reports compartmentalising the offence from the group member. The process appears to reflect some level of a denial of the group members' sexual offending behaviour which appears to serve a number of functions. It appears to enable this tutor to deny the effect the offence has on victims and thus being personally distressed through empathising with the victims of sexual offending. The process of 'splitting off' group members offending behaviour also seems to enable the participant to empathise with group members. The following extract where the same tutor discusses his relationship with a group member reflects some of the potential hazards of such a strategy.

> *'I didn't know exactly at the time that this particular patient was...targeting me in group, singling me out… befriending me, targeting me in that way. A lot of laying heavy stuff on me. And I didn't pick up on it. I didn't notice. I just thought he was being a geezer.'*
>
> Gerry, lines 290-294

The extracts from this participant illustrate the complexity and individual nature of the experience of working on the treatment programme.

Tutors also appeared to face a further challenge in regard to empathy for group members. A number of the participants talked of learning how many of the group members had themselves been victims of abuse or a difficult childhood and highlighted the challenge of making sense of them being both victims and victimisers. For some, awareness of group members' adverse early life experiences helped them make sense of the group members offending. It is possible that learning of the group members' life experiences enabled participants to feel a degree of empathy

for group members. However, feeling empathy for people who have sexually offended may be particularly challenging experience. The complexities of this issue are illustrated by the following extract:

> *'... a lot of sex offenders, have, okay, it's no excuse for what they've done, but have bad lives, bad childhoods. A lot of abuse issues, nine times out of ten. You read people's histories…what an awful life you've had…You can't actually link that to what they've done… But when you look at these offender lives and what conditions and the abuse they suffered with, whether physical, mental, whatever. You actually think how, the hell, have you survived this long, how have you coped with this. Then you start thinking, hang on, why am I worrying about this fella? You know, because, if you think about what he's done, the reason he's here. Why should I be worrying about his childhood and what he's gone through. So you almost switch that off. You think… I can't be bothered, you know, about your crappy childhood…You can't have that connection. You can't feel sorry for them. You can't. If you started to do that, you can't work with them. Because then you'll have an emotional commitment, as it were in the group. You can't do that with sex offenders. As a man, it's very difficult.'*
>
> Eric, lines 539-532

In this case, the tutor describes a process of beginning to feel empathy for group members but then rejecting these feelings and understanding of group members. There appears to be gender related challenge in identifying with group members because of their sex offending.

The issue of empathy was one of the challenges that participants appeared to face in relation to the process of effecting change with group members. Other issues that related to non-offending aspects of group members are discussed in the following section.

4.3.2. Relating to group members

The experience of relating to group members was a major theme for the participants, with many sub-themes. Tutors perceptions of group members appeared to have an important link with the

some of the processes involved in effecting change and so this area has been chosen for discussion.

The group members' learning disability was seen to have an impact on the group process by many of the tutors and this challenged them to adapt the content and delivery of the treatment programme.

> *'You've go to adapt the material a lot more…The teaching style's a bit different from what I was used to and I'm now more confident in actually adapting the material and trying to use more simple language'*
>
> Hazel, lines 383 - 395

Tutors also identified how group members' personal characteristics could affect the dynamics of the group. Here a tutor talks about how in his experience individuals and groups differ, and the need to be responsive to these variables in order to improve the effectiveness of the treatment programme.

> *'That's how every group's different. I've done, part and parcel, at least ten, I suppose, over the years… All the group members, themselves, they're all from different backgrounds, and that makes it interesting… No group has actually been like this, but you might have one that's quite a happy group. You might have a very down group. You might have very young group. You might have a group that's mixed. You see, so every groups going to be different in how it's structured. You might have, say we'll pick six out of nowhere, you might that might have a lot of difficulties in taking in any sort of innovation. You'll have two that probably quite adept at speaking. And then you'll have another two that, perhaps one might be a speech impediment and another one might have a hearing impediment. So, that group would be quite complex. Probably, take a couple of months to actually get geared in right. That's how I look at it anyhow. And, then you finely tune it over that first two blocks, so you get the best out of the group, and how you can deliver the programme best.'*
>
> Frank, lines 196 - 214

In the above extract the tutor describes the complexity of the group process which involves being aware of and responsive to the group members as individuals, and how this can affect the

cohesiveness of the group, and in turn the effectiveness of the intervention.

Participants working on the treatment programme appeared to face a number of challenging issues in relation to the process of effecting change with sex offenders with a learning disability. Some of the challenges related to the personal and emotional challenges of dealing with the issue of group members sexual offending behaviour, while others related to group members needs as individuals, and as a group with a learning disability.

4.4. The personal impact of working with sex offenders

Working with sex offenders also appeared to present participants with a challenge in relation to the personal impact of the work. There were a number of themes under this super-ordinate theme. One in particular has been chosen for further discussion because it was related to staff well-being.

4.4.1. *'It's really intense to an extent'* - the emotional impact of group work

One or two of the participants in this study identified some intense emotional reactions in relation to group members' sexual offending.

> *'Yeah, you go back a bit and your thoughts and feelings/it's like everybody else, you're shocked at first… Its not a nice thing, by any stretch of the imagination.'*
>
> Frank, lines 302- 303

> *'We've got one group member that I feel quite disgusted at…but glad that he's been stopped. So that sort of makes it a bit easier to deal with that.'*
>
> Brit, lines

The above extracts were quite unusual amongst the accounts, generally the emotions directly identified by the participants were milder in intensity. The emotion that most of the participants identified readily was one of frustration.

> *'I mean, feelings of…frustration…if you feel that we haven't been able to… haven't met the session aims with a group member, or if they…just haven't been very co-operative, or expressed a lot of negative attitudes… I think, for me, its usually…I don't know, I don't get… angry very easily, it's sort of…it's more just frustration, really, and sometimes… just feeling, a bit…disillusioned and, just… thinking it's not working, just a bit of like pessimism…'*
>
> Carol, lines 236 - 246

In the above extract there is a sense of hopelessness about the treatment programme making a difference, but also a sense of difficulty exploring feelings within the narrative of this extract and in the interview there were many pauses and 'erms' as the participant seemed to consider what to say. This was not unusual, a number of participants seemed to find it a challenge to describe their emotional experiences. One participant used certain words such as 'difficult, 'weird' and 'intense' throughout his account to identify situations that appeared to be potentially emotionally distressing as in the following extract where he talks about meeting a group member unexpectedly while out shopping with his wife and children:

> *'so, it's very, very weird, it makes you aware. You walk around and watch everybody, you clock everything. It's really intense to an extent. '*
>
> Alan, lines 236-239

In the above extract the participant seems to be describing a state of hyper-arousal and vigilance related to anxiety about his family being exposed to a sexual offender. In the following extract another participant is asked about her negative experiences of the group.

> *'If we have those egg-shell episodes, that's draining, like physically draining…You can be really tired after that. Or if, you've just got a session where they just don't want to talk at all, not interested. Happens very rarely, but that's probably the negative part of it. And*

then…try not to think about it when you go home. I think I'm quite good at that. I just sort of switch off and watch stupid tv programmes so you don't have to think about it, that's quite a good one. Or have a rant before I go home, it's gone.'

Brit, lines 699 - 706

This extract reflects how some tutors may experience and make sense of negative emotions. Emotional tension and anxiety are described in terms of physical phenomenon and metaphor. The participant identifies that her desire not to think about or reflect on her emotional experience. Despite this desire to avoid thinking about the personal impact of work, there was some evidence of awareness of the potential to be emotionally overwhelmed in the following extract from the same participant.

'So, dealing with it, is all about the support you've got around you, so I think you'd go crazy if you had to go home on your own, and then it would be on your brain, and then you'd be back in work and it'd be on your brain. I think you'd go mad, to be fair.'

