



UNIVERSITY OF
BIRMINGHAM

**FORENSIC HEALTHCARE WORKERS WORKING WITH SEX
OFFENDERS:**

TREATMENT OUTCOMES AND STAFF WELL-BEING

Written by:

Chloe Wheeler

Supervised by:

Dr Artur Brzozowski

A thesis submitted to the University of Birmingham

for the Forensic Psychology Practice Doctorate (ForenPsyD)

Centre of Applied Psychology

School of Psychology

College of Life and Environmental Sciences

The University of Birmingham

UNIVERSITY OF
BIRMINGHAM

University of Birmingham Research Archive

e-theses repository

This unpublished thesis/dissertation is copyright of the author and/or third parties. The intellectual property rights of the author or third parties in respect of this work are as defined by The Copyright Designs and Patents Act 1988 or as modified by any successor legislation.

Any use made of information contained in this thesis/dissertation must be in accordance with that legislation and must be properly acknowledged. Further distribution or reproduction in any format is prohibited without the permission of the copyright holder.

Abstract

The purpose of the current thesis is to explore how working with individuals convicted of a sexual offence impacts treatment outcomes amongst this client population and the well-being of staff involved in their care. Underlying psychological mechanisms such as attitudes and perceptions, workplace factors and the therapeutic relationship are focal points. Within the first chapter, background literature relevant to theories of sex offending, risk reduction through therapeutic interventions, and the well-being and attitudes of forensic staff is discussed. The second chapter presents a Systematic Literature Review exploring how the therapeutic relationship between therapists and individuals convicted of a sexual offence impacts treatment outcomes. The findings from the review conclude that a positive therapeutic relationship is related to desirable short-term treatment outcomes. Specifically, individuals convicted of a sexual offence in positive alliances demonstrate desirable changes in attitudes and behaviours related to their risk. The review highlighted the need to explore further the psychosocial concomitants of working with sex offenders. Chapter three critiques the Perception of Sex Offenders Scale (PSO). The critique proved that the PSO is a valid and reliable measure for assessing perceptions and judgements of sex offenders and is more efficient than most of its counterparts. It is also proposed that the scale is complementary to measures exploring other psychological processes, such as attitudes towards sex offenders. Chapter four describes a research project exploring psychosocial concomitants of forensic healthcare workers without professional qualifications working with sex offenders. Specifically, the study explores how forensic healthcare workers' attitudes and perceptions towards sex offenders, as well as workplace arrangements such as environmental safety, quality of supervision, and co-worker support, predict workplace well-being. The results suggest favourable attitudes towards sex offenders and advantageous workplace arrangements increase workplace well-being. Contrastingly, certain negative perceptions of sex offenders

are also shown to increase well-being. The complexity of findings emphasises the usefulness of exploring attitudes and perceptions as separate constructs when predicting well-being amongst forensic healthcare workers without professional qualifications. Additionally, the findings highlight the importance of maintaining adequate levels of environmental safety as well as providing good quality supervision. The final chapter provides a synthesis of the findings from each of the preceding sections and an overall conclusion of the thesis.

Dedication

I want to dedicate my journey on the doctorate to my father, John Wheeler. I cannot emphasise enough how your determination to continuously self-improve has motivated me throughout my personal and professional life. You have inspired me to always be critical, to see the good in people, and to be a voice and support for those that require compassion but do not always receive it. Thank you for your consistent support and belief in me.

Acknowledgements

Firstly, I would like to express my immense gratitude to my academic supervisor, Dr Artur Brzozowski. Your continuous wisdom and motivation throughout the development of this thesis and my time on the course have made the process enjoyable but, most importantly, incredibly valuable to my academic and professional development.

I would also like to thank Dr Nicola Shaum for her support in proofreading chapters one, three, four, and five of this thesis. You have provided me with valuable feedback that has enhanced my academic skills.

It is also important that I express my appreciation for all my wonderful friends and family for always believing in me and my goals to pursue this career. I am so thankful for your consistent words of motivation and unwavering support which has pushed me through some challenging times.

Finally, I would like to thank all the participants who took the time to partake in my study. You represent the source of inspiration for the study's aim, as my time as a support worker has taught me how essential it is for the well-being of all forensic healthcare workers to be looked after, not only for the benefit of the staff but for the clients we support.

Table of Contents

CHAPTER ONE	9
Introduction	10
Overview of the Thesis	21
CHAPTER TWO	24
Abstract	25
Introduction	27
Aims of the Current Systematic Literature Review.....	34
Methodology	35
Results	45
Discussion	71
Conclusion.....	80
CHAPTER THREE	82
Introduction	83
Overview of the Scale	87
Conclusions	96
CHAPTER FOUR.....	97
Abstract	98
Introduction	100
Summary of the Background and Research Aims	108
Methodology	113
Results	120
Discussion	128
Conclusion.....	136
CHAPTER FIVE	137
Discussion	138
General Interpretations and Conclusions	150
List of References	152
Appendices.....	181
Appendix A: Database Search Table	181
Appendix B: Quality Assessments	183
Appendix C: Data Extraction Table.....	208
Appendix D: Advertisement for Healthcare workers	210
Appendix E: Information Sheet.....	211
Appendix F: Consent Form	213

Appendix G: Demographic Questionnaire	214
Appendix H: The Perceptions of Sex Offenders Scale.....	217
Appendix I: Professional Quality of Life Scale.....	218
Appendix J: Quality of Work Life Survey.....	220
Appendix K: Attitudes Towards Sex Offenders – 21	221
Appendix L: Raffle Entry	222
Appendix M: Debrief Form.....	223
Appendix N: SPSS Output for Multiple Regression Analysis on Compassion Satisfaction	224
Appendix O: SPSS Output for Multiple Regression Analysis on Secondary Traumatic Stress.....	234
Appendix P: SPSS Output for Multiple Regression Analysis on Burnout	243

List of Tables and Figures

Table 1.....	Error! Bookmark not defined.
<i>Inclusion and Exclusion Criterion using PICO</i>	Error! Bookmark not defined.
Table 2.....	Error! Bookmark not defined.
<i>Quality Assessment Scores</i>	Error! Bookmark not defined.
Figure 1	Error! Bookmark not defined.
<i>PRISMA Flow Diagram</i>	Error! Bookmark not defined.
Table 3.....	Error! Bookmark not defined.
<i>Systematic Data Extraction Table</i>	Error! Bookmark not defined.
Table 4.....	Error! Bookmark not defined.
<i>Psychological and Workplace Variables Predict Compassion Satisfaction</i>	Error! Bookmark not defined.
Table 5.....	Error! Bookmark not defined.
<i>Psychological and Workplace Variables Predict Secondary Traumatic Stress</i>	Error! Bookmark not defined.
Table 6.....	Error! Bookmark not defined.
<i>Psychological and Workplace Variables Predict Burnout</i>	Error! Bookmark not defined.

CHAPTER ONE

Introduction to Thesis

Introduction

This chapter provides an overview of the key concepts discussed within the current thesis whilst highlighting the necessity for each chapter's contribution to existing literature. The thesis focused on the experience of those working with individuals who were convicted of a sexual offence, and how therapeutic relationships, workplace factors and psychological processes impact treatment outcomes as well as well-being. The offences committed by sex offenders have severe negative consequences for their victims, including sexual, physical, and psychological harm (Darkness to Light, 2020; Master, 1986; RAINN, 2023; Tomasula et al., 2012; Ullman & Najdowski, 2009; Van Egmond et al., 1993). For this reason, criminal justice policies have responded to the public's growing concern (Levenson et al., 2007), by expanding legislation in attempts to mitigate the risk of sex offenders re-offending. However, the psychological treatment of sex offenders is also considered paramount to the reduction of risk (Johnke et al., 2015). This type of risk reduction is overseen by a variety of professionals and paraprofessionals (Lea et al., 1999). Due to the harmful nature of sex offences, there is an ongoing need to scientifically explore the influence of various factors involved in offender treatment, including worker and workplace characteristics (Lea et al., 1999; Mivshek & Schriver, 2022; Sandhu et al., 2012).

Sex Offenders and Risk Factors

Individuals who have committed an unwanted sexual act onto or towards another person are classed, by British law, as sex offenders; this can include contact and non-contact exposure (Sexual Offences Act, 2003). Legislations and laws relating to sexual offences have been rapidly adapting as the prevalence of this crime is increasing (Office for National Statistics, 2023). Since 1997, anyone in the United Kingdom who was convicted or cautioned for a sexual offence had their details listed on a Sex Offender Register. The register was designed in an attempt to monitor and manage community-based individuals to reduce the

risk of further harm to the public. As such, all convicted sex offenders are required to register with the police by providing several personal details to ensure they can be easily located and contacted (Sex Offenders Act, 1997). In 2003, the Sex Offenders Act was expanded by including clear definitions of the terms *consent* and *sexual*. Moreover, several public protection measures that were identified within the initial Sex Offenders Act (1997) were amended (legislation.gov.uk, n.d.). The Sex Offenders Act (2003) also stipulates a wide range of offences against both adults and children that would classify the perpetrator as being a sex offender (legislation.gov.uk, n.d). These legal arrangements further emphasise the dynamic, expanding nature of what is considered to be a sexual offence and ongoing attempts to tackle the problem.

Psychological typologies have been developed in attempts to better understand the behaviours and predispositions of sex offenders and to inform the appropriate treatment approach (Simon, 1997; 2015). Typologies of sexual offending are commonly defined by the victim or the offence, such as, but not limited to, child sexual abusers, rapists, female sexual offenders, and internet offenders (Simon, 1997; 2015). It is important to note that the commonality between all classifications involves the term consent; this is when each party involved must agree to the act by choice and have the freedom and mental capacity to do so (rapecrisis.org.uk, n.d). Furthermore, theories relating to sexual offending also refer to the use of force and coercion (Finkelhor, 1984), where it is proposed that the offender, particularly in child sexual abuse cases, views the act as acceptable and mutual (Groth, 1983). However, sex offender typologies have been criticised for their use in behaviour and treatment analysis due to their dependence on official statistics; negligence in acknowledging cross-over offending, and research suggesting that a risk of recidivism is related to individual factors rather than typologies (Simon, 2015; Ward & Gannon, 2015).

Theories of sexual offending explore personality factors that are hypothesised to contribute to the onset and maintenance of harmful behaviours and could predict a likelihood of recidivism. Attachment difficulties and adverse childhood experiences are two reoccurring factors discussed within such theories, for example, the Attachment Theory (Bowlby, 1969; Marshall, 1993). Marsa et al. (2004) reported that 93% of individuals convicted of a sexual offence have an insecure attachment style, which can be attributed to the adversities they experienced during childhood relating to their attachment with a parent or caregiver (Cicchetti & Lynch, 1995; Jonson-Reid & Way, 2001). Such adversities are suspected to contribute to mid-age difficulties related to social skills, low self-esteem, and difficulties developing and maintaining intimacy (Marshall, 1993). Theories such as the Self-Regulation Model (Ward & Hudson, 1998; 2000) and Integrated Theory of Sexual Offending (Marshall & Barbree, 1990) also explore an individual's ability to self-regulate; empathy deficits as well as increased exposure to sexual contact in childhood (Craissati & Beech, 2006; Marshall & Barberee, 1990; Ward & Hudson, 1998; 2000). These aforementioned characteristics are classed as dynamic risk factors, which in combination with static risk factors (i.e., the offender's age, biological sex at birth, or marital status) can predict the likelihood of recidivism with variable measurement error (Craissati & Beech, 2006).

Recidivism is defined as an individual's probability to re-engage with criminal behaviour (Weisberg, 2013). It is crucial to identify predictors of recidivism for sex offender populations due to the potential severity of psychological and physical harm to victims. In response to this need, Actuarial Risk Assessments have been developed to provide dependable estimates of risk; these risk assessments incorporate static and dynamic risk factors (Brown & Singh, 2014). Static risk factors include aspects of an individual's life that are unchangeable, such as the frequency and severity of past offences and the age of the individual upon arrest and release. However, Beech et al. (2002) reported that although

Actuarial Risk Assessments, such as the Static-99 (Hanson & Thornton, 1999), demonstrate high levels of predictive accuracy, the inclusion of dynamic factors significantly increases this.

Dynamic risk factors involve measuring and identifying the psychological, environmental, and behavioural aspects of a perpetrator. A meta-analysis conducted by Hanson and Morton-Bourgon (2019) concluded that those whose initial offence was of a sexual nature were on average not likely to sexually reoffend, rather they were more likely to perpetrate a nonsexual offence. Dynamic predictors of general recidivism included antisocial traits, psychopathy as measured by the PCL-R (Hart et al., 1992), and a history of rule violation. For those who did sexually reoffend, sexual deviancy and antisocial traits were reported to be major dynamic predictors. Interestingly, factors that are commonly explored within treatment programmes such as psychological distress, victim empathy, denial of crime and motivation for treatment did not report a significant relationship with recidivism. Substance abuse, impulsivity and social factors, such as peer group, employment and marital status, have also been identified as factors contributing to the risk of sexual reoffending (Craig et al., 2005; Kruttschnitt et al., 2000). Awareness of static and dynamic risk factors can be integrated into assessments to determine the risk of recidivism and also inform appropriate treatment interventions.

The Treatment of Sex Offenders

Despite the ongoing scientific and legal efforts designed to protect the public from sex offenders, the rate of sexual offences is reported to be increasing (Office for National Statistics, 2023). Consequently, several treatment programmes have been standardised and implemented to reduce the risk of reoffending (Lea et al., 1999; Marshall & Hollin, 2006). The treatment programmes can be facilitated in various professional services, such as community-based services, prisons and forensic inpatient settings. Typically, once an

individual is convicted of a sexual offence, they receive a sentence to serve out in prison. In some cases, the individual may have a mental health diagnosis, which could result in them receiving a hospital order from the Crown Court or Magistrates' Court (Sentencing Council, 2023). This detains the individual in an inpatient hospital rather than a prison to receive the relevant treatment for their mental health diagnosis as well as their risk of reoffending. The treatment provided in these settings commonly takes the form of group-based interventions, however, this can also be supplemented or substituted by individual-based treatment.

Generally, findings have demonstrated a positive relationship between completion of sex offender treatment and a reduction in sexual and non-sexual recidivism (Gannon et al., 2019; Hanson et al., 2002; 2009; Lösel & Schmucker, 2005; Schmucker & Lösel, 2017). A variety of group programmes have been developed with an overarching aim to target dynamic risk factors, through fostering behavioural, cognitive and attitudinal change. One such treatment is the Sex Offender Treatment Programme (SOTP) which was introduced in 1991 by Her Majesty's Prison Service of England and Wales (Grubin & Thornton, 1994). The programme comprises 20 learning blocks aimed at supporting group cohesion, developing healthy coping strategies, challenging belief systems around the impact of sexual offending and building awareness around sexual deviant fantasies. Treatment outcomes were commonly measured by pre-and post-treatment psychometrics. However, in 2017, the programme was stopped following a comprehensive data analysis of the re-offending rates amongst those who had completed the programme (Mews et al., 2017). On average, the authors concluded that the programme demonstrated little to no change in reoffending rates, with a slight yet significant increase in reoffending amongst child imagery offenders. Since the publication of the Mews et al. (2017) study, an extensive meta-analysis conducted by Gannon et al. (2019) concluded opposing findings. It was reported that specialised sex offender treatment programmes such as the SOTP demonstrated a reduction in sexual and non-sexual recidivism

and that this effect was found within community and prison-based services. Nonetheless, since delivery of the SOTP was ceased, further accredited programmes have been introduced, such as the Horizon and Kaizen programmes (McCartan & Prescott, 2017), in attempts to contribute to a reduction of risk factors amongst this offending population.

Like any form of therapeutic intervention, research is generally conducted to identify factors that influence treatment engagement and treatment outcomes (Carl & Lösel, 2021; Carr, 2011; Howard, 2016; Howard et al., 2019; Nelson et al., 2002; Olver & Wong, 2011; Sewall & Olver, 2019; Sowden & Olver, 2017; Sandhu & Rose, 2012; Stück et al., 2022; Stumpf, 2022). Amongst the sex offender population, a number of factors have been identified for increasing the likelihood of treatment non-completion such as a sex offender's age, marital status, education, and personality characteristics including psychopathy, treatment readiness, and other mental health diagnoses (Carl & Lösel, 2021; Carr, 2011; Howard, 2016; Howard et al., 2019; Olver & Wong, 2011; Sewall & Olver, 2019; Sowden & Olver, 2017; Stück et al., 2022; Stumpf, 2022). These factors also mirror static and dynamic risk factors that predict recidivism (Craig et al., 2005; Kruttschnitt et al., 2000), highlighting that projects exploring treatment engagement and outcomes also contribute to risk factor literature.

Therapist characteristics have often been explored in relation to their meaningful influence on treatment engagement and treatment outcomes (Marshall et al., 2003; Sandhu & Rose, 2012; Thornton et al., 2010). Previously, published literature exploring the effects of the therapist's characteristics on treatment gains amongst sex offenders concluded that therapist characteristics such as their biological sex at birth, honesty, non-judgemental approach, ability to demonstrate empathy and positive and caring attitudes, influenced the treatment outcomes and engagement (Nelson et al., 2002; Sandhu & Rose, 2012). Such characteristics have also been reported to facilitate the therapeutic relationship; a

collaborative, interpersonal process which involves the client and the therapist developing an emotional bond with an overarching aim to work towards desirable treatment goals (Ackerman & Hilsenroth, 2003; Marshall et al., 2003; Martin et al., 2000).

Amongst the general clinical population, the therapeutic relationship has repeatedly proven to be a strong positive influence on treatment outcomes (Marziali & Alexander, 1991). A meta-analysis conducted by Martin et al. (2000) demonstrated that the therapeutic relationship was associated with treatment outcomes and that this effect was independent of confounding variables. This suggests that the therapeutic relationship can facilitate treatment change regardless of the intervention used. Similar effects were also reported among sex offenders and treatment outcomes relevant to risk (Marshall et al., 2003; Youssef, 2017). A significant negative relationship was observed between sexual recidivism risk and a sex offender's perceived relationship with their therapist (Blasko & Jeglic, 2014). It was also reported that sex offenders who hold more positive attitudes towards their intervention facilitator were more likely to engage in treatment (Levenson et al., 2009). Therefore, outside of the interventions provided to sex offenders, the therapist, their characteristics, and the relationship they build with the client have a crucial role in facilitating treatment change and engagement.

The Psychological Consequence of Working with Sex Offenders

As mentioned in the preceding subsection, the quality of the therapeutic relationship when working with sex offenders can have a strong influence on treatment outcomes (Marshall et al., 2003; Youssef, 2017). However, as the well-being of forensic staff was shown to impact the care provided and treatment outcomes obtained (Delgadillo et al., 2018; Salyers et al., 2015), it is also important to consider the psychological consequence that working with sex offenders can have on staff. Professionals who work with sex offenders include but are not limited to, psychiatrists, psychologists, therapists, and nurses. Their role

often involves providing interventions such as medical treatment or therapy designed to manage and reduce mental health symptoms and risks associated with the clients' offences. Paraprofessionals include prison and probation officers who manage risk behaviours within prison settings and the community. Whereas, within inpatient settings, forensic healthcare and support workers provide care by supporting sex offenders with their daily living routine and to support with implementing behavioural strategies as identified by qualified professionals employed by the service. Previously published research sampling from populations of individuals working with sex offenders has typically explored the well-being of qualified professionals and prison officers (Ennis & Horne, 2003; Hatcher & Noakes, 2010; Kadambi & Truscott, 2003; Munger et al., 2015; Steed & Bicknell, 2001). To the author's knowledge, very limited attention has been allocated to the well-being of forensic healthcare workers without professional qualifications, when working with this client population.

The *cost of caring* is well established within literature exploring the psychological impact on those within a caring job role (Stamm, 1998). This cost is most frequently observed when working with individuals who have experienced some form of trauma (McCann & Pearlman, 1990). *Vicarious trauma* is the process of the treatment provider experiencing a negative change to their internal state when they demonstrate empathetic concern for a client's traumatic experiences (McCann & Pearlman, 1990). Another relevant term is *compassion fatigue* which is used interchangeably with *secondary traumatic stress* (Bride et al., 2007; Figley 1995). Compassion fatigue is said to occur when a caregiver provides repeated support to those in distress or who have experienced trauma (Figley, 2002; Sorenson et al., 2016). Repeated exposure can lead to the development of symptoms associated with Post Traumatic Stress Disorder (PTSD) for example recurrent disturbing thoughts, anger and irritability, and sleep disturbance as well as decreased levels of compassion after prolonged exposure to stress or secondary trauma within their job role

(Hinderer et al., 2014; Sinclair et al., 2017). As the treatment provided to sex offenders commonly involves the treatment facilitator being aware of the sex offence(s) and harm caused to the victim(s) (Ellerby, 1997), it is proposed that those working with sex offenders may be at increased risk of developing vicarious trauma and compassion fatigue.

On the whole, there is not a clear picture of the psychological consequences to those caring for and working with sex offenders (Baum & Moyal, 2020; Hatcher & Noakes, 2010; Scheela, 2001; Steed & Bicknell, 2001). Some scientific publications emphasised low to moderate findings of vicarious trauma and compassion fatigue amongst therapists working with this client population (Ennis & Horne, 2003; Kadambi & Truscott, 2003). Contrastingly, other research reported that therapists treating sex offenders experienced low satisfaction in their job role, with 46.2% of the participant sample experiencing moderate to high levels of compassion fatigue and 97% experiencing low levels of compassion satisfaction (Steed & Bicknell, 2001). *Compassion Satisfaction* is the positive psychological effects such as pleasure, derived from helping others (Stamm, 2009). Conflicting findings suggest that moderating factors may influence this relationship.

Work-related and individual factors have been considered when exploring the well-being of those involved in the treatment of sex offenders (Ennis & Horne, 2003; Hatcher & Noakes, 2010; Kadambi & Truscott, 2003; Steed & Bicknell, 2001). Personal factors such as gender have previously been assumed to influence the psychological impact on those working with sex offenders, in that male therapists report significantly higher levels of vicarious trauma (Baum & Moyal, 2020). However, further review of the literature has concluded that personal factors such as gender, ethnicity, age, and a personal trauma history did not have a predictive or influential effect on the psychological consequences observed amongst those working with this client population (Ennis & Horne, 2003; Hatcher & Noakes, 2010; Steed & Bicknell, 2001). Work-related factors have demonstrated a mitigating effect in that variables

such as perceived peer support and supervision can reduce the negative psychological impact of working with this population (Ennis & Horne, 2003; Kadambi & Truscott, 2003; Hatcher & Noakes, 2010). It is reported that peer support has supported the well-being of therapists working with sex offenders through sharing their experiences, such as their perceptions and attitudes towards this client group (Hatcher & Noakes, 2010). This suggests that psychological processes may also influence the relationship between well-being and working with sex offenders.

Attitudes and perceptions are two separate psychological processes that are formed to help humans make sense of the world. Attitudes involve an evaluative judgement of a particular entity and can be viewed as an affective process (Maio & Haddaock, 2010). Perceptions are a cognitive process that reflects our understanding and knowledge of the world (Cacioppo et al., 1999). Generally, mixed findings have been reported when exploring the attitudes and perceptions of those working with sex offenders (Higgins & Ireland, 2009). In prisons, therapists were shown to report more favourable attitudes towards sex offenders in comparison to the strong negative attitudes held by prison officers (Higgins & Ireland, 2009). Moreover, in a qualitative analysis conducted by Hatcher and Noakes (2010), professionals' perceptions of humanity, that is how one views the world and others, changed when working with sex offenders. Specifically, they felt they needed to install alarms to protect their family. They also reported an increased suspicion of interactions between children and men (Hatcher & Noakes, 2010). The experience of working with sex offenders has been observed to provoke psychological processes such as attitudes and perceptions, but it is not clear how this impacts the well-being of those working with them.

Furthermore, similar to scientific publications exploring well-being, professionals and prison officers have been the main participant sample when measuring attitudes, with limited attention given to forensic healthcare workers without professional qualifications. Forensic

healthcare workers are generally employees who are responsible for the daily living needs of clients within inpatient and community services. Therefore, to gain a further understanding of the relationship between well-being and psychological processes, research related to the views of forensic healthcare workers without professional qualifications is required.

Overview of the Thesis

Chapter one has provided an overview of the key topics that are relevant to the current thesis. Notable points included that the therapeutic treatment of sex offenders is perceived to be a paramount process in reducing the risk of recidivism (Hanson et al., 2002; Hanson et al., 2009; Lösel & Schmucker, 2005; Schmucker & Lösel, 2017). However, several factors have been found to influence this process such as a sex offender's age, marital status, education, and personality characteristics (Carl & Lösel, 2021; Carr, 2011; Howard, 2016; Howard et al., 2019; Olver & Wong, 2011; Sewall & Olver, 2019; Sowden & Olver, 2017; Stück et al., 2022; Stumpf, 2022). Furthermore, the therapist, their characteristics, and the relationship they have with this client group have been found to significantly contribute to treatment engagement and outcomes observed amongst sex offenders (Marshall et al., 2003; Sandhu & Rose, 2012; Thornton et al., 2010; Youssef, 2017). It is also noted that the experience of working with sex offenders has demonstrated harmful psychological consequences, however, these findings appear to be mixed (Baum & Moyal, 2020; Hatcher & Noakes, 2010; Scheela, 2001; Steed & Bicknell, 2001). Moderating variables of this relationship include workplace factors such as perceived peer support and supervision, with further exploration of the findings suggesting psychological processes such as attitudes and perceptions towards this client group may also play a role (Ennis & Horne, 2003; Kadambi & Truscott, 2003; Hatcher & Noakes, 2010).