Brit, lines 729 - 733

One of the tutors described how he came to have a break from working on the treatment programme.

'I had a break for three years. Because I got to the point where, I can't believe this anymore. I just don't need this anymore. This is a complete waste of time. Why am I doing it? And that was me thinking the process was a waste of time. I got to the point where I just couldn't do it anymore. So, I had to have a break.'

Eric, lines 474 - 479

This extract seems to reflect some of the symptoms of burnout, although it is not directly labeled as such by this participant nor does the tutor talk about his emotions in the extract.

One or two of the participants appeared to be more aware of the emotional impact of the work and able to reflect on the personal impact of the work.

> *'You know, I hear, some people might think that when you do this long, you're going to be thinking, oh I've heard it all. The more you hear it, the more it goes in, the more you understand and the more it probably hurts you when you hear it, you know. You hear some quite horrendous things. they can be quite shocking, because when you put them in a safe place in the group, where they can actually say what's happened, you're going to hear some quite horrendous things. And, that you know, it still upsets me, you know. I feel, you know, at the end sometimes, I think, I can walk out and be quite. Exhausted? It's probably not the right word. Shocked…sort of a bit, bit annoyed with the world, and all them sort of things. It's unpleasant sometimes, it's ugly. '*
>
> Frank, lines 315-327

This tutor's openness to his emotional experiences appeared to enable him to be more sensitive to some of the group processes as illustrated in the following extract when he talks about the emotional atmosphere of the group when group members talk about their offences.

> *'Material comes about that's, well…it does get very strong the atmosphere, you know…its not a very nice subject that, when you're talking about abuse. Rape and etc. then… you have to have control of that to make sure that it doesn't go out of control. But, it can be quite, its quite emotional, you know. You might have some group members, themselves might get…quite upset and we have to have control over that, you know.'*
>
> Frank, lines 363 - 377

There appears to an awareness of the emotional atmosphere of the group and of the need to be able to contain these emotions in the above extract.

Although there appears to be evidence of a range of negative emotional experiences in relation to working on the sex offender treatment programme, there is a sense that participants varied in their awareness or wish to explore these issues. The following section expands on some of the ways in which participants dealt with the personal and emotional challenges of work.

4.5. Meeting the challenge

There were a number of themes that came under this super-ordinate theme which reflected the way in which participants dealt with the challenge of working on the treatment programme.

4.5.1. Feelings, what feelings? – emotional defences

The theme of emotional defences emerged from the accounts of a number of participants in relation to how they dealt with their emotional reactions or how their emotions changed over time.

In the following extract Eric describes how feelings change with continued exposure and claims that tutors are generally resistant to being shocked by accounts of sexual offending.

> *'The crimes they commit, would shock most people outside these type of services. Because they'd see straight away what they'd done. I wouldn't say you become hardened to it, but… it takes a lot to shock… because you've heard that many offence accounts and stuff that these guys have done, that it almost becomes a pattern…So the actual offence drops back in the background.'*
>
> Eric, lines 205-213

There is a sense of emotional distance and normalizing of the offences of group members, which in the above case is claimed to be a result of continued exposure and habituation over time. The following offers a slightly different perspective on this process.

> *'Whereas, I'm just looking for them half a dozen key points, and as soon as he touches on any of them, that's it, my consciousness comes back and I focus again. Whereas a lot of it, I just let go over my head. So I'm not actively listening. I'm listening enough to challenge, to question, to know, you know keep the clock going and all the rest of it. But, most of it, I'll*

just let go over my head. I don't absorb it, I don't listen to it. It's, you know, because I know what my mission is.'

Dave, lines 729-737

In this extract there seems to be an active process of emotional dissociation and in this case it is identified as having a function in enabling Dave to focus on his 'mission' for the group. However, this process also appears to have a defensive function in protecting tutors from being emotionally affected by listening to accounts of sexual offences, which is illustrated in the following extract when this defence is overcome.

'I remember being angry once. And that threw me, because I was thinking, hang on, I don't do emotions. Normally, that doesn't bother me, I've heard it that many times…But…I was doing an active account with a guy, he made a comment, regarding his victim, and I was drawing it up at the time…that's even worse, because you're actually drawing pictures of what these guys have done. So that way you're feeling it, and thinking about what they're telling you… And this guy just made a throw-away comment. And it just hit me. I thought how callous, how, totally. You just don't care, do you? And, I had to call a time-out and I was out for about five minutes. I was pacing up and down thinking, if I met this bloke in a pub (laughs). It's the one and only time it ever happened. And, then I'm thinking. Why did you get like that?'

Eric, lines 568-590

In this case the participant seems to question himself for having these emotions in a group setting while relating that in other circumstances they would be more acceptable. In many of the accounts there appeared to be a need for tutors to minimise the negative emotions that they experienced. For instance, Brit talking about her reaction to a group members' behaviour labels her emotion as annoyance but her reactions seem to reflect a much more intense feeling of anger:

'You know, capable of controlling it… that just grates on me a bit. It's like niggling thinking, like you know if you see a bit of fluff up there you can't get to, really annoying. But, other than that, it's only little things, silly little things that'll grate, and then I'll just come out of the session, swear a lot and say 'I can't believe he effing did this'

Brit, lines 749 - 756

In both the previous extracts there seems to be a sense that negative emotional reactions are unacceptable both within the context of the group and on a personal level. In the following extract, there is a more emphatic denial of the emotional and personal impact of group work:

> *'Personally, I enjoy the work. I don't find it stressful. I don't find it's a strain. When we first started tutoring, and trained as tutors, there was a big emphasis on support and counselling… you learn things, you won't be able to deal with, you'll need a counselor…and all that kind of stuff. And, I haven't had any of that. I think I accessed a counsellor once, because I was told to, and, because they was losing counselling services if we didn't …I ended up listening to the counsellor talking about the husband. So, I thought …there was not much point in that. I don't, I don't...I don't feel I get stressed and strained by it. I obviously do, because they laid me off for a while. When a patient was giving me a hard time and I couldn't recognise it. But, they picked up on it and held me out of the group for a while.'*
>
> Gerry, lines 275-286

In the above extract the denial is asserted, elaborated on and repeated a number of times before the participant finally acknowledges that he is affected by the work. He identifies that he has difficulty in recognising the emotional impact on himself and this is reflected in the narrative of the above account. In this case denial of the emotional impact appears to help this tutor to deny the personal impact of working on the treatment programme.

The experience of emotional vulnerability may be one that is difficult to tolerate for some participants. This is illustrated in the following in extract, where the same participant describes de-briefing after group:

> *'just generally light hearted banter. And it helps you get rid of all that sort of garbage that you might otherwise carry about.'*
>
> Gerry, lines 365-369

The language he uses conveys a sense that emotional experiences are a worthless but potentially toxic burden. In the above extract he identifies the role of humour in processing

emotional experiences. This mechanism was also identified by many of the other participants along with a number of other functions for humour.

4.5.2. '*If you didn't laugh, you'd cry'* – the many uses of humour

The theme of humour appeared to be a rich source of meaning in this study. An example of the richness of this theme emerges in this short extract from Eric:

> *'Because there are a lot of funny parts in groups. Where, the guys will laugh, the tutors will laugh. And, so you can focus on those. And, that's where you get rid of that pent up sort of frustration, whatever.'*
>
> Eric, lines 438-441

Here the participant makes the claim that there are less serious aspects to working in the treatment group, and describes how tutors and group members share this experience of the group. He also identifies how humour can be used to release emotional tension. There also appears to be an allusion to another function which humour may serve – as a strategy for maintaining a positive attitude towards the group and group members. These sub-themes are illustrated more clearly in the following extract from Hazel:

> *'You've go to see the funny side of things that have been said, just to keep it going. Otherwise, it gets too serious all the time. it's just to have a laugh, and you know, I try and to have a laughing and joking style with the clients as well, my interaction with the clients, and try make jokey comments, not about sex offence or anything, but just generally about the how the week's been and you know. And just have a laugh with the clients as well, makes for a more relaxed atmosphere.'*
>
> Hazel, lines 806-812

In the above extract humour is seen to play a role in creating a therapeutic group climate for both tutors and group members. Participants also spoke of the use of humour outside of the group when they met together as a team of tutors.