A review of the background literature has highlighted the importance of gaining a further understanding of the therapeutic relationship and how psychological processes impact the well-being of those working with this client group. Furthermore, limited attention to forensic healthcare workers without professional qualifications and their experience of working with sex offenders was observed. Therefore, research exploring this particular

participant sample will further contribute to the existing literature. Resultingly, the current thesis has attempted to explore these areas in the following chapters:

- a) Through a Systematic Literature Review, chapter two explores extant research considering the impact of the therapeutic relationship on treatment outcomes amongst sex offenders. A total of seven studies were included in the review. Six out of seven of the studies utilised pre- and post-treatment measures to assess treatment changes, with one employing an observational design. Five of the studies assessed treatment outcomes through behavioural, cognitive and attitudinal changes, with two studies focusing on rates of recidivism over a ten-year period. The findings from the systematic review were synthesised with the use of a narrative synthesis approach. The findings highlighted the importance of therapeutic rapport in relation to short-term treatment outcomes. Implications for treatment and recommendations for future research were also discussed.
- b) Chapter three provided a critique of the Perception of Sex Offenders Scale (PSO; Harper & Hogue, 2015a). This scale has been designed to measure perceptions related to sex offenders' risks and sentencing management as well as stereotype endorsement. The scale can be used to measure a variety of populations' perceptions towards sex offenders with the most common being those involved in their treatment or members of the general public. The critique evaluated the psychometric properties of the measure and provided an overall conclusion on its efficacy. The scale was also used to measure the psychological processes of the participants recruited within chapter four.
- c) The fourth chapter reported an empirical study exploring predictors of well-being amongst forensic healthcare workers without professional qualifications who indicated an ongoing experience of working with sex offenders. Predictors included attitudes and perceptions towards sex offenders as well as workplace factors. A

quantitative study design was employed with multiple regression analysis conducted to identify potential predictors. The discussion of the study highlighted psychological concepts for the relationships found as well as consideration of limitations and implications for forensic practice.

- d) The fifth and final chapter provides an overall discussion and summary based on the findings presented in chapters two, three and four and in relation to the overall thesis aims. It links back to elements of chapter one and summarises and intertwines the findings of the remaining chapters. This chapter also contained a research and findings-based view of how this thesis contributes to practice, presenting overall limitations and conclusions.

CHAPTER TWO

Systematic Literature Review

**How Does the Therapeutic Relationship Impact Treatment Outcome When Working
with Sex Offenders: A systematic review of the literature**

Abstract

The impact of the therapeutic relationship has been explored amongst the forensic population. Findings suggest that a therapists' psychological characteristics can induce positive treatment changes amongst sex offenders, for example, the therapist's ability to demonstrate empathy. However, there has yet to be a systematic review exploring the influence of the therapeutic relationship on treatment outcomes amongst sex offences. The current systematic review sets out to investigate this.

The review consisted of a screening process using four databases; Ovid: PsycINFO, Web of Science, Scopus, and ProQuest. The search output identified a total of 227 papers; once 53 duplicates were removed a total of 174 papers remained. These were then screened for relevance to the current review topic. After a robust elimination process, eight papers that met the inclusion and exclusion criteria remained for further processing. An adaption of the National Heart, Lung, and Blood Institute quality assessment tool (NIH, 2021) was used to conduct quality assessments on each of the papers. A dual-coding approach was employed for the quality assessment. Following this process, one paper was removed due to producing a 'poor' score. Out of the remaining seven studies, four utilised a pre-and-post-measures design to assess treatment changes, two utilised a correlational design and one employed an observational design.

The samples focused on sex offender treatment facilitators which included a range of professionals, namely psychiatrists, forensic mental health nurses, psychologists and social workers. Concerning sex offenders, the sample size ranged from 19 to 427 offenders ($N = 785$), all of which were male. Five of the studies assessed treatment outcomes through behavioural, cognitive and attitudinal changes with two studies focusing on rates of recidivism over ten years.

Findings from the current review conclude a strong relationship between the therapeutic relationship and treatment outcomes. Findings in accordance with past literature also emphasise the importance of empathy and warmth as therapist characteristics facilitating the therapeutic relationship. These characteristics were also observed to demonstrate positive attitudinal changes in that sex offenders reported an improvement in victim blaming, denial of harm, denial of responsibility, and denial of premeditation. However, it is important to note, that no significant effect was found when exploring rates of recidivism. A further interesting finding suggests that peer alliances also report positive effects on treatment outcomes.

Introduction

Individuals who experience ill mental health may seek out professional help in the form of therapy. In the United Kingdom, if the individual experiences a mental health disorder and places themselves or others at risk, they may also be sectioned under the Mental Health Act (MHA; 1998/2007). Whilst detained, they will likely have access to therapeutic interventions from mental health professionals. Therapeutic intervention is an important procedure within the individual's recovery, which requires a lot of skill and training to obtain positive treatment outcomes. Moreover, research has identified several aspects of an intervention that are key to positive outcomes; one such aspect is the therapeutic relationship (Marziali & Alexander, 1991).

The therapeutic relationship is defined as the rapport established between the client and the therapist (Ackerman & Hilsenroth, 2003; Marshall et al., 2003; Martin et al., 2000). The formation of the relationship commonly begins following the initial introduction and within optimal cases, will continue to develop and strengthen as treatment progresses. The relationship is multidirectional in that it requires an active and conscious collaboration between therapist and client (Ackerman & Hilsenroth, 2003). Furthermore, the therapeutic relationship can be measured qualitatively or quantitatively, however, when concerning the influence on treatment outcomes, literature has identified that the most reliable effects are found from the client's rating rather than the therapist (Bedi et al., 2005). Although the definition of the therapeutic relationship has evolved over time, the importance in relation to client satisfaction and treatment outcome remains irrefutable (Marziali & Alexander, 1991), making this an important process to explore.

The process of establishing a therapeutic relationship can be challenging and is influenced by the characteristics of the therapist (Ackerman & Hilsenroth, 2003; Flückiger et

al., 2018; Forster et al., 2014). Personal attributes of the therapist such as being critical, tense, distant, and uncertain reported a negative impact on the client's ability to establish a healthy working relationship (Ackerman & Hilsenroth, 2001). Whereas therapists who embody psychological characteristics, such as empathy, honesty, warmth, and respectfulness, and employ techniques such as flexibility often see greater treatment success in their clients (Hersoug et al., 2001; Ackerman & Hilsenroth, 2003). This emphasises the need for relevant training and skillsets to facilitate therapeutic interventions, however, it is also important to note that the formation of the relationship can also be influenced by the client.

Client factors impacting the therapeutic relationship have been observed in relation to their need for treatment as well as personal characteristics (Couture et al., 2006; Flückiger et al., 2018; Forster et al., 2014; Meier et al., 2005; Lorenzo-Luaces et al., 2014). Concerning personal characteristics, higher levels of conscientiousness, motivation, coping strategies and a secure attachment style previously predicted the development of a strong working alliance (Meier et al., 2005; Lorenzo-Luaces et al., 2014). Additionally, factors related to treatment such as increased anxiety and fewer depressive episodes before treatment have also shown positive predictive effects on the therapeutic relationship (Lorenzo-Luaces et al., 2014). However, clients with difficulties relating to interpersonal functioning, forming trust in others, personality difficulties, and displaying high levels of challenging behaviour have reported impairments in the working alliance (Couture et al., 2006; Flückiger et al., 2018; Forster et al., 2014; Lorenzo-Luaces et al., 2014). One client population who displays challenging behaviour and can be seen as having difficulties in forming trust are sex offenders.

Sex Offenders

Sex offenders are individuals who have committed an unwanted sexual act against another person, often with the use of force, threat or coercion (Sexual Offences Act, 2003).

An unwanted sexual act involves a lack of consent or inability to consent from the individual exposed to harmful sexual behaviour (rapecrisis.org.uk, n.d). In some instances, the individual who has committed a sexual offence may experience ill mental health. Within the United Kingdom, such sex offenders may be detained under the Mental Health Act (MHA; 1998/2007) where they will likely receive treatment by mental health professionals (College of Policing, 2023).

Different typologies have been defined to describe sex offenders. These are often based on the victim's age or type of crime, for example, child sex offender, rapist or exhibitionist (Robertiello & Terry, 2007; Simons, 2015). However, some typologies also reflect the offenders' age and whether they have exclusively committed sexual offences (Martínez-Catena et al., 2016). A limitation to sex offender typologies, more specifically, when they reflect the type of crime, is that they fail to provide a valuable contribution to treatment as they do not consider other factors relevant for therapeutic needs such as sexual preoccupation or self-regulation difficulties (Bickley & Beech, 2001; Hanson & Morton-Bourgon, 2019; Simons, 2015). Furthermore, sex offender typologies are advised to be considered with caution as they do not account for crossovers in offending (Ahlmeyer, & Simons, 2003; Robertiello & Terry, 2007). Irrespective of the typology, the impact of this crime on the victim's life is severe.

Individuals who have been affected by a sexual offence are likely to experience significant psychological and in some instances, physical harm. Men and women who experience sexual assault are reported to experience sexual dysfunction, low self-worth, and a variety of severe mental health difficulties as well as the risk of contracting sexually transmitted infections (Master, 1986; RAINN, 2023). Additionally, those who are accessing support from mental health services are significantly more likely to attempt to end their life in comparison to those who have not been abused (Tomasula et al., 2012; Ullman & Najdowski,

2009; Van Egmond et al., 1993). Furthermore, the long-term impact on children affected by sexual abuse includes a greater risk of developing substance misuse, physical health, and mental health difficulties such as eating disorders and depression (Darkness to Light, 2020). These digressions highlight the ongoing need for improvements to processes preventing sexual assaults, including therapeutic interventions.

Treating Sex Offenders

Understandably, the treatment of sex offenders is widely researched due to the severity of the risk posed to potential victims and society. Treatment outcomes tend to be measured by pre-and-post psychometrics and rates of recidivism post-treatment (Przybylski, 2015). Recidivism is an individual's relapse into criminal behaviour after serving a sentence for a previous conviction or engaging in relevant treatment (Weisberg, 2013). Simons (2015) suggests that sex offender recidivism rates may be underestimated due to reliance on analyses on official recordings around arrests and cautions. Nonetheless, a focus on reducing recidivism rates remains fundamental to the aims of sex offender treatment programmes (Schmucker & Lösel, 2017).

Sex offender treatment programmes tend to be tailored to reduce risk factors which are considered to be predictive of recidivism (Przybylski, 2015). Risk factors are separated into static and dynamic. Static includes characteristics that are stable over time; concerning sex offenders this can include prior criminal history, psychopathy, and sexual interests (Craig et al., 2005). Dynamic risk factors include characteristics of the individual that can change over time. Dynamic risk factors can also be separated into stable and acute, with stable representing factors that are persistent but changeable such as attitudes and responsibility, whereas acute reflect factors that can suddenly change such as substance misuse and emotional state (Brown & Singh, 2014; Craig et al., 2005). Examples of dynamic risk factors relevant to sex offenders include unemployment, substance abuse, impulsivity and social factors such as employment and marital status (Craig et al., 2005; Kruttschnitt et al., 2000).

Additionally, risk factors focused upon within sex offender treatment include attitudes supportive of criminality, cognitive distortions relating to sexual offences, social skills, and deviant sexual fantasies (Kenny et al., 2001; Nunes et al., 2013). Additionally, a review conducted by Craig et al. (2005) also concluded that treatment dropout amongst sex offenders was observed more in those with higher recidivism rates. Hence, treatment dropout constitutes a type of static risk factor and structured treatment programmes should also account for this risk.

Another dynamic risk factor in relation to sex offender recidivism is the presence of shame (McAlinder, 2005; Jong & Schout, 2012). Shame is the process of experiencing discomfort and humiliation towards the self after engaging in an act that can be perceived as immoral (Gilbert, 1998). The presence of shame has repeatedly been observed amongst sex offenders in relation to their offences as well as withdrawal from treatment (Marshall et al., 2009; Proeve & Howells, 2002). Shame has also been shown to contribute towards sex offenders being less transparent about their risks and desires, subsequently perpetuating their risk and potentially reoffending rates (Marshall et al., 2009). Furthermore, shame is reported to be a primary risk factor for establishing a less effective therapeutic relationship between the therapist and client (Black et al., 2013). Black et al. (2013) also proposed that clients experiencing shame are more reserved in behavioural presentation and therapeutic conversations, and this limits the ability to establish therapeutic rapport.