> *'...we get together, we de-brief in our own special way…laughing, joking…I think they warned me before I became a tutor that your sense of humour will change, and I was like, no, no, no, I'll still be me, I'll still be me, and it changes. You get quite a sick sense of humour because I think/like saying the word masturbate, it's just like saying the word apple, you know. You get quite a sick sense of humour when you come to think about that. Because you all know exactly what you're going through, and exactly what the work entails, you're all on the same level/that it's, it's just fun to be around them, because you're in your own little circle, and no-one else…understands your sense of humour or anything.'.*
>
> Brit, lines 578-590

Brit talks of the 'special' humour that the tutors share. In this extract there is a sense of how the change in her sense of humour reflects some level of change in her identity, which was initially denied but is now accepted and valued. Her use of the word 'sick' to characterise the tutors' sense of humour reflects how the sense of humour might be perceived as being socially unacceptable in other contexts. She also describes the process whereby tutors become normalised to topics that may be taboos in other social environments. Humour is also seen to represent a shared sense of identity for the tutors, in some ways embodying the experiences and challenges they face as a group.

Although participants mentioned the use of supervision, humour and peer support appeared to be most important and valued means of meeting the emotional challenges of working on the treatment programme.

4.6. Interaction between themes

There were links within and across super-ordinate themes which have been discussed in the previous sections which reflected the complexity of the experience of working on the treatment programme. While carrying out the analysis there also seemed to be links between the super-ordinate themes which are represented diagrammatically in Figure 2. Working on the treatment programme seemed to present the challenge of balancing the rewards and motivation (theme 4.2) with the personal impact of work (theme 4.4). Working on the treatment programme contributed to these areas in different ways for individual participants. The resources that individual have to meet the challenge (theme 4.5) were also seen to contribute to being able to maintain a balance and effect change (4.3). The broader the foundation of resources an individual has to manage this challenge, the easier it may be to balance personal needs and emotional well-being, and to effect and sustain therapeutic change in the group.

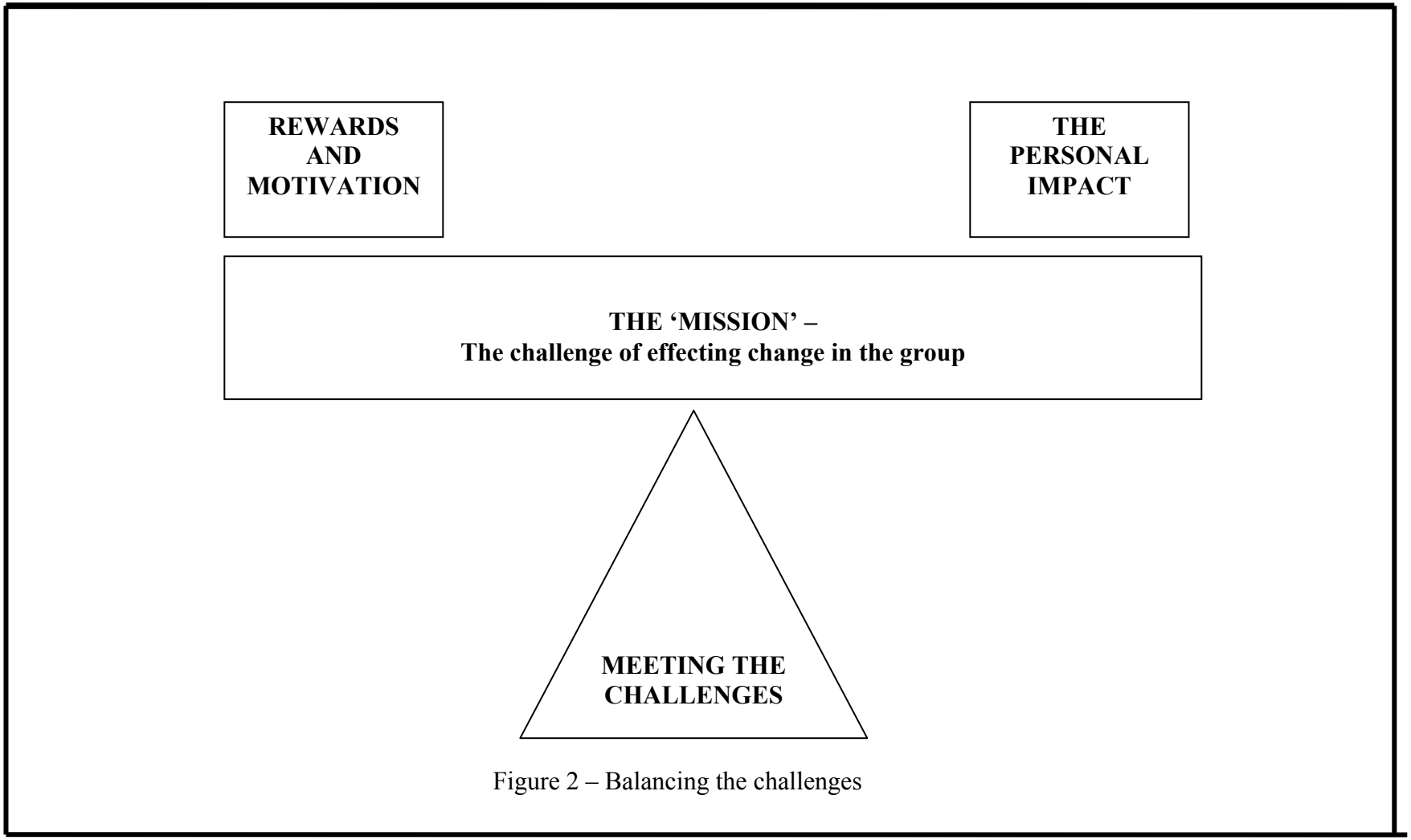

Figure 2 – Balancing the challenges

5. Discussion

5.1 Conclusions

The aims of this study were to explore the experiences of staff working with sex offenders with a learning disability in the context of a treatment programme. The use of IPA has given a subjective, interpretive and phenomenological perspective on participants' experience. The results suggest that the experience is complex with both shared and individual aspects a feature of the experience of being a tutor on the treatment programme.

The results of this study suggest that although working with sex offenders with a learning disability can be characterised as a challenging experience, this challenge does not necessarily have a negative connotation. In the case of many of the participants in this study, the challenge was actually sought after and valued. Some of the rewards and motivation identified in this study were similar to those identified by therapists in a study by Kadamabi and Trustcott (2006) even though there were differences in treatment context and professional background. Both groups of participants appeared to share an interest in protecting victims, enjoying the process of therapy, the professional rewards, and seeing change in offenders. There were individual differences between participants in relation to rewards and motivation for working on a treatment programme with sex offenders. Work had personal meaning in relation to an individual's personal experiences, interests and professional development. The findings of this study suggest that these rewarding and motivating factors may have an important role in counterbalancing the stresses of working in this area. Other studies with different staff groups working in potentially stressful

clinical situations also suggest that such factors may have a more general role in moderating psychological distress. A qualitative study of palliative care nurses also found that personal meaning and a sense of purpose were among the factors that seemed to have a role in maintaining staff resilience and well-being (Ablett &Jones, 2007).

There appeared to be some context specific issues in relation to the issue of professional development for the participants in this study. Although working on the treatment programme offered many of the participants some opportunity for professional development relative to their health care assistant role, the scope for professional status and further development was also quite limited. The consequences of this appeared to be degree of frustration for some of the staff working on the treatment programme, and the likelihood that a number would leave due to the lack of opportunity for career progress or professional development.

The therapeutic and psychological aspects of the work seemed to be an important motivating force for some, but not all, of the participants in this study. A number of the participants appeared to consider the role of process issues in relation to the effectiveness of the treatment programme. Participants identified a number of factors such as group cohesiveness, a therapeutic climate, therapist and offender characteristics as being an important part of the group treatment for learning disabled sex offenders. These results reflect some of the research evidence for the role of group processes in treatment outcome with mainstream offenders (Beech & Hamilton-Giachritsis, 2005). There is emerging research to suggest that therapists play a vital role in sex offender treatment and are not simply 'technicians'(Drapeau, 2005). The therapeutic aspect of sex offender treatment appeared to pose a number of challenges both for participants and the

treatment programme in which the study took place. There appeared to be some tension with this aspect of the treatment programme and the manualised approach of the treatment programme. Mann (2004) in her review of innovations in sex offender treatment highlighted the fact that relying on a manual based approach limited the role of therapists. However, one of the difficulties of expanding the role of the therapists in sex offender treatment programmes may arise where staff running the groups lack training or experience of therapeutic work, as was the case for many of the participants in this study. The treatment programme under study appeared to address the issue of therapeutic competence by having a mix of experience levels in the tutor team and through the existence of regular tutor team meetings where there appeared to be both formal and informal supervision around group related issues. The effectiveness of these strategies rely on experienced tutors being more therapeutically minded than their inexperienced peers, and supervision addressing process issues. There was some evidence from the results of this study that there were limitations to the effectiveness of these strategies, particularly in relation to the link between experience and therapeutic competence, and the use of supervision.

As a group, the participants seemed relatively dismissive of the role of formal supervision in supporting their work on the treatment programme. Participants in this study preferred the more informal style of peer supervision both as a way of exploring difficulties in group and dealing with the emotional stresses of the work. According to Linton and Hedstrom (2006) the finding that group supervisees highly value and sometimes prefer feedback from peers to that of supervisors, has been consistently found by research looking at group supervision. Their qualitative study of counsellor trainees also found that informal contact outside of group supervision was also valued and had an impact on how supervisees fedback to each other within

the formal supervision setting. For the participants in this study, their team loyalty appeared to be particularly strong and important and may have proved an obstacle to providing each other with constructive feedback. Linton and Hedstrom (2006) highlight the importance of group supervisors modelling and creating an environment where feedback is both supportive and constructive.

The preference for informal support mechanisms in this study was reflected in the participants' use of humour as means of processing some of the stresses of the work. Although humour appeared to be a useful mechanism for helping participants cope with the challenges of working on the treatment programme, there also appeared to be some negative consequences to an over-reliance on it as a means of addressing difficult issues. At times the use of humour was used to defend individuals and the tutor team as a whole from exploring the personal and emotional impact of work, with negative consequences for staff well-being and the process of therapy. Humour was one of the many defences participants used to maintain a sense of emotional and personal invulnerability in the face of the challenges of sex offender work. Although some of the participants in this study identified a range of negative emotions associated with working on a sex offender treatment programme, generally these tended to emerge indirectly from the accounts. There was evidence to suggest that tutors working on the treatment programmes experienced strong emotional responses as well as what appeared to be more enduring emotional difficulties such as stress and anxiety. Some tutors considered leaving or had stopped working as tutors for a period of time. The negative impact appeared to be associated with experiences of working on a sex offender treatment programme rather than working on the units or in relation to group members' learning disability. These negative aspects of sex offender treatment are similar to

those reported by a number of other studies (Farrenkopf, 1992). Even studies where therapists report enjoying their work (Scheela, 2001), they also report that working on sex offender treatment programmes is associated a degree of emotional stress. Some of the most experienced tutors in this study seemed to have quite different experiences of work on the sex offender treatment programme which suggests that personal characteristics may have a role in mediating individual responses to work with sex offenders. The results also indicate that longer experience of work on the treatment programme is not necessarily associated with greater awareness of the impact of personal and emotional issues on the process of therapy.

The complexity of the experience of working on the sex offender treatment programme was reflected by the case of two of the male participants in this study who were highly experienced in terms of years of working on the treatment programme, and who both appeared to be avoidant of emotional experiences, and yet held almost opposite positions on the issue of empathy for group members. Other individuals appeared to face different challenges in relation to empathising with group members, due to the emotional experience of empathising with the victims of sexual offenders. Kearns (1995) has commented on the victim victimiser paradox that therapists face in working with sex offenders and highlighted the importance of self- reflection to make sense of this issue. Peaslee (1995) recommends that therapists working with sex offenders take a neutral and dualistic view, which enables them to empathise with offenders' experiences of abuse, but also allows offenders to take responsibility for their behaviour. The variety of responses around the issue of empathy in this study, appear to indicate that personal characteristics play an important role in relation to this issue, and have an impact both on staff emotional responses and on group processes. This is a particularly pertinent issue in sex offender treatment as the research

suggests that therapist empathy for group members may contribute to positive changes in offender denial and minimisation, even within the context of manualised treatment approaches (Marshall, 2005). A study by Polson and McCullom (1995) suggests that therapist empathy for offenders, enables offenders to empathise with themselves, and then their victims. From the responses of participants it appears that the issue and challenge of empathy in sex offender treatment is an area that needs addressing.

The therapeutic aspects of sex offender treatment appear to be particularly important aspect of the group experience for sex offenders. A study with mainstream offenders found that they rated catharsis and self-understanding as the two most important aspects of treatment (Reimer & Mathieu, 2006). Although there were some references to group members' emotions and self-understanding within this study, these themes were given less prominence in the accounts of participants in this study than other aspects of group work. This may reflect both the treatment focus of the programme and many of the participants' relative lack of comfort with exploring these issues for themselves. There appeared to be some evidence that tutors who were more aware of and accepting of their own emotional experiences, appeared to be more aware of and able to contain group members emotions, and maintain a therapeutic climate and appropriate therapeutic boundaries with group members. There may well be parallels with the process of empathy for offenders, whereby therapists who have empathy for their own experience are able to have empathy for clients. Whereas therapists who avoid, deny, or are unable to contain their own emotional experiences, use the same strategies in dealing with clients emotional experiences in therapy. A number of people have commented on the importance of therapist awareness of their own emotional response in relation to transference and counter-transference issues, which may be

particularly intense in therapeutic work with sex offenders (Mitchell & Melikian, 1995; Scheela, 2001; Tyagi, 2006). The results of this study suggest that awareness, understanding and containment of emotional responses was a particularly challenging area for the tutors in this study and had an impact on both their well-being, and their ability to effect therapeutic change on the treatment programme. Overall, there appeared to be evidence that some participants were more therapeutically minded than others, and that therapeutic competence appeared to be a personal characteristic rather than simply associated with years of experience on the treatment programme.

It was apparent from the results of this study that the issue of participants' emotional reactions was generally not considered to be an important aspect of clinical work and the general lack of understanding of the relevance of these issues may reflect both a group and systemic lack of appreciation of the role of such process issues in sex offender treatment. Clinicians working with offenders typically face a number of problematic emotional and attachment challenges due to the nature of the client group, which can have an impact on the process of clinical work (Mothersole, 2000). According to Mothersole clinical supervision in relation to such issues is particularly important in forensic work, as it may be particularly difficult even for clinically experienced individuals to make sense of their responses to offenders without external support. He identifies that although the issue of clinical supervision may be challenging for individuals and organisations, it is nevertheless essential because forensic work not only has an impact on clinicians and offenders, but on wider society. The results of this study suggest that difficulties with clinical supervision may arise in cases where clinical supervision is not particularly valued, utilised, or focuses solely on the content over the process of clinical work.