Previously published literature has highlighted that the therapist's rapport, characteristics, interaction style and relationship with their clients, impact treatment outcomes among sex offenders (Marshall et al., 2003; Sandhu & Rose, 2012; Thornton et al., 2010). Desirable treatment outcomes have been associated with a variety of therapist characteristics, namely honesty, a non-judgemental approach, ability to demonstrate empathy and positive and caring attitudes, influenced the treatment outcomes and engagement (Nelson et al., 2002;

Sandhu & Rose, 2012). Concerning interaction style, Thornton et al. (2000) reported a significant difference in offending attitudes between offenders who were treated by therapists who showed a hostile interaction style and offenders who were treated with a warm and compassionate interaction style. The latter style was related to improvement in offending attitudes, whereas the hostile approach did not appear to influence the attitudes. This highlights the powerful effects the therapist has on affecting treatment outcomes.

Furthermore, the role of empathy as a therapist characteristics has repeatedly demonstrated a strong effect on obtaining positive treatment outcomes amongst this client population (Marshall et al., 2003; Sandhu & Rose, 2012). Empathy is described as a complex construct, with neuroscience identifying various ways one may experience empathy and similarly, various ways to express it (Eisenberg & Eggum, 2009; Elliot et al., 2011; Elliot et al., 2018). Generally, empathy is portrayed by the therapist by showing genuine efforts to understand the client, remaining present with the client's experience, and being actively supportive (Elliot et al., 2011). However, empathy has also been described as an emotion regulation process to soothe one's own distress when they are exposed vicariously to the trauma of another (Eisenberg & Eggum, 2009). This is of particular importance as the development of the therapeutic relationship with sex offenders will likely expose the therapist to traumatic events perpetrated by their clients. Thus, this may present barriers to the therapeutic rapport due to the presence of vicarious trauma and burnout among therapists and other forensic staff (Moulden & Firestone, 2007; Kadambi & Truscott, 2003; Munger et al., 2015). This emphasises the complexity of developing a well-nourished therapeutic relationship and warrants systematic research aimed at exploring the therapeutic relationship in the context of working with sex offenders.

Previous Literature Reviews

For the current review, an initial scoping exercise was conducted, providing one systematic review relevant to the current topic as well as two literature reviews. Marshall et al. (2003) and Youssef (2017) both conducted literature reviews exploring the importance of the therapeutic alliance and challenges when working with sex offenders. Such challenges include systemic issues, transference, and the dual role of the therapist to provide therapeutic intervention whilst answering to the prison or psychiatric hospital. Marshall et al. (2003) provided interesting reports to suggest that the therapeutic relationship has a greater influence on treatment outcomes than the treatment programme. Additionally, Marshall et al. (2003) propose that the therapeutic relationship can influence treatment outcomes to a greater extent among sex offenders than among the general clinical population.

Moreover, Youssef (2017) concluded similar findings, stating that the presence of the therapeutic relationship is likely to promote positive treatment gains. Youssef (2017) further reported that emotional expression from the therapist in the form of empathy and warmth is a strong mediator of the relationship between therapeutic alliance and behavioural and attitudinal changes within this population. However, the two reviews were not systematic, therefore, all potential literature available on this topic was not included.

Furthermore, Sandhu and Rose (2012) conducted a systematic literature review exploring the role of characteristics of therapists on treatment outcomes amongst sex offenders. The review concluded that gender, the therapists' attitudes, and the ability to demonstrate empathy played an influential role in treatment outcomes. For example, a supportive therapist style was associated with greater group cohesion and positive treatment change. Conversely, a more controlling therapeutic approach was associated with lower levels of group cohesion. The review by Sandhu and Rose (2012) provides a valuable overview of the role of the therapist's personal characteristics in the treatment of sex offenders. Nonetheless, similar to other reviews, such as Marshall et al. (2003), the review

was published over 10 years ago and as stated previously, the rate of sex offending has been increasing and the law and knowledge related to this group of offenders has been under substantial revision.

The Current Systematic Review

From the information presented in the preceding sections, it is apparent that the therapeutic relationship has a meaningful effect on treatment outcomes amongst the general population (Bedi et al., 2005; Flückiger et al., 2018). Additionally, reviews conducted by Marshall et al. (2003), Sandhu and Rose (2012) and Youssef (2017) suggest that the therapist's qualities can contribute to treatment success amongst the population of sex offenders. However, although Marshall et al. (2003) and Sandhu and Rose (2012) have provided informative findings, there have been further studies since their publication dates. Additionally, when examining the literature that has been included in Youssef's (2017) review in comparison to the current authors screening search, it seems that not all scientific literature has been included within the review. Therefore, the current review aims to build on the pre-existing picture and supplement it by exploring the effect of the therapeutic relationship on treatment outcomes amongst sex offenders.

Aims of the Current Systematic Literature Review

The primary aim of this systematic literature review is to determine whether the therapeutic relationship impacts treatment outcomes when working with sex offenders. A secondary aim is to explore factors that contribute to this potential relationship.

Methodology

This systematic literature review broadly followed guidance published by Bolland et al. (2017). An initial scoping exercise was completed to assess the size of the relevant literature as well as to ensure that the current review would not be replicating an existing one. On 29/01/2021, PROSPERO, Cochrane Library, CRDWeb, and Campbell Collaborative were searched with the key term *sex offenders*. A total of 70 SLRs were identified, however, they were not relevant to the current review. This process was conducted again on 16/04/2023, and no further papers were listed.

With the same aim, the NHS evidence database was searched on 29/01/2021 and again on 16/04/2023 with the term *therapeutic relationship sex offender*, this provided 370 results, one of which was relevant to the current review. This was a literature review written by Serran and Marshall (2010) investigating the impact of the therapeutic process when working with sex offenders.

A less formal scoping search was later conducted on a variety of relevant databases, this provided three further papers relevant to the current topic. Out of all four reviews discovered, one was a systematic review exploring the influence of the therapist on treatment outcomes amongst this population (Sandhu & Rose, 2012). Whereas the remaining three were literature reviews exploring process issues and the importance of the therapeutic alliance when working with this population (Marshall et al., 2003; Serran & Marshall, 2010; Youssef, 2017). Concerning the literature reviews, two are over ten years old, therefore, it is likely that further valuable research has been conducted since. The most recent review by Youssef (2017) was non-systematic, it is plausible that it did not include a comprehensive literature search. Additionally, a concluding recommendation from the systematise literature review (Sandhu & Rose, 2012), was for future reviews to explicitly explore the impact of the

therapeutic relationship on treatment outcomes amongst this population. Therefore, an informed decision was made to proceed with a systematic exploration of the previously stated research question; How does the therapeutic relationship impact treatment outcomes when working with sex offenders.

Study Selection

The literature search for a systematic review is crucial to identify relevant studies to address the research question. To support this process, it has been proposed that a clear definition of the intended participant sample and the problem be established, which led to the development of the four-step model: PICO (Richardson et al., 1995). The elements of the PICO include *patient, population, problem, intervention, comparison, and outcome*. The framework has since been a widely used tool to formulate research questions with inclusion and exclusion criteria and to select suitable terms to conduct a comprehensive literature review (Brown, 2020; Erikson et al., 2018). However, a recent study conducted by Frandsen et al. (2020) concluded that the inclusion of the final two components: *comparison and outcome*, produces a lower recall of studies, potentially overlooking valuable literature. Therefore, the current review will focus on the first two components and broadly define the outcome component to inform the inclusion and exclusion criteria as well as the search terms; please refer to Table 1.

Table 1*Inclusion and Exclusion Criterion using PICO*

	Inclusion	Exclusion
Patient, Population, Problem	Individuals convicted of a sexual offence. All categories of sexual offending will be included. Healthcare professionals as treatment facilitators such as therapist, psychiatrist, forensic mental health nurse, psychologist and social worker.	Literature has identified that the most reliable effects of the therapeutic relationship are reported from the client's rating rather than the therapist and that there are occasional discrepancies between therapists and offenders view of the therapeutic relationship (Bedi et al., 2005). Therefore, research relying exclusively on the therapist's perception will be excluded from the study.
Intervention	The therapeutic relationship between treatment facilitator and sex offender will be the intervention focused upon within the review. The therapeutic relationship will be measured within sex offenders' treatment, with group and individual interventions being included within the current review.	No specified exclusion criteria.
Comparison	No specified inclusion criteria.	No specified exclusion criteria.
Outcome	Treatment gains and outcomes related to recidivism rates, risk assessments scores, and behavioural, attitudinal, and cognitive change were included within the study.	No specified exclusion criteria.

Sources of Literature and Search Terms

A mixed strategy approach was employed when searching for published literature, meaning that an automated and manual search was undertaken. This was to ensure a thorough search was conducted, minimising the likelihood that relevant research would be overlooked. The following databases were used to conduct the literature search. They were selected based on their relevance to the research topic:

- ProQuest
- Web of Science
- Ovid: PsychINFO
- Scopus

Automated searches were conducted by searching for keywords and subject headings within the above-mentioned databases. When conducting the database search, the search field and search terms were adapted for each database, this can be found in Appendix A. The search fields were adjusted to search within the papers' *topic* and *abstract*. An initial search on each database was conducted on 10/12/2021 which was then repeated on 16/04/2023 to ensure all available literature was included. Below are the key search terms used within this review:

“Sex Offender*” or “sexual offender*” or “child sex offender” or “paedophile*”

AND

therapeutic* NEAR/1 relationship* OR therapeutic* NEAR/1 rapport* OR working*

NEAR/1 relationship* OR professional* NEAR/1 relationship* OR therapeutic* NEAR/1 alliance* OR therapeutic* NEAR/1 process*

AND

“treatment respons*” or “treatment efficacy” or “efficacy” or “treatment outcome*” or “recidivism rat*” or “behaviour* change*” or “attitude change*” or “risk level”

Additionally, manual searches were conducted by reading through the reference list of the reviews identified within the initial scoping exercise (Marshall & Serran, 2010; Marshall et al., 2003; Sandhu & Rose, 2012; Youssef, 2017). Furthermore, once relevant literature was obtained through the automated approach, the reference lists from each paper included was also searched.

Quality Assessment

Following the screening process of publications against the pre-determined inclusion and exclusion criteria, it was noted that three study designs were used within the included literature: observational, correlational and pre-and-post measures. Therefore, the quality assessment tool used in this review was adapted to meet the requirements for study designs. The adaptation was based on the National Heart, Lung, and Blood Institute quality assessment tools for pre-post studies with no control as well as observational studies (NHLBI; NIH, 2021). The NHLBI quality assessment tool was chosen as it was consistent with the study designs included in this review.

After the inclusion and exclusion process, the main researcher identified eight viable publications. Dual coding of all eight research papers was undertaken by the main researcher’s colleague who was perceived as an impartial individual with a similar level of experience in conducting systematic literature reviews to the main researcher. As indicated by Powell and Koelemay, 2022, the quality of a review is only as good as the quality of the studies included, meaning that studies with poor methodological quality may present misleading results. Therefore, the research team agreed that for the seven papers utilising pre and post-study designs a score of 10 (out of 13) and above would be

rated as good, 7 and above as fair and anything from 6 and below would be rated as poor and excluded from the current review. Concerning the single observational study, the NHLBI quality assessment tool was used however, three of the items were specific to pre-and-post measures and were not applicable; therefore, they were excluded, and it was decided that a score of 8 out of 11 would be rated as good, 6 and above would be rated as fair and anything below 5 would be rated as poor and excluded from the study. There were no conflicts throughout the dual coding process. A detailed summary of all quality assessment tools and the respective ratings can be found in Appendix B.

Following the quality assessment, Marshall et al. (2003) were excluded from the current review due to receiving a rating of poor based on the NHLBI quality assessment tool. The study did not provide clear information within the methods section concerning the participant's sample and it neglected to consider confounding variables. The total number of papers included in the review is seven. A total of three papers were rated as good, four papers rated as fair, and one paper rated as poor. Table 2 contains an overview of the included papers and their scores.