Although participants mentioned the role of group members' learning disability, and this was discussed in relation to effecting change in the group, this seemed to take far less prominence in the accounts than the role of group members' sexual offending. There may be a number of reasons for this. Most of the participants also worked on the units with clients with a learning disability who had not sexually offended, and so may not have seen group members' learning disability as being an important factor in their offending behaviour. Participants may have also been influenced by the view that sex offenders will often try to excuse their offending behaviour and not take responsibility for their actions, and so considering the role of group members' learning disability may be perceived as colluding with sex offenders 'cognitive distortions'. In addition, the main goal and focus of the treatment programme is on the sexual offending aspect of group members' identity, which in turn would focus participants on this issue rather than on the role of group members' learning disability. However, the relative invisibility of individual's learning disability has also been commented on in relation to non-offender therapy (Whitehouse et al., 2006) which suggests that therapists may generally have difficulty exploring the meaning of this issue in the lives of people with a learning disability.

5.2 Reflection on researcher position

By its very nature the subjective experience of participants is not directly available but is constructed and conveyed by the participants through the use of language and was then construed by the researcher through the method of interpretive analysis. In terms of this research I had quite a unique position in terms of my relationship with the participants and the service in which the research was carried out. I had shared some of the roles and experiences of the participants in this

study due to my prior work experiences. In the initial stages of the research I had a degree of identification with the participants, and certainly a sense of emotional attachment to them as a group of staff group, which I believe may have been a factor in the willingness of the participants to take part in the research. However, when I returned to the service to carry out the research I was there in a different professional role. I was aware that the change in my professional role may have had some impact on the research process both for myself and the participants, and indeed one participant joked that I had 'gone over to the dark side'. Throughout the time that I had been involved in the service there had been a debate about the role of 'unqualified' staff delivering psychological interventions, and this is a debate that is occurring within the wider health service. I was aware that initially I was quite sympathetic to the delivery of therapy by non-psychology staff groups due to my own previous experiences, and this may have influenced my initial interpretations of the data. Self reflection and discussion with my supervisors and psychology colleagues also seemed to suggest that I was generally more sympathetic in my interpretation than they may have been. As a result of these discussions I was aware of becoming increasingly critical in some of the conclusions that I drew from the data. However, I am also aware that part of the process of being on a clinical psychology trainee involves a process of socialisation to the profession, and this may also have been an influence upon the conclusions that have been drawn. In the end, I have endeavoured to provide an account that balances some of the challenging experiences faced by the participants in this study, with a critical and hopefully constructive interpretation from my own subjective perspective.

5.3 Strengths and limitations of study

The research method chosen for this study required a degree of interpretation by the researcher which inevitably introduces a level of subjective bias into the research process. What this study has endeavoured to do is to produce transparency about where claims are made participants, and where and how the researcher is offering her interpretation of participants' experiences. The verbatim extracts and details of the analysis process are provided to give the reader the opportunity to examine the evidence for claims made in this report.

This study was carried out with a small purposive sample of participants working within a particular context. Some of the findings of this study may be related to the context within which this study was carried out which may limit the transferability of these results. The discussion of the findings has considered the role of the context in which this research was carried and identified which issues may be context dependent and which have wider applicability.

The use of IPA methods has allowed the identification of issues that are common to participants and also allowed an exploration of how individual experiences may also differ and the psychological meaning both of shared and idiographic accounts. This method has been particularly useful at highlighting and exploring the complexity of participants' experiences. The use of qualitative methods has greater naturalistic validity as it is closer to the phenomena being studied and the use of exploratory methods allowed themes to emerge that were not directly probed by the interview schedule.

One of the limitations of this study was that the credibility of the claims were not checked with the participants. Given some of the interpretations that have been made, it is debatable whether some participants would have agreed with the conclusions that have been reached and so it is questionable how useful this would have been as a method of validating the results of the study.

5.4 Future research

This was an exploratory study in the area of sex offender treatment with service users with a learning disability. The results indicated that there were a number of important features of this experience in relation to staff well-being and the process of treatment. These are areas for further research in different contexts, using different methods, and participant samples. The participants in this study were tutors on the treatment programme and although they offered a perspective on the treatment programme it would also be useful to get group members perspective on the experience. It would also be interesting to get the perspective of staff who did not work on the treatment programmes as they are important part of group members' lives.

5.5 Clinical implications

The results suggest that therapists have an important role to play in the process of sex offender treatment with service users with a learning disability and that treatment approaches should have greater scope for the role of the therapist in the treatment programme.

That therapists working in sex offender treatment would benefit from training, understanding and experience in using therapeutic approaches in sex offender treatment and particularly of the factors which contribute to change.

The results suggest that self-reflection and supervision have an important role in therapist well-being and the process of therapeutic change. In some contexts, where staff groups are unfamiliar with the role of clinical supervision, teams may need to be socialised in to the use and role of supervision in therapeutic work. Supervision should also explore the role of process issues and particularly therapists' emotional responses to group members.

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APPENDIX 1

[Not available in the digital copy of this thesis]

Appendix 2

Participant Information Sheet (PIS) **Version 2Feb08**

Working with learning disabled sex offenders: a qualitative study of the experiences of staff working on a treatment programme.

You are being invited to participate in a research study about the above topic. This information sheet will provide you with some details about the research and what will be involved if you decide to take part.

.

What is the purpose of the study?

The purpose of the study is to understand more about the experiences of staff who work with clients who have a learning disability and who have also sexually offended. The researcher would like to find out more about your experiences of working with this client group. The study is being undertaken as part of an academic qualification.

Why have I been chosen?

You have been chosen to participate in this study because you work with learning disabled sex offenders on a treatment programme.

Do I have to take part?

You are under no obligation to take part in this study. You will be given this information sheet to keep and at least 24 hours to consider whether you would like to take part in the study. You will then be asked to give your written consent to participation in the research. You are free to withdraw from the study without giving any reason.

What will happen to me if I take part?

If you decide to take part in the study, you will be contacted to arrange an interview.

What do I have to do?

The study involves filling out a brief background questionnaire and participating in an interview, which will generally last about an hour. During the interview, you will be asked a number of questions about your experiences. There are no right or wrong answers.

The interview will take place in a private room at [place], within working hours. The interview will be recorded with an audio digital recorder and the interviewer will also take written notes.

After the interview, the recording of the session will be transcribed. After the interview you will have a up to a week to withdraw your data from the study. A summary of the research will be sent to you once the research is completed. If you wish to have a copy of the full research report, this will be sent at your request.

What are the possible disadvantages and risks of taking part?

It not anticipated that there will be any disadvantages or risks to taking part in the research. However, there is a possibility that you may become emotionally distressed talking about your experiences. In the

first instance, you will be encouraged to seek the support of your clinical supervisor or Su Thrift (Consultant Forensic Psychologist at [place]) who has agreed to be available for support. Alternatively, you will also be able to talk the chief investigator (Daljit Sandhu – see below for contact details) or to John Rose (see below for contact details), who is a psychologist with experience of working with this client group, if you so wish to discuss any further issues.

Please note that if you were to disclose any instances of malpractice, the interviewer would have to report this to the appropriate authorities.

What are the possible benefits of taking part?

Taking part in the research will give you an opportunity to discuss your experiences and for these to be considered by other people. You will not be financially reimbursed for taking part in this study.

What happens when the research study stops?

If the research were to stop while in course, participants will be contacted and informed of this by the researcher. A report will be written once the research is finished.