Table 2*Quality Assessment Scores*

Reference	Study Design	Quality Assessment Score
Aylwin (2010)	Pre-and-post measures	Good: 10/13
Beech & Hamilton (2005)	Pre-and-post measures	Good: 10/13
DeSorcy et al., (2014)	Correlational Design	Good: 10/13
DeSorcy et al., (2017)	Correlational Design	Fair: 8/13
Fenske (2007)	Pre-and-post measures	Fair: 9/13
Rothman (2007)	Pre-and-post measures	Fair: 9/13
Marshall et al., (2002)	Observational	Fair: 6.5/11
Marshall et al., (2003)	Observational	Poor: 4.5/11 (excluded)

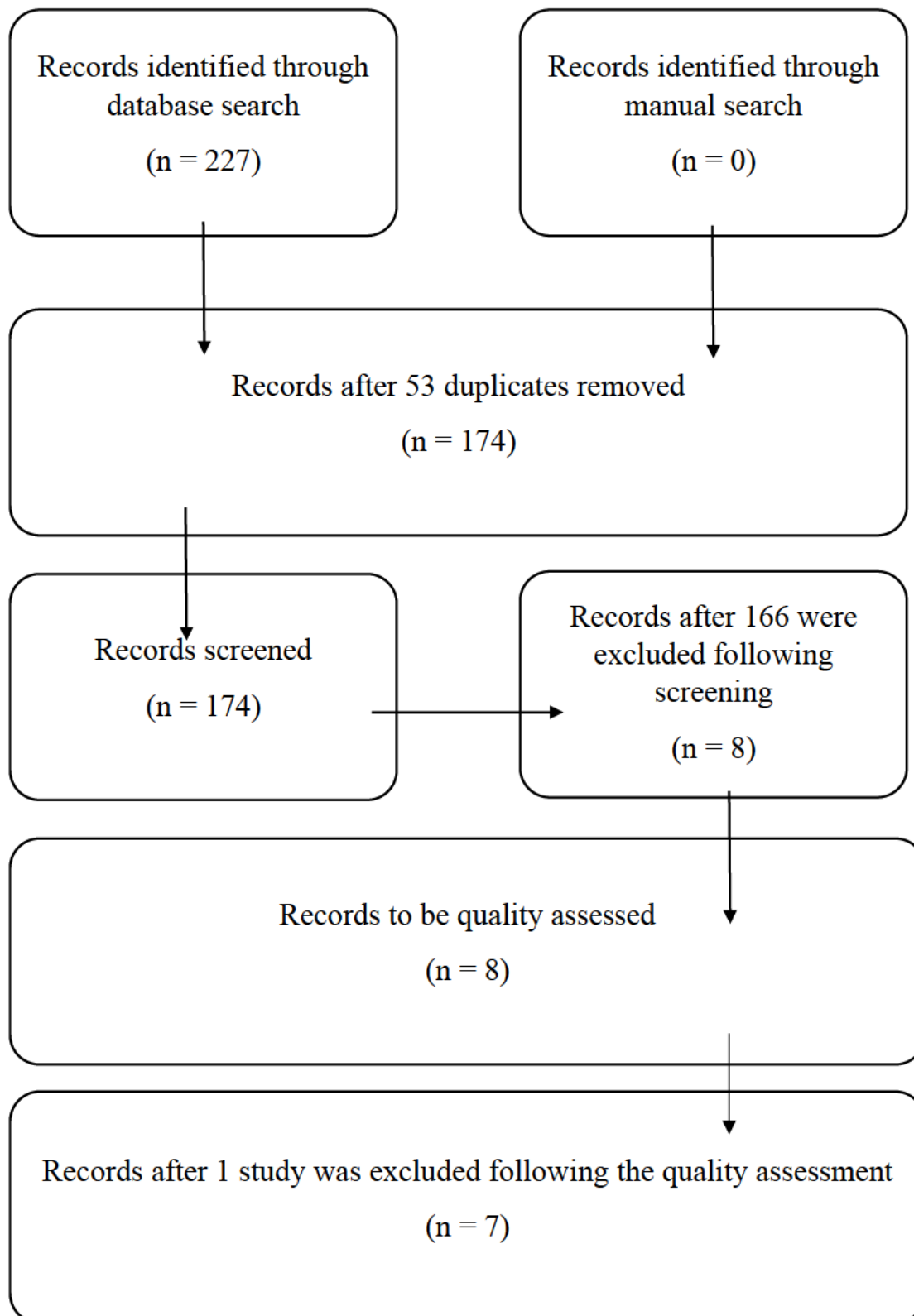
Note: All papers were quality assessed by two individuals who used the National Heart, Lung, and Blood Institute Quality Assessment Tool (NIH, 2023).

PRISMA Flow Diagram

Figure 1 is a graphical depiction of the search and screening stages for the current review. A total of 227 papers were obtained through the automated search strategy. Zero papers were identified as relevant based on the manual search. All references were imported into endnote and duplicates were removed, resulting in 174 papers being screened. Following the screening process, 166 papers were identified as not relevant for the current review and consequently excluded, resulting in a total of eight papers that were quality assessed. Following this process, one paper was excluded due to receiving a rating of 'poor', totalling the remaining seven papers to be included within the review. The exclusion criterion was not required throughout this process.

Figure 1

PRISMA Flow Diagram



Data Extraction and Synthesis

After the quality assessment stage, relevant information from the included studies were extracted using a pre-designed data extraction form (Appendix C). The form was broadly based on guidance from Fleeman and Dunder (2014) and jointly agreed upon by the research team. The data extraction form was developed to comprise different sections that would identify relevant and informative details from each study, namely details about the study aims, methodologies such as participant samples and measures, findings and conclusions, and possible limitations of research. For conciseness, if there was no data/information to include under a relevant subheading, it was then removed from the table. Finally, a narrative synthesis of all research was conducted with the aim of addressing the research questions and any other emerging patterns.

Results

In total, seven scientific papers were extracted for analysis, four of which were a quasi-experimental, pre-and-post measures design, two were a correlational design and one was an observational design. Elements of these studies were extracted using the previously mentioned form and crucial details for each study were simplified. Table 3 contains the simplified data extracted for each included study.

Table 3

Systematic Data Extraction Table

Study Details	Population and setting	Method of intervention	Method of measuring and recording	Results (Include Mean, P Value, Standard Deviation and Effect Size where appropriate)	Limitations
Authors: Aylwin, A. Year: 2010 Citation: Aylwin (2010) Aim of Study: a) To explore the therapeutic alliance between therapist and sex offenders as reported by the sex offenders. b) Examine the	Eligible population: Individuals who have committed sexual offences and received treatment/therapy Healthcare professionals; psychiatrists, psychologists, group facilitators or occupational therapists Selected population: 95 adult male convicted sex offenders that have attended the first phase of the three phase Phoenix Programme for treating convicted	Group: Phoenix Programme – three-phased group programme Secure inpatient service: Treatment was provided at Alberta Hospital Edmonton	Pre and post-test measures or observational: - All measures were completed pre-treatment and post treatment (1 month before discharge) How was the therapeutic relationship defined? The therapeutic alliance was defined by offenders' perception of the relationship as well as therapists' affective response. Who reported on the therapeutic relationship and treatment outcome	Quality of relationship: There was a gradual increase in alliance ratings over the months of treatment – this effect was found for therapist, programme and peer ratings provided by the SOs. The above effect was also found in the non-completers group however, their overall mean score was considerably smaller. Peer alliance score was the most smallest. GES: medium to high positivity was scored for relationship dimensions, system dimensions and personal growth dimensions.	Aylwin (2010) noted that the many scales used within the study increased the risk of Type 1 error which was in fact, actively influencing the results.

relationship between therapeutic alliance and treatment outcome measures. Study Design: Pre-and-post measure no control Quality score: Good: 10/13	adult male sex offenders. Treatment facilitators: 1 psychiatrist, 1 programme manager, 1 psychologist, 1 social worker, 8 registered nurses, 5 forensic therapists and recreation therapists. Categories of sex offenders: 58% were categorised as child molesters, 16% as adult hands off or rape offenders, 5% were mixed category offenders, 4% internet offenders, 5% with a non-sexual index offence, but past sexual convictions and 15% had missing data in this category. Additional identified participant factors: Four exclusion criteria for the treatment:		(Offenders or therapists): Male sex offenders completed two self-report measures and the therapists rated their affective response Self-report scales - Edmonton Therapeutic Alliance Scale – modified for the current study – this was used to measure experience with therapist, overall programme and peers. - Group environment scale - 38 item REACT scale to measure affective response and counter transference Risk assessment levels: - Static-99 - RRASOR - PCL-R	REACT scale: FACTOR 1- <i>Therapists conflict with self-increased over treatment</i> – this was seen in both male and female therapists as well as for treatment completers and non-completers. FACTOR 2 – <i>Therapists focusing on their own needs</i>. Female therapists demonstrated a great deal of variability for both treatment completers and non-completers. Whereas for male therapists, there was a gradual increase. FACTOR 3 – <i>positive connections with clients increased over time for all groups</i>. FACTOR 4 – conflict with client remained relatively stable within each group, but a slight decline at the beginning particularly for females. FACTOR 5 – positive emotions towards clients remained stable for both male and female with a slight increase and then return	
---	--	--	---	---	--

	• IQ less than 80 • History of psychotic episodes or major mental illness • Denial of offence • Voluntary attendances/not mandated. • Therapists; 9 male and 12 female Controlled factors: Treatment completion		Behavioural change: - The Network of Relationship Inventory Qualities Version – pre and post-treatment – used to assess interpersonal health/relationship maturity - Inventory of interpersonal problems – used to evaluate interpersonal problems Attitude change: - Personality research form - Jackson Personality Inventory - revised	to baseline at the end of treatment. FACTOR 6 – negative emotions towards clients remained stable for male therapists throughout treatment with a slight increase for women in the middle of treatment but shortly after return back to baseline. Overall findings (treatment outcome and working alliance): - Stronger alliance with therapist and peers was associated with a reduction on the JPI-R Anxiety Scale - Growth rate of the therapeutic alliance was strongly associated with JPI-R Responsibility - Therapeutic alliance with the therapist is	
--	---	--	---	--	--

				negatively related to dominance in the PRF-E - Therapeutic alliance with therapist is associated with a reduction in domineering and vindictive in the IIP-64 - Peer alliance was strongly associated with a reduction in domineering, vindictive, cold and intrusive in IIP-64	
--	--	--	--	---	--

Study Details	Population and setting	Method of intervention	Method of measuring and recording	Results (Include Mean, P Value, Standard Deviation and Effect Size where appropriate)	Limitations
Authors: DeSorcy, D., Olver, M. & Wormith, S. Year: 2014 Citation: DeSorcy et al. (2014) Aim of Study: a) Exploring the cultural difference in working alliances between non-aboriginal sex offenders and aboriginal sex offenders with treatment providers. b) Exploring the relationship between the	Eligible population: 1) Aboriginal and non-aboriginal sex offenders 2) Treatment providers for sex offenders' programmes Selected population: 1) 427 male sex offenders enrolled onto the Clearwater Programme Categories of sex offenders: 93.4% had a sexual index offence, whereas the remaining participants had a previous history of sexual violence. Of those with a sexual index offence, 50.8% were classified as	Group: Participants took part in the Clearwater group programme. Individual: Individual sessions were also offered as part of the treatment. Secure inpatient service: A federal maximum-security correctional treatment facility in Canada.	How was the therapeutic relationship defined?: Working Alliance Inventory (WAI) which was completed three months into the programme. Who reported on the therapeutic relationship and treatment outcome (Offenders or therapists): Clients (sex offenders) Self-report scales: Working Alliance Inventory – 36-item self-report instrument Recidivism rates: A score of 1 was given if the participant had received any new	Recidivism rates: - 13.2% were convicted for a sexual offence. - 37.1% were convicted for a violent (including sexual) offence. - 57.4% were convicted for any new offence (general recidivism). Working alliance/therapeutic relationship: The highest rate of treatment non-completers was observed amongst those who had the lowest WAI scores Overall findings (treatment outcome and working alliance):	The therapeutic relationship was only measured on one occasion throughout the treatment programme, roughly three months into the programme. As the therapeutic relationship can change over time, repeating the measure at the end of treatment may have reported different results.

working alliance and recidivism Study Design: Correlational study design with no control group. Quality score: Good 10/13	rapist with adult victims, 21.3% were extrafamilial child molesters, 18.9% were mixed offenders (adult and children), 2.1% were intrafamilial child molesters, 0.9% were non-contact, 0.2% offended against adult family members and 0.7% non-sexual offences that were sexually motivated. Additional identified participant factors: - 45.9% were self-identified aboriginal groups and 51.8% were white.		convictions following attendance of the programme and release back into the community. A score of 0 was given if they did not receive a new conviction. The recidivism rates were followed up for a mean of 10.4 years.	No relationship between treatment outcome/recidivism and therapeutic relationship	
--	--	--	--	--	--

Study Details	Population and setting	Method of intervention	Method of measuring and recording	Results (Include Mean, P Value, Standard Deviation and Effect Size where appropriate)	Limitations
Authors: DeSorcy, D., Olver, M., & Wormith, S. Year: 2017 Citation: DeSory et al. (2017) Aim of Study: The study investigated the impact of psychopathy on the relationship between working alliances and recidivism in adult male sex offenders. Study Design:	Eligible population: 427 Selected population: 111 Additional identified participant factors: Serving at least 2 years Participating in Clearwater rehabilitation programme.	Group: Yes Individual: Yes Prison environment: Yes	How was the therapeutic relationship defined measured?: Measured through a self-report scale three months into the programme. Who reported on the therapeutic relationship and treatment outcome (Offenders or therapists): Clients (sex offenders) Recidivism rates: A score of 1 was given if the participant had received any new convictions following attendance of the programme and release back into the community. A score of 0 was given if they did not receive a new conviction. The recidivism rates were	Recidivism rates: - 9.3% were convicted for a new sexual offence. - 43% were convicted for any new violent offence. - 58.9% were convicted for any new offence. Working alliance/therapeutic relationship: - There was no significant difference in WAI scores between those that scored high and low on the PCLR-R. - The affective facet of the PCL-R was associated with weaker Bond scores from the WAI whereas the Lifestyle facet was	1. The therapeutic relationship was only measured on one occasion throughout the treatment programme, roughly three months into the programme. As the therapeutic relationship can change over time, repeating the measure at the end of treatment may have reported different results. 2. DeSorcy et al. (2017) identified that the clients may have inflated their WAI

Correlational study design with no control group. Quality score: Fair: 8/13			followed up for a mean of 10.4 years.	associate with lower task scores from the WAI - Higher scores on the affective facet from the PCL-R predicted lower WAI scores Overall findings (treatment outcome and working alliance): - There was no relationship between working alliance and treatment outcome - Psychopathy predicted violent and general recidivism	scores as the therapists were rating their treatment progress which may have contributed to the high WAI across both high and low scoring PCL-R sex offenders.
--	--	--	--	---	---

Study Details	Population and setting	Method of intervention	Method of measuring and recording	Results (Include Mean, P Value, Standard Deviation and Effect Size where appropriate)	Limitations
Authors: Rothman, D. Year: 2007 Citation: Rothman (2007) Aim of Study: To explore the relationship between the therapeutic relationship and treatment outcome with sexual offenders. Study Design: Pre-and-post measure no control Quality score: Fair: 9/13	Selected population: - 45 voluntary sex offenders who had participated in sexual offenders' treatment. - 7 therapists (5 male and 2 female) Categories of sex offenders: 54.5% had child victims, 36.4% had adult victims and 9.1% had mixed victims (adult and children) Additional identified participant factors: Exclusion criterion: - Only those functionally literate were able to take	Group: 65.9% engaged in group and individual sessions. Individual: 34.1% engaged in individual sessions only Community: 77.3% were based in the community. Secure inpatient service: 22.7% were based in a medium secure federal service.	Pre and Post measures: Completed when mutually agreed upon by therapist and participant. How was the therapeutic relationship defined?: The therapeutic relationship was defined by two self-report questionnaires exploring the working alliance and clients experience. Who reported on the therapeutic relationship and treatment outcome (Offenders or therapists): Sex offenders completed self-report scales for the working alliance as well as further scales to measure treatment outcome.	Overall findings (treatment outcome and working alliance): - Stronger therapeutic relationship was associated with better overall client functioning and better treatment outcome. - Positive relationship between therapist empathy and measures of global psychological, social, and occupational functioning and sex-offender treatment progress - Negative association	- The study utilised a convenience sample where offenders were at different stages of treatment however, data analysis showed no moderating effect for treatment duration.

	part in the study - Treatment length ranged from 1 to 120 months Controlled Factors: - Age of participant - Therapist-client ethnicity match - Treatment duration		Self-report scales: - The relationship inventory - The working alliance inventory - Qualitative data was collected through asking clients about their treatment experience Risk assessment levels: Static – 99: Ranged from 0 to 9 Behavioural change scales: - Global Assessment of function scale - Assessment of cognitive distortions - Assessment of intimacy deficits - Standard goal attainment scaling - Rape and Molest scales	between therapist empathy and cognitive distortions supportive of sexual assault and intimacy deficits - Higher levels of client-therapist agreement were related with lower levels of emotional loneliness.	
--	--	--	---	---	--

Study Details	Population and setting	Method of intervention	Method of measuring and recording	Results (Include Mean, P Value, Standard Deviation and Effect Size where appropriate)	Limitations
Authors: Fenske, A Year: 2007 Citation: Fenske (2007) Aim of Study: a) To explore whether the therapeutic relationship impacts offender symptoms. b) Whether feedback on therapist empathy would foster better treatment outcomes.	Selected population: 19 male sex offenders Additional identified participant factors: 90% of participants were mandated to take part in the programme but were not mandated or coerced into consenting to the study. Group 1: Therapy duration ranged from 2 months to 147 months with an average of 29 months. Group 2: Therapy duration ranged from 4 months to 42 months with an average of 27.40 months. Group 3: Therapy duration ranged from 12 months to 60 months	Group: Group led – three groups, the first two are controlled group where therapists were not provided feedback on their empathy. Prison environment: Yes	Pre and post measures: Each scale was completed following each session. This took place over ten sessions. How was the therapeutic relationship defined?: Through a self-report questionnaire Who reported on the therapeutic relationship and treatment outcome (Offenders or therapists): Clients (sex offenders) Self-report scales: - The helping alliance questionnaire - Empathy scale revised - The outcome questionnaire	Working alliance/therapeutic relationship: From the pre-and-post scores, group 3 (experimental group where therapists were not provided with feedback on their empathy) was the only group to report a significant increase in the helping alliance. Overall findings (treatment outcome and working alliance): - Group 1: decrease in distress as captured by OQ-45.2 - Group 2: decrease in distress as captured by OQ-45.2 - Group 3: decrease in distress as	- Fenske (2007) noted that the feedback given to the therapist relating to their display of empathy could have been improved by being more direct. - Fenske (2007) noted that a longer time frame between measuring perceived empathy and providing feedback could have provided

Study Design: Quasi- pre-and- post measure Quality score: Fair: 9/13	with an average of 26.14 months. Relationship status: 8 married, 4 single and 7 divorced			captured by OQ- 45.2 - Two-step regression revealed that as the helping alliance improved, symptoms decrease. Suggesting that the therapeutic relationship has positive effects for treatment outcome. - No significant effects were found when exploring the controlled conditions. Suggesting that the relationship between WA and TO was not influenced by therapists receiving feedback on empathy.	<i>“better data”</i>. - The Outcome Questionnaire includes three subscales however, the data analysis focused on the total scale score rather than exploring each subscales, making the findings less informative.
--	---	--	--	---	---

Study Details	Population and setting	Method of intervention	Method of measuring and recording	Results (Include Mean, P Value, Standard Deviation and Effect Size where appropriate)	Limitations
Authors: Beech, A., & Hamilton, C Year: 2005 Citation: Beech and Hamilton (2005) Aim of Study: To explore whether there is a relationship between the therapeutic climate and the effectiveness of CBT treatment for sex offenders in U.K. prisons. Study Design: Pre-and-post measure no control	Eligible population: Men engaging in the SOTP group that have a sexual conviction. Selected population: 100 men with a sexual offence. Only 88 completed the Group Environment Scale measure. Categories of sex offenders: 82% had committed offences against children, 14 had committed offences exclusively against adults and 4 men had committed against adults and children (mixed victim group). Additional identified participant factors:	Group: 12 separate sexual offender treatment groups Prison environment: 6 medium secure Prisons	How was the therapeutic relationship defined?: The therapeutic relationship was accounted for by different sub-scales in the GES; cohesion, leader support and expressiveness, Quality of relationship/alliance: The Group Environment Scale – measuring ten components to the experience of the programme: 1. Cohesion 2. Leader support 3. Expressiveness 4. Independence 5. Task orientation 6. Self-discovery 7. Anger and aggression 8. Order and organization	Working alliance/therapeutic relationship: Significant difference was found between the members and leaders scoring, suggesting they perceived and experienced the group very differently. This effect was found for independence (leaders viewed themselves as encouraging independence more than the members), leader control (leaders viewed themselves as more controlling than members) and order and organization (leaders viewed the group as better organized than the members). Significant differences were found for each group on 8 subscales. The only two subscales where there was no difference were	Treatment hours differed drastically - this was explored within the study and treatment length was reported to be a contributing factor to efficacy for some of the groups, but not all and this was only found in the percentage of offenders that had offended against children.

Quality score: Good: 10/13	Treatment hours ranged from 74 to 186 amongst the 12 groups due to the ongoing transition between the 80 hour treatment programme to 160 hour treatment programme		9. Leader control 10. Innovation Who reported on the therapeutic relationship and treatment outcome (Offenders or therapists): - Group members (sex offenders) and group leaders. Attitude change: - Victim Empathy Distortions Scale - Cognitive Distortions Scale and Sex Questionnaire - Emotional Identification with Children and Sex Questionnaire	independence and order and organization (the two-system maintenance/system change factors) Overall findings (treatment outcome and working alliance): A significant positive relationship was found between treatment change and cohesion as well as expressiveness. Two of the three subscales that accounted for group relationships. The latter concerning the facilitators and the first concerning peer relationships.	
--	--	--	---	--	--

Study Details	Population and setting	Method of intervention	Method of measuring and recording	Results (Include Mean, P Value, Standard Deviation and Effect Size where appropriate)	Limitations
Authors: Marshall, W., Serran, G., Moulden, H., Mulloy, R., Fernandez, Y., Mann, R., Thornton, D. Year: 2002 Citation: Marshall et al. (2002) Aim of Study: Two studies conducted in the current piece of literature. The first of the two studies was not relevant to the current review therefore will not be included in the extraction. The	Eligible population: a) Sex offenders taking part in the offending behaviour programme unit b) Therapists providing treatment for the programme. Selected population: a) 17 therapists' videos were selected and screened by an experience judge that were involved in the initial study b) An exact number of participants were not provided for	Group: Offending behaviour programme Prison environment: Videotapes from five prison environments	How was the therapeutic relationship defined?: The relationship was defined by therapists' characteristics – this was measured through observation and rated by judges. Who reported on the therapeutic relationship and treatment outcome (Offenders or therapists): An experienced judge reviewed tapes of the therapist and client interactions. Behavioural change: - Each selected tape covered a different treatment target(e.g.	Overall findings (treatment outcome and working alliance): Below is a list of the therapist characteristics that demonstrated positive treatment change: - <i>Empathy</i>: Reported a significant increase in relationships and a significant decrease in denial of harm and responsibility, victim blaming, and denial of premeditation, minimization and lie scale. - <i>Warmth</i>: reported a significant decrease a decrease in denial of responsibility, premeditation, minimization, victim blaming and	- The videotapes selected were recommended by the programme as the sex offenders had shown some form of behavioural change – this is then excluding those that did not show behavioural change. This reduces the validity of being able to suggest the behavioural change was down to therapists' behaviour, as

second study aimed to identify a relationship between therapists' behaviour towards client and treatment outcome. Design: Observational study Quality score: Fair: 6.5/11	sex offenders. Rather the study stated that there were roughly 5-8 offenders per 2-3 therapists.		disclosure of the offence, empathy for victims, pro-offending attitudes, offence chain, and relapse prevention plans).	rape myth acceptance. - <i>Rewarding:</i> Reported a significant decrease in denial of harm, responsibility, minimization, premeditation and victim blaming. - <i>Directive:</i> Reported a decrease in denial of responsibility, premeditation, minimization and victim blaming.	they may have behaved in the same way towards another offenders but not received the same outcome, however, this will not be discovered due to eliminating those that had not shown change. - Reliance on observation rather than offenders' perception of the relationship and/or characteristics of the therapist
--	---	--	---	---	--

Note: For references of scales used in the summarised studies please refer to sections below.

Descriptive Overview of Results

Sample Characteristics

Within the included studies, the sample sizes ranged from 19 to 427 with a total of 785 sex offenders, all of which were male. The biological sex and number of therapists were not reported within each study as for some they were not classified as part of the study's population sample. For the studies that did report the number of therapists, this ranged from seven to 17 and included a variety of professions such as psychiatrists, forensic mental health nurses, psychologists and social workers (Aylwin, 2010; Rothman, 2007). One study reported on the therapists' biological sexes, explaining that there were five male and two female therapists (Rothman, 2007). Concerning the categories of sex offenders, the definitions varied between victim age and offence type. Rothman (2007) documented that over 60% of participants were classified as moderate-high risk on the Static-99 (Hanson & Thornton, 1999) risk assessment for recidivism.

Study Characteristics

The date range for the included studies involved the years 2002 to 2017. Treatment outcomes were frequently measured by psychometrics which were used in the pre-and-post and observational studies. The stage at which psychometrics were administered varied, with some of the studies conducting the assessment throughout the treatment programme (Fenske, 2007; Rothman, 2007) and one administering directly before the intervention and then one month before discharge (Aylwin, 2010). Separate from pre-and-post measures, rates of recidivism were also explored across a ten-year period within two studies (DeSorcy et al., 2014; 2017).