What if there is a problem?

If there are any problems, or you have any concerns about the research, you should initially contact the researcher who will try to answer your questions (see contact details below). If your concerns are not answered satisfactorily and you wish to complain, you can do this through the NHS Complaints Procedure. If you were to lose capacity during the course of the research, your data will be destroyed and will not be included in the final study.

Will my taking part in the study be kept confidential?

All information collected during the course of the research will be kept in anonymised format. All identifiable information will be removed from both written and computer held data and from the final report. Verbatim quotes will be used in the final report, but again these will be anonymised. The only people who will see unedited data will be members of the research team. All material will be destroyed five years after the research is completed.

Contact Details:

If you have any further questions about the study, please contact:

Daljit Sandhu *(Principal Investigator)*
Department of Clinical Psychology,
University of Birmingham
Birmingham
[Tel:] [e-mail:]

John Rose *(Research supervisor)*
Department of Clinical Psychology
University of Birmingham
Birmingham
[Tel:]

Appendix 3 –

CONSENT FORM Version 2Feb08

Title of Project: *Working with learning disabled sex offenders: a qualitative study of the experiences of staff working on a treatment programme.*

Name of researcher: *Daljit Sandhu*

Please tick box

I confirm that I have read the Participant Information Sheet for the above study dated Feb08 (Version 2) and have had the opportunity to consider the Information, to ask questions about the research and have had these answered satisfactorily.	☐
I confirm that my participation in the research is voluntary and that I understand that I am free to withdraw, without giving a reason and without my legal rights being affected.	☐
I agree to the interview being tape recorded and direct quotes used	☐
I agree to take part in the above study	☐

---	---	---
Name of participant	Signature	Date
---	---	---
Name of person taking consent	Signature	Date

Appendix 4 – Demographic information form

BACKGROUND INFORMATION QUESTIONNAIRE Version1Nov07

1. Your current job title:…….

2. How long have you been in your current job?

   Less than a year ☐ between 1 – 2 years ☐

   3 – 5 years ☐ 5 – 10 years ☐ more than 10 years ☐

3. How long have you worked with clients with a learning disability?

   Less than a year ☐ between 1 – 2 years ☐

   3 – 5 years ☐ 5 – 10 years ☐ more than 10 years ☐

4. How long have you worked on the treatment programme?

   Less than a year ☐ between 1 – 2 years ☐

   3 – 5 years ☐ 5 – 10 years ☐ more than 10 years ☐

5. Age range: 20 -30 ☐ 30 – 40 ☐ 40 – 50 ☐ 50 + ☐

6. Are you? Male ☐ Female ☐

7. Are you? Living on own ☐ Living with partner/married ☐

8. Do you have any have any dependent children living with you?

   Yes ☐ No ☐

Appendix 5 – Interview schedule

Tell me about a typical week at work.

I want to focus on your work as a tutor on the treatment programme, can you tell me more about different aspects of your role?
(prompt)

- what is it like in a session?
- what do you do afterwards?

Tell me about your thoughts and feelings about sexual offending by people with a learning disability?
(prompt)

- what were your thoughts and feelings before you became involved with this work
- what are your thoughts and feelings now?
- What have you noticed about the thoughts and feelings you had before and now?

I'd like to ask you about your interest in this work
(prompt)

- how did you come to this work?
- What keeps you doing this work?
- How long do you see yourself doing this work?
- What would stop you doing this work?

Tell me what it's like working with this client group
(prompt)

- How is it for you personally?
- What does doing this work mean to you?
- Can you tell me about positive and negative aspects of the work?
- (if negative aspects identified – ask 'How do deal with the negative aspects of the work?')
- What have you noticed over the time you have been doing this work?
- Have you noticed any differences in yourself since doing this work? (if so – how are things different for you?)
- Have others noticed any differences? (if so – what have they noticed?)
- How do others view the work you do? (prompt for family, friends, colleagues, managers)

Is there anything else that you want to tell me, that I haven't asked you about?

Appendix 6 – Stage 1 and 2 of analysis

Stage 1: Participants claims and concerns	Transcript from Brit: Lines 414 - 478	**Stage 2:** Emerging themes
Prompt for thoughts and feelings about sexual offending Claims not to have thought about sexual offending Before becoming tutor ensured knew of offenders risks Knowledge important for managing risk But too much understanding may be stressful and and affect life outside clinical understanding not too deep an understanding about why easier to deal with sex offenders on the units as they are detained Being opposed to sexual offending is a normal attitude to have	*I: for instance, what were your thoughts and feelings before you came to be a tutor?* P: before I came to be a tutor..em, I didn't really think a lot about it to be fair. Erm, obviously I worked on the units before I became a tutor, so I was aware, I always read the file notes, because I think, knowledge is the utmost, if you know..their target group, if you know there behaviour pattern, you can watch out for it, and..I took it as face value and tried not to think too deep about it because then, god knows, I'd be paranoid about it constantly, couldn't go to the shops without looking out..and tried not to think in too much depth about it, and sort of took it on the clinical side, okay, so why did this happen? Erm, thank god they're in here, it's more the ones that aren't here that I'd be worried about, to be fair. So I'm not too worried about these guys that I work with, because I know where they are 24 hours a day. It's more the ones that aren't caught that are the issue. And, er (laughs) obviously, I don't agree with it,	Relating to sex offenders Knowledge as a coping strategy Avoidance of emotional response? Psychological understanding Risk and vulnerability Attitude to sexual offending

Disgusted with one group member Angry about sexual offending Knowledge and experience with offenders helps to keep child safe Feeling angry not particularly helpful in stopping sexual offending Need to be vigilant and reduce opportunities a way of dealing with threat Prompt re. thoughts about offending Personal knowledge of victims of sexual offending Interest in understanding behaviour	obviously, er, some of them, we've got one group member that's..I feel quite disgusted at, erm..but glad that he's been stopped so that sort of makes it a bit easier to deal with that..quite angry at what they do..quite angry at what they do, but also I think that I'm better prepared outside of work, because I've got a daughter as well, so I'm better prepared because I know what not to let happen, sort of thing. I feel for those people that think, argh, the bastards and you know, okay but, you can get angry with them, by all means, get angry with them, but that's not going to stop them doing it,(voice quietens) you know, just be careful, don't let them have the opportunity and that,(voice quitens and emotive) that way they can't ..(indistinct) and people like that, so.. *I: was there anything else like about your thoughts about why they might of offended, before you came to this work?* P: erm, before I came to this work..em, obviously I knew in the newspapers, erm, I'd known people that'd, erm, been victims of it any way. Erm, and I was always interested in why people do things, but also since I was young. Why do they do that? And, I couldn't work it out as	Emotional responses - to client - to sexual offending Personal vulnerability Pro-active approach Attitude to emotions Approach to sexual offending Victim experience Psychological interest

Lacked knowledge previously	well as I do know, I didn't have the knowledge, I was only young any way, I started here when I was eighteen, so I was quite young, and it didn't really come in to my head that, erm/I'd always think, okay, read up on it or something, find out/I didn't really know why, I just knew that, okay, there's something wrong, they obviously don't believe in what everybody else believes in, and they need some sort of help, you know, quite sick basically, what I thought beforehand. But, I was always, I was never like, they're just evil, evil, evil..what they do is evil definitely, but..I was always wondering, why, not sort of angry, I was angry at what they'd done, but not..I wasn't sort of pre-occupied with, so if I saw one I'd batter em, sort of thing, which I've heard loads of my friends say, how do you do that, you know, I always thought, if I find out why, then I'll know sort of thing, so, more sort of (voice quietens) pro-active approach to it. Which is how I ended up here, basically (half laugh). *I: so what are your thoughts about it now, why people commit offences?* P: erm..millions and millions of different reasons, and I don't think we've found	Work experience
Gaining knowledge a way of understanding		Psychological understanding
Offenders socially abnormal		
Offence bad but not person		Attitude to sexual offending and offenders
Denies anger because doesn't have feelings of aggression towards offenders		Emotional response
Responses of friends angry and difficulty understanding work		Attitude of friends
Understanding and being a tutor a pro-active approach to sexual offending		Pro-active approach Motivation
Prompt: attributions about sexual offending		
Lot of reasons for sexual offending		Offending attributions

Can still be shocked by sexual offending Can categorise sexual offenders Role of family background Psychological factors Factors relating to learning disability Lack of understanding contributes but not a cause of offending because know behaviour is wrong	every single one yet. Erm, there's always going to be one that shocks (voice quietens), always. But I think, maybe you can, sort of, place things in categories, erm, you've got your typical rapists, you've got your typical child abuser, erm, which in a lot of it, running in families, learnt behaviours, that's accepted at home, so that , why would they know any different? erm, you've got the inadequacy issues..especially with learning disabilities..the lack of social skills, as well comes into part, where, they don't actually, have the capacity to understand how to behave appropriately, in certain situations. It doesn't give them the excuse, as they know what there are doing is wrong and hide it, yeah.	Emotional response Perception of offenders Attributions about sexual offending Role of learning disability

Appendix 7 – Example of stage 3 of analysis for Brit

(SUPERORDINATE THEME)			
(theme)	(sub-theme)	(*extract)*	*(*page and line number)
PERCEPTIONS OF GROUP			
relationship to unit			
	- different to and seperate from unit	*it's completely black and white. Group's group*	
	- communication with	*if communication breaks down*	10:311-13
group tasks			
	- educating clients	*check understanding...introduce oncept*	2:58-9
	- identifying risk issues	*going through any risks*	1:28
	- following manual	*via how the manual's told us*	2:52
	- giving clients guidance	*discussions on what they could do better*	2:44
	- giving client's positive reinforcement	*praise them*	2:45
	- planning with PDU managers	*planning on Friday at clinical metting*	3:75
	- enhancing coping strategies	*discussing coping strategies*	*2:32*

group processes		
- being responsive to clients	*depends what mood they're in*	4:97
- impact of unit issues	*outside issues can affect them*	11:312-21
- different learning styles	*all got different styles*	4:105
- group cohesiveness	*you can throw in anything...roll with it*	10:303-9
- therapeutic climate	*start with touchy-feely*	2:60
- emotional containment	*don't want group members frightened*	11:316-23
- client characteristics	*praise works really well with some clients,*	
	but not with others, because not used to praise	8:224
	capabilities different to each other	26:791
	backwards and forwards..to change	5:126
- gender dynamics	*I obviously wouldn't be the best person to challenge*	
	a rapist...because of his ideas of women	9:270-5
	I think it works better with two males and a female	
	than two females	10:281-5
	two male tutors...saying..she's got as much right	*9:278-9*
- tutor client dynamics	*choose... carefully who led each member's*	

	active account because of the rapport	
	and who'll work best with whom.'	7:202-7
- effect of unit relationship	*don't want to tel the staff on the unit their most*	
	intimate fantasises...tell someone neutral	8:234-9
	guy from the clinic...had a good very good rapport	
.	*...Involved in restraint...put a barrier up...was his*	
	keyworker...	8:242-260

TUTOR TEAM

roles in team		
- distinct roles related to tasks	*leading, co-tutoring, note-taking*	1:22
- dynamics	o*ur group's quite fluid*	7:192
- taking on different styles	*good cop, bad cop'*	7:206
tutor characteristics		
- individual needs/strenghths	*depends what mood we're in....how confident*	
	with the stuff	7:193-197

team support			
- to develop skills	*expereinced tutors with me...learning from them*	1	10:290-5
group identity			
- use of humour	*talk about what makes us giggle...keep a straight face in group*		6:180-6

RELATING TO GROUP MEMBERS

perception of clients		
- special needs	*range in group...one on autistic spectrum*	3:80-93
- role of learning disability	*they're not as capable*	26:789
- manipulative	*can be quite manipulative*	6:165
relating to clients		
- creating boundary -	'us' and 'them'	throughout text
	Giggle...straight face...group members haven't noticed..	6:184
- attitude to sex offending		
- psychological understanding	*knowledge is the utmost*	14:419

- proactive approach	*done a bit to help*	17:520-535
- personal experience of victims	*known people that had been offended against*	17:507-508
- attributions about offending behaviour	*inadequacy issues...learning disabilities...*	16:467-482

PERSONAL ISSUES

gender		
- denies gender issues	*work better with males...*	10:279-298
changes in self		
- greater flexibility in approach to work	*at first..too rigid*	4:108
	listen alot more...accept support...	
	w*as very driven...organised...more relaxed*	27:804-23
- ambivalence to change	*might be thinking I'm getting a bit lazy*	27:826
- denial of personal impact	*ultimately I'm the same*	28:834

motivation

- changing anti-socail behaviour	*criminality angers me*	17: 513-518
- personal efficacy	*I've done a bt to help*	17:523-524
- public protection	*kept away from the public*	18:525-528
- client rehabilitation	*give them a chance*	18:529-532
- psychology career	*interested in psychology*	18:546-57
- opportunity to develop	*like to learn*	19:567
- stimulation and challenge	*it doesn't bore me*	19:570

EMOTIONS

Coping strategies

- reluctance to explore	*it's fine*	4:100
- self reflection and exploration	*go over it afterwards*	6:164
- sharing and checking out with team	*good old gossip afterwards*	6:169
- venting in debrief	*we can just vent it out*	5:150
- use of humour	*deal with it with alot of humour*	5:151
- team support	*got two very experienced tutors with me*	10:290
- avoidance	*try not to think about it*	23:703
- distraction	*switch off and watch stupid tv*	23:704

Positive emotions		
- satisfaction	*tutors full of energy*	10:303-9
Negative emotions		
-frustration	*can't usually plan backwards and forwards...*	
	whether they want to change	4:124-6
- anxiety/stress	***be**cause you're sort of walking on eggshells*	11:316-7
- anger minimised	*it just grated on me..really annoying...*	
	just come out of the session and swear alot	25:742-55
- overwhelmed	*it wacked my brain*	24:711
- distress suppresses	(voice quietens)*..that's how they are you*	
	get used to it.	26:773-
- disgust	*one group memeber I feel quite disgusted at*	14:431
coping mechanisms		
- humour a defence	*erm, laugh or cry syndrome, I think*	6:173
	I think it just cheers you up, you're not sad	6:185
- team support	*all about the support that you've got around you.*	24:720-30

- avoidance and distraction	*try not to think about it when you go home...*	
	just sort of switch off	23:703-4
- venting at work	*ranting before I go home*	23:706

APPENDIX 8 – Example of stage 4 of analysis

Extracts from transcripts illustrating theme of humour

ALAN

Yes, we do joke and have a laugh, but we kind of use that, all the tutors meet up and we use that as a debrief. It's a kind of chill out, as well as a Friday, sort of, debriefing at the same time. So..(voice trails off)

*we've got very warped sense of humour..that's another thing we've probably gained a very warped sense of humour..erm, we will talk about anything, and everything. Obviously, we talk about the war with J** (laughs), we have to. Erm..we'll talk about stuff in the news, on the papers..erm.. general work, on the units..how naff life is generally, erm...the sense of humour's are just, I don't know, I wouldn't say they're warped, to an extent,*

BRIT

P: yeah, we have, we have a good chat afterwards, we have debrief and we have supervision where we can, if we're really frustrated we can just vent it out and then, then you sort of, we deal a lot of it with humour, a lot of it, I mean our tutoring styles, me and the other tutors in our group, we have a lot of humour. I just sort of think, how stupid are we for getting so frustrated, we know the job, and we'll crack a few jokes and then we're all smiling and giggling on the way home, and then we look forward to Fridays, you just let it out, I think talking's the best thing. Because I think if you just let it get frustrating, you'd get, you'd get over your head..