Furthermore, only four of the studies described the intervention that was facilitated which included the Phoenix Programme, Offending Behaviour Programme and two studies reporting on the Clearwater programme (Aylwin, 2010; DeSorcy et al., 2014; 2017; Marshall

et al., 2002). Additional factors were also explored, such as the location in which treatment was delivered such as a community placement, a secure hospital, and four prisons and one study reported a combination of secure hospital and community-based treatment (Rothman, 2007). Treatment duration was reported in hours and months; concerning hours, this ranged from 24 to 186 hours (Beech & Hamilton, 2005), whereas months, a range from one to 147 months was noted across studies (Fenske, 2007; Rothman, 2007).

Measures Used in the Included Articles

Excluding the observational study (i.e., Marshall et al., 2002), the construct of the therapeutic relationship was unanimously defined by the client's perception. Marshall et al. (2002) were not excluded from the study as a judge objectively observed the therapeutic relationship rather than it being rated by the therapist. Concerning the client's perception of the therapeutic relationship, the following psychometrics were used; The Group Environment Scale (Moos, 1986) as used within Beech et al. (2005) and Aylwin's (2010) studies, The Helping Alliance Questionnaire (Luborsky et al, 1996) used within Fenske's (2007) study, The Relationship Inventory (Barrett-Lennard, 1962/1986) used within Rothman's (2007) study, and The Working Alliance Inventory (Horvath & Greenberg, 1986) used within Rothman (2007), DeSorcy et al. (2014; 2017) studies. Moreover, there were some additions such as the therapist's affective response to the client as well as the therapist's perception of the group environment. In the observational study, the relationship was defined by the observation and rating of therapists' characteristics (Marshall et al., 2002).

When assessing treatment outcomes, a variety of measures were employed, generally with a focus on cognitive and attitudinal change, these included: The Victim Empathy Distortions Scale (Beckett & Fisher, 1994), Cognitive Distortions Scale (from the Children and Sex Questionnaire, Beckett, 1987), and Emotional Identification with Children (from the

Children and Sex Questionnaire, Beckett, 1987) as used within Beech and Hamilton's (2005). Furthermore, receiving a score within the normative range for each scale was interpreted as effectively treated within Beech and Hamilton's (2005) study. The Outcome Questionnaire-45.2 (OQ45.2; Lambert et al., 1996) was employed by Fenske (2007), measuring three core areas: Interpersonal Relationships, Social Roles, and Distress. The Relationship Inventory (Barrett-Lennard, 1962), Global Assessment of Functioning Scale (Lambert & Hill, 1994), RAPE and MOLEST Cognitive Distortion scales (Bumby, 1996), The Revised UCLA Loneliness Scale (Russell et al., 1980) and the Goal Attainment Scaling (GAS; Kiresuk & Sherman, 1968), were all used to measure treatment outcomes within Rothman (2007) study. Moreover, Aylwin (2010) used The Network of Relationships Inventory-Relationship Qualities Version (NRI-RQV; Buhrmester & Furman, 2008), The Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988), The Personality Research Form-English version (PRF-E; Jackson, 1989), and Jackson Personality Inventory-Revised (JPI-R; Jackson, 1994) to measure treatment outcomes.

Additionally, the Psychopathy Checklist-Revised (PCL-R; Hart et al., 1992) was used within Aylwin (2010) and DeSorcy et al. (2017) studies to measure the effect of psychopathy on the relationship between the therapeutic relationship and treatment outcomes.

Themes Derived from the Reviewed Papers

The following subsection includes themes derived from the process of narrative synthesis of studies included in the current review. The researcher became thoroughly accustomed to the extracted data and the summary table by re-reading the information. The reported themes were devised based on the resulting understanding of the summaries, article quality scores, significance of findings, and repetitiveness of findings. The process led to the forming of six distinct themes that jointly provide a comprehensive overview of the literature concerning the role of the professional therapeutic relationship in treatment outcomes of sex

offending clients, and the therapist characteristics interacting with the process of therapeutic relationship.

Theme One: The Impact of the Quality of the Therapeutic Relationship on Short-Term Treatment Outcomes

The therapeutic relationship accounted for several positive changes that were consistent with treatment goals. These effects were found exclusively for short-term treatment goals that measured behavioural, cognitive, and attitudinal changes through a variety of psychometrics.

The study by Aylwin (2010) identified several meaningful post-treatment changes associated with the therapeutic relationship which included a reduction in anxiety and interpersonal problems such as being overly domineering and vindictive and a significant increase in responsibility. These findings were obtained through the IIP-64, a measure designed to explore maladaptive behaviours within relationships. Additionally, Rothman (2007) concluded that aspects of the working alliance such as client-therapist agreement contributed to a reduction in emotional loneliness.

Furthermore, Fenske (2007) reported that the therapeutic relationship facilitates an improvement in offender functioning and goal attainment as well as a decrease in symptoms consistent with sexual offending. Fenske (2007) measured treatment outcomes using a scale that explored an individual's perceived distress, interpersonal problems as well as social and occupational functioning. However, it is important to note that Fenske (2007) reported on the total outcome of the scale and did not explore relationships between the therapeutic relationship and the separate subscales, therefore, the findings were less informative.

Theme Two: The Quality of the Therapeutic Relationship does not Reduce Recidivism Rates

When exploring recidivism rates over a ten-year period, no effect between the therapeutic relationship and treatment outcomes was found (DeSorcy et al., 2014; 2017). DeSorcy et al. (2014) explored the relationship between working alliance and treatment outcomes amongst sex offenders. Furthermore, DeSorcy et al. (2017) utilised 111 participants from the original sample included within DeSorcy et al. (2014) research with an aim to investigate whether high scores on the PCL-R would account for differences in the working alliance and its relationship with treatment outcome. Both studies measured male sex offenders' perception of the working alliance and their recidivism rates over a ten-year period.

The findings from DeSorcy et al. (2014) concluded that the working alliance did not impact post-treatment recidivism, and this did not differ for aboriginal and non-aboriginal offenders. Within the ten-year follow-up, 13.2% of men were reconvicted for a sexual offence, 37.1% for a violent offence and 57.4% for general recidivism. It is worth noting that higher levels of treatment dropout were observed amongst those with lower-rated working alliances (DeSorcy et al., 2014). Additionally, no significant effects were found between the working alliance and recidivism following the ten-year follow-up when exploring sex offenders that met the threshold on the PCL-R (DeSorcy et al., 2017). It was reported that 9.3% of participants were convicted for a new sexual offence, 43% were convicted for a new violent offence and 58.9% were convicted for any other new offence.

Theme Three: Therapist Characteristics Influence the Quality of the Therapeutic Alliance

Within each study that explored empathy as a therapist characteristic, it was reported as a powerful influence on the therapeutic relationship as well as desired treatment change (Beech & Hamilton, 2005; Fenske, 2007; Marshall et al., 2002; Rothman, 2007). Empathy showed to facilitate the therapeutic relationship and demonstrated an improvement in

intimacy deficits and cognitive distortions consistent with sexual assault within Rothman's (2007) study. Additionally, Marshall et al. (2002) reported that empathy displayed within the therapeutic relationship significantly decreased the offender's victim-blaming, denial of harm, minimization and rape myth acceptance whilst increasing responsibility.

Marshall et al. (2002) study was the most relevant in reporting on the influence of the therapist's characteristics and treatment outcomes. The findings from the study concluded that 17 therapist features were present throughout observations of the therapists' interactions with clients. The identified features were then used to evaluate client change within the second section of the study. This included 25 videotapes being closely examined by the two trained judges included in the first segment of the research. The tapes included five sessions amongst five prison services facilitating accredited programmes. It was estimated that there were five to eight sex offenders per two to three therapists. The judges were shown three 15-minute segments from each tape, one at the beginning, middle and end of the programme before rating the 17 features identified within the first study.

During the data analysis, Marshall et al. (2002) excluded four of the features due to unsatisfactory frequency throughout the recordings (appearing less than 30% of the time), these included humour, confrontation, encouragement of prosocial attitudes and dealing effectively with problematic behaviours. Further analysis concluded four key therapist features accounted for significant changes following treatment, the features included warmth, empathy, rewards and directiveness. The change from these features demonstrates an increase in relationships and a decrease in victim blame, denial of harm, responsibility and premeditation as well as rape myth acceptance, lie scale and minimization.

Other therapist characteristics and processes included that of biological sex and emotional expression. Only one study explored the influence of the therapists' biological sex

reporting that different experiences as perceived by the therapists occurred depending on whether they were a man or woman (Aylwin, 2012). It was demonstrated that female therapists encountered a more negative experience, however, their experience of the relationship was less influential than that of the male therapists. Concerning, Beech and Hamilton's (2005) study, results showed treatment changes relating to cognitive distortions, victim empathy and emotional identification with children were significantly related to the emotional expression as encouraged by the therapists within the programme. These findings provide insight into the factors facilitating the therapeutic relationship and how they impact treatment outcomes.

Theme Four: PCL-R Scores Report Conflicting Interactions with the Therapeutic Relationship

DeSorcy et al. (2017) report that PCL-R scores were related to lower levels of working alliance. More specifically, the affective facet of the PCL-R was negatively associated with the bond component of the working alliance and the lifestyle facet was negatively associated with the task component. Conversely, Aylwin (2010) reports that the therapeutic relationship was not affected by the client's PCL-R scores, rather the therapeutic relationship was independent of all client characteristics measured within the study, including risk assessment scores and number of prior convictions.

Theme Five: Peer Relationships Facilitate Desirable Treatment Outcomes

Furthermore, an unintentional but valuable discovery from this review was the powerful influence of peer support on treatment change. Two of the seven studies included explored the impact of peer relationships on treatment outcomes as an additional research aim (Beech & Hamilton, 2005; Aylwin 2010). The findings from both studies concluded that perceived positive peer support has a significant and positive impact on treatment outcomes. As reported in Aylwin's (2010) study, perceived peer support facilitated an improvement in interpersonal problems such as a reduction in being vindictive, cold and intrusive.

Interestingly, the perceived peer alliance demonstrated the strongest influence on treatment change when compared to the therapist and programme alliance.

Furthermore, Beech and Hamilton (2005) reported a significant relationship between group cohesion and treatment outcome. The subscale of group cohesion measures the participant's friendship and concern for one another, suggesting that positive peer alliance contributes to an improvement in victim empathy, cognitive distortions relating to the responsibility of their victims in the assault, and the emotional significance they hold towards children.

Theme Six: Mandated Treatment May Not Hinder Formation of the Therapeutic Relationship

Amongst the eight studies included in this review, it was only reported in one that the participants were mandated to take part in the treatment programme (Fenske 2007).

Therefore, it can be assumed from the remaining six participant groups, that the treatment engagement was voluntary. Fenske (2007) reported that a positive therapeutic relationship facilitated symptom reduction amongst male sex offenders. These findings were consistent with other included studies that reported behaviour, cognitive and attitude change (Aylwin, 2010; Beech & Hamilton., 2005; Marshall et al., 2002; Rothman, 2007), suggesting that the mandating of treatment does not hinder the ability to form a therapeutic relationship and/or desirable treatment outcomes.

Theme Seven: Aspects of Intervention Design

Each study included within the review commented on the location where the client was receiving treatment (i.e., prison, community, or hospital) however, this variable was not reported to influence the process of the therapeutic relationship and its impact on treatment outcomes. This was also the case for the type of treatment intervention, category of sex offenders, whether group-led interventions were supplemented by individual sessions and the profession of the therapist.

However, it is important to note that Beech and Hamilton (2005) reported significant differences in perceived group processes between treatment groups. Differences captured by the GES (Moos, 1986) included Cohesion, Anger and Aggression, Expressiveness, Leader Control, Leader Support, Self-discovery, Task Orientation and Innovation. Only two subscales did not report a significant difference: Independence and Order and Organisation. The latter reflects the structure and rules of a group, suggesting that the programme was tightly structured and facilitated as such.

Furthermore, Rothman (2007) reported that variables such as treatment duration and the client-ethnicity match with the therapist were significant predictors of treatment progress. The longer the duration of treatment and client-therapist ethnicity match predicted a reduction in goal attainment and cognitive distortions relating to sexual assault. Such variables were subsequently used as a control in further analyses but reported no moderating effect.