P: erm, laugh or cry syndrome I think (laughs as talking). No, I think, you just boosts morale I think, if you've had a bad day and then you just laugh at how stupid you've been or something, or some of the comments we've got are we've got a really bizarre client in our group, and er, we've got some really bizarre mannerisms that are put on for affect, and they are very amusing, and you can just laugh about it afterwards and think he's really amusing, you can sit and watch him for hours. You usually talk about what makes us giggle or, erm, if a tutors said something that er, that could be seen as something else, then we usually giggle about that, we keep a straight face in the group, I can't believe that you just said that. Obviously the clients, the group members haven't noticed, it just our, we know each other so well, that t you can laugh about that. I think it just cheers you up, you're not sad, you're just a bit frustrated. We just have a good laugh, afterwards.

P: erm, the staff team are great. Love the tutors, they're great. Erm, Friday's my favourite day of the week. Erm..
I: can you tell me more about that?
P: yeah, erm, we get together, we de-brief in our own special way. Erm, laughing, joking, erm. I think they warned me before I became a tutor that your sense of humour will change, and I was like, no, no, no, I'll still be me, I'll still be me, and it changes. You get quite a sick sense of humour because I think/like saying the word masturbate,

it's just like saying the word apple, you know. You get quite a sick sense of humour when you come to think about that. Because you all know exactly what you're going through, and exactly what the work entails, you're all on the same level/that it's, it's just fun to be around them, because you're in your own little circle, and no-one else, even on this site, unless they've been a tutor understands your sense of humour or anything. So its good little group and we all get on really well. So I enjoy that side of it.

ERIC

you talk among yourselves. In a very, erm… in this informal way that we talk, it's very relaxed, almost jokey in some respects… some of the people we're working with. But, if you haven't got that sense of humour, that you can talk amongst yourselves… And you can actually look back on yourself and laugh, I was stupid, whatever. Why get wound up about that. Which, the Friday meetings especially, are extremely important for the tutors. It's time when we get (inaudible) get done. But, we can also talk amongst ourselves and then vent our frustrations and everything else. And then you do pick up on the funny parts in groups. Because there are a lot of funny parts in groups. Where, the guys will laugh, the tutors will laugh. And, so you can focus on those. And, that's where you get rid of that pent up sort of frustration, whatever.

How you can sit there with six guys..five of which may have offended against children, which straight away gets people's backs Up…dislike the most. And, how do you sit there with them and have a laugh with them, how do you?

FRANK

And we, you know, we can talk between each other. And, like that helps. It's probably in common with, you've probably heard this a few times, we've got this, sense of humour that is..probably not. It's the way we get over things. you cannot be hearing some of the things that we hear, and not, you go/I think some people couldn't do this job.

I: you talked a little bit about your sense of humour..
P: (coughs). Well, I think I've got a, I've got a fairly good sense of humour, yeah, I suppose, I think, I've got one, yeah. You know, we all have a laugh, a joke. If you couldn't have a laugh and a joke you'd be..you know. But, when we're all together, it's a bit juicy. The sense is probably quite bizarre I suppose..But, yeah, I've got quite a good sense of humour. I'm never going to be a stand-up comedian, but, I've got a fairly good sense of humour. I can see a joke when I see it coming. And there are some funny moments in group, like … horrible, not very nice way of looking at it and there are the moments that are quite good and are genuinely humourous.

I: can you tell me more about those moments?
P: ..well, you know, it might be, er, you know. The particular way a person, the way they says something. It might be one of us, you know. It might be something that I've, myself have…It might be tripping over one time or you know, getting the camera set up wrong and, you know. Generally there's a bit of banter and taking the mickey out of each other a little bit. That keeps us all on friendly terms. It part of the joining in when new tutors come in. they have to fit in, like, you know. (coughs). And..I mean, if you

can't laugh at yourself, you know, you don't really laugh at anybody else…But, that might again…(laughs). You know what I mean. I think that helps. I've got a very good humour, I think. Wouldn't be able to do the job otherwise..

GERRY

P: oh the, yeah, we support each other. We have this, as you know, our Friday sessions very light-hearted, easy-going and people get to say what they like and we have loads and loads of rubbish that we pick up during the Friday session. Er, that's our support network in there.

it's just, just getting all the, umm, having a laugh about things, taking the micky out of some of the people. Some of the staff. Er, just generally light-hearted banter. And it helps you to get rid of all that sort of garbage that you might otherwise carry about.

HAZEL

P: yeah….a good laugh and a, a joke. Erm, just sometimes to off-load really. You've go to see the funny side of things that have been said, just to keep it going. Otherwise, it get too serious all the time. it's just to have a laugh, and you know, I try and to have a laughing and joking style with the clients as well, my interaction with the clients, and try make jokey comments, not about sex offence or anything, but just generally about the how the weeks been and you know. And just have a laugh with the clients as well, makes for a more relaxed atmosphere.

Appendix 9

Public domain briefing paper

Working with learning disabled sex offenders: A qualitative study of the experiences of staff working on a treatment programme

Background

Research with mainstream sex offenders has found that cognitive behavioural treatment approaches are effective and that therapists may play an important role in treatment. The evidence for the effectiveness of treatment with learning disabled sex offenders is not so strong. Research suggests cognitive behavioural approaches need to be adapted for people with a learning disability. To date, there has not been any research into the role of therapists in sex offender treatment with people with a learning disability. It has been suggested that staff well-being may have an impact on the effectiveness of therapeutic interventions with this group of offenders.

Research into the well-being of staff working with people with a learning disability, and of therapists working on sex offender treatment programmes, found that experiences varied. Some studies found evidence of stress and burnout, while others reported more positive experiences. Research into the experiences of staff working with sex offenders with a learning disability found that staff experiences appeared to be complex. The aims of this study were to explore the experiences of staff working with sex offenders with a learning disability on a treatment programme, as this area has not previously been researched.

Method and participants

Semi-structured interviews were carried out with eight staff working on a sex offender treatment programme for people with a learning disability. The interviews were taped, transcribed and then analysed using Interpretative Phenomenological Analysis (IPA).

Results

Four higher order themes were found. These were: (i) rewards and motivation for working on the treatment programme; (ii) the challenge of effecting change; (iii) the personal impact of working with sex offenders; (iv) ways of managing the impact of work. Themes appeared to be inter-related.

Discussion

The results indicated that staff experiences were complex and challenging. Although staff shared some experiences there was also individual variation particularly in relation to the issues of empathy, and openness to emotional experiences, which in turn appeared to relate to processes of effecting therapeutic change with group members.

Some of the results of this study were similar to those reported in studies with therapists working with mainstream offenders, while some appeared to be appeared be distinct to the treatment context in which the research was carried out. Some of the distinct features of this study were the non-professional background of staff, group members' learning disability, and the use of humour as a coping strategy. Some of the clinical implications of these issues were discussed and recommendations made in relations to staff well-being and the effectiveness of the treatment programme.

The method of analysis used in this study involved a level of interpretation by the researcher. This issue was explicitly identified and discussed as part of the research study particularly in relation to the limitations of the study. There is a need for further research in this area using different methodological approaches and groups of participants in order to investigate both issues of staff well-being and the process of effecting therapeutic change with sex offenders with a learning disability.

Appendix 10 – Notes for Authors JARID

Journal of Applied Research in Intellectual Disabilities

[Not available in the digital version of this thesis]