Discussion

The primary aim of the current systematic literature review was to explore whether aspects of the therapeutic relationship between treatment facilitators and clients impact treatment outcomes amongst sex offenders. A secondary aim focused on the characteristics of the therapist that facilitate this relationship. Information extracted from seven quality-assessed research articles was analysed and systematically reported with the use of narrative synthesis. Overall, five papers demonstrate that the quality of the therapeutic relationship facilitates short-term treatment outcomes consistent with behavioural, attitudinal, and cognitive changes. However, no such effect was found when exploring recidivism rates. Moreover, therapist characteristics were found to influence the quality of the therapeutic relationship. The next section of this review will discuss the current findings in relation to previous literature before identifying the limitations posed and future recommendations.

Therapeutic Relationship and Short-Term Treatment Outcomes

Findings from the current review support the notion that the therapeutic relationship is valuable in the process of facilitating treatment change amongst sex offenders. As aforementioned, the therapeutic relationship was unanimously defined by the sex offenders (clients) within the included studies (excluding the observational study, i.e., Marshall et al., 2002), providing highly reliable findings (Bedi et al., 2005). The therapeutic relationship facilitated a number of desirable changes in relation to sex offenders' behaviours, attitudes, and cognitions (Aylwin, 2010; Beech et al., 2005; Fenske, 2007; Marshall et al., 2002; Rothman, 2007).

Findings of particular interest concern the relationship between improved interpersonal difficulties and stronger working alliances (Aylwin, 2010; Fenske, 2007; Rothman, 2007). It is proposed that within therapy, the therapist becomes a temporary

attachment figure for the client (Skourteli & Lennie, 2010). Literature has demonstrated that a positive new relationship experience which embodies stability and supportiveness can move an individual into a secure attachment style (Mikulincer et al., 2013; Shaver & Mikulincer, 2008). Suggesting that, a positive working relationship with the client's therapist may unintentionally support the treatment of unresolved attachment difficulties; this relationship has also been shown to reduce symptoms of ill mental health (Mikulincer et al., 2013; Muller & Rosenkranz, 2009). Attachment difficulties have been identified within theories of sexual offending as a contributing factor to the onset of such harmful behaviours mediated by poor social skills and difficulties with developing and maintaining intimate relationships (Marsa et al., 2004; Marshall et al., 1993). Therefore, the therapeutic relationship may have provided a secure attachment for the sex offenders included in the current review, contributing to their improved interpersonal problems.

Furthermore, as the therapeutic relationship involves the active collaboration between therapist and client to obtain mutual goals (Ackerman & Hilsenroth, 2003), it is suggested that this process can role model valuable interpersonal skills. An experimental study conducted by Doley and Zilcha-Mano (2019) demonstrated that the therapeutic relationship can be used as a correction process for maladaptive interpersonal skills and produce effective treatment outcomes related to symptoms of ill mental health and interpersonal problems. Additionally, the process of developing adaptive interpersonal skills through the therapeutic relationship has been shown to positively support the process and outcome of future therapeutic interventions (Doley & Zilcha-Mano, 2019). Therefore, these findings are of great significance as it is suspected they reflect the mechanisms involved in obtaining desirable outcomes relevant to treatment.

A further important finding was the strong positive relationship between the therapeutic relationship and treatment outcomes as reported by Fenske (2007). Treatment

outcomes were measured by the Outcome Questionnaire--45.2 (Lambert et al., 1996). The OQ-45.2 explores three core domains: symptom distress, interpersonal relationships, and social role. Each subscale is reflective of dynamic risk factors associated with recidivism amongst sex offenders (Craig et al., 2005; Kruttschnitt et al., 2000). However, as aforementioned, Fenske (2007) did not analyse each subscale, rather results were interpreted from the total outcome of the scale, making the findings less informative on which factor(s) interacted the strongest with the therapeutic relationship. Nonetheless, Fenske's (2007) findings further strengthen the notion that the therapeutic relationship is a valuable process within the treatment of sex offenders.

Therapeutic Relationship, Recidivism and Sex Offender PCL-R Scores

When exploring recidivism rates within the current review, the therapeutic relationship was reported to not have an effect (DeSorcy et al., 2014; 2017). Reduction in recidivism tends to be the primary aim of sex offender treatment (Przybylski, 2015); therefore, these findings are an important addition to the literature exploring treatment outcomes amongst sex offenders. The findings, however, are surprising as the pre-and-post measures employed within the other studies are suspected to measure domains relevant to sex offender recidivism. This would suggest that when a significant effect is found between the therapeutic relationship and dynamic risk factors, this would in turn impact observed recidivism rates. An explanation for this may consider the time frame between measuring the therapeutic alliance, dynamic risk factors and rates of recidivism. As the behavioural, cognitive and attitudinal changes were measured immediately after treatment with no follow-ups, it is therefore plausible that the therapeutic relationship only accounts for short-term effects.

Nonetheless, explanations could be proposed for the lack of desirable findings within the studies exploring recidivism. An explanation proposed by DeSorcy et al. (2017) includes the possibility of participants answering the WAI in a socially desirable way, suggesting that the scores for the working alliance may not be a true reflection of participants' perception of the relationship. Additionally, the lifestyle facet of the PCL-R which reflects impulsivity, lack of goals, and irresponsibility (Hart et al., 1992) was related to lower task scores on the WAI, which measures an individual's engagement with therapeutic activities (Horvath & Greenberg, 1986). As the engagement and practice of therapeutic skills are commonly required for successful treatment gains, it is also plausible to expect this relationship contributed to the lack of long-term effects observed amongst this study sample.

Furthermore, a relationship between the affective facet of the PCL-R and the bond component of the WAI was reported (DeSorcy et al., 2017). A high score on the affective facet of the PCL-R reflects callousness and being unemotional (Hart et al., 1992). The bond component of the WAI measures the bond formed between the client and therapist (Horvath & Greenberg, 1986). Therefore, it is plausible that an individual who is unemotional is not likely to respond to the warmth and empathetic efforts displayed by a therapist when developing a therapeutic rapport. Additionally, past literature has identified high scores on the affective facet correlate to higher levels of treatment non-completion (Olver & Wong, 2011), a risk factor associated with sexual recidivism (Craig et al., 2005). Therefore, despite no relationship being found between the therapeutic relationship and recidivism, it is apparent that sex offenders who score high in specific facets of the PCL-R are less likely to respond to the mechanisms involved in developing a therapeutic rapport and reducing the risk of recidivism.

Therapist Characteristics and the Therapeutic Relationship

Regarding therapist characteristics, empathy, warmth, and the encouragement of emotional expression reported a positive effect on the development of the therapeutic relationship and treatment outcomes; these findings were supportive of past literature (Marshall et al., 2003; Sandhu & Rose, 2012; Thornton et al., 2010). Therapists' empathy and encouragement of emotional expression reported a number of valuable treatment gains such as a significant decrease in victim-blaming, denial of harm, and rape myth acceptance whilst improving responsibility, intimacy deficits, and cognitive distortions consistent with sexual assault (Beech & Hamilton, 2005; Marshall et al., 2002; Rothman, 2007). Cognitive distortions and denial of harm are reported to be risk factors of recidivism, but also therapy-interfering behaviours within early sex offender treatment (Bumby, 1996; Kenny et al., 2001; Nunes et al., 2013). Therefore, training and supervision of sex offender treatment facilitators should focus on how the encouragement of emotional expression and display of empathy can be optimally achieved with an aim to obtain meaningful treatment goals.

Furthermore, the role of empathy is of particular importance due to the presence and influence of shame amongst this population (McAlinder, 2005; Marshall et al., 2009; Proeve & Howells, 2002). Shame is associated with social withdrawal and reduced transparency, two factors that can inhibit an individual's experience within treatment and negatively impact the therapeutic relationship (McAlinder, 2005; Black et al., 2013). Although shame was not explicitly discussed in the studies included within the current review, empathy has been shown to promote social connection and acceptance (Jordan, 1997). Therefore, it is anticipated that the display of empathy by the therapist can support participants to feel less stigmatised and overcome the barrier of shame when establishing therapeutic rapport amongst this population.

Psychological characteristics are not the only factors that play a role in establishing a successful alliance. Biological sex was an additional therapist characteristic that moderated the relationship between the therapeutic rapport and treatment outcome. As aforementioned, within Aylwin's (2010) study, the effect appears to be the strongest for the male therapists, with minimal correlations found amongst the female therapists. Sex was recognised as influential within Sandhu and Rose's (2012) review, the direction is, however, in contrast to the current findings. Sandhu and Rose's (2012) review does not explicitly discuss the influence of male therapists; however, it does describe that the presence of a female facilitator promoted positive change within treatment outcomes. Unlike characteristics such as displaying empathy and warmth, the biological sex of the therapist is not typically considered to be a dynamic predisposition (Aylwin 2020; Sandhu & Rose, 2012). Therefore, the current findings suggest that sex offenders may form productive alliances with empathic males. However, it is recommended that future research be conducted to explore the interaction between types of empathy and biological sex in the context of short-term changes to cognitions, attitudes, and behaviour resulting from sex offender treatment interventions.

Peer Relationship

Two of the seven studies included in this review explored the impact of peer relationships on treatment outcomes as an additional research aim (Beech & Hamilton, 2005; Aylwin 2010). Peer relationships were defined by the sex offenders (clients) perceptions of how understood they felt by their peers as well as the friendship and concern they showed to one another. The findings from both studies conclude that perceived positive peer support has a significant and positive impact on treatment outcomes. Remarkably, the perceived peer support was related to stronger therapeutic effects than therapist and programme alliance (Aylwin, 2012). Considering the previous interpretations of findings, it can be suggested that reduced perceptions of being stigmatised by individuals in caring roles and peers and

possibly being seen as an individual who needs care and support play a substantial role in forming desirable treatment outcomes.

Limitations

Although the current review obtained valuable answers to the initial research question, certain limitations should be held in mind when considering the findings. One such limitation was the exclusive reliance on male sex offenders within each studies' population, therefore, it is assumed that the implications from the current findings are only applicable to male sex offenders. However, men are overrepresented among sexual offenders as they are estimated to account for 98% of the population (Office for National Statistics, 2021). Therefore, the current review maintains relevant and meaningful valuable contributions to the topic.

It is also worth noting that not all the studies reported on the type of intervention employed. Excluding the two studies from DeSorcy et al. (2014; 2017), each of the therapeutic interventions utilised in the included research was conceptually different. The authors also did not report on whether the influence of the type of intervention was controlled for within the studies. This is important to consider, as identified within Marshall et al.'s (2003) review, the therapists' style can be more influential than the programme itself. However, the strict procedures enforced by standardised programmes can also impact the therapist's approach, for example being encouraged to employ a more confrontational approach (Marshall et al., 2003). Therefore, it would have been valuable to gain further insight into whether the treatment programme has any moderating effects on the relationship explored within the current review.

Recommendations for Future Research

Upon considering the current review's discoveries and limitations, several recommendations can be proposed for future investigation. The first concerns the aforementioned limitation to the exclusive reliance on male sex offenders. Sex differences seem to play an influential role when working with the male sex offender population and biological sex is reported to correlate with the participant's perception of the relationship (Aylwin, 2010). Therefore, it is suggested that future research can explore the influence of the therapeutic relationship on treatment success amongst female sex offenders.

Furthermore, the current review reports that the therapeutic relationship promotes treatment change consistent with treatment goals, specifically when conceptualised as dynamic risk factors. However, no such effect was found in relation to recidivism rates over a ten-year period. This finding contrasts with previous literature that suggests dynamic risk factors enhance the ability to predict recidivism. As aforementioned, a plausible explanation for this finding is that the dynamic risk factors are measured immediately after treatment, whereas recidivism was recorded over a ten-year period. Therefore, it is proposed that future research exploring recidivism consider a longitudinal approach to treatment and measure behavioural and attitudinal changes over a period following treatment. This is to closely examine the predictive abilities of dynamic risk factors on recidivism and how stable they are across time following the influence of the therapeutic alliance.

The final recommendation for future literature is to extend research exploring the influence of peer support on treatment outcomes and the potential moderating effect of shame. There is no dispute of the importance of encouraging positive treatment outcomes amongst this population, therefore, with the impact of peer support being identified as a significant contributing factor (Aylwin, 2010; Beech & Hamilton., 2005) this should be

further explored thoroughly. Furthermore, shame has a polarising ability to increase and decrease risk and is commonly provoked within a social context (McAlinder, 2005).

Therefore, despite shame not being discussed within the included papers, it can be deduced here that it is a moderating variable and should also be explored within the context of peer support.

Conclusion

It is clear from the current findings that the quality of the therapeutic relationship can positively impact treatment outcomes amongst male sex offenders. More specifically, a positive therapeutic relationship can improve interpersonal problems which are related to risk factors associated with recidivism and the onset of harmful sexual behaviours (Marshall et al., 1993; Kruttschnitt et al., 2000). Furthermore, characteristics of the therapist such as empathy, warmth and the encouragement of emotional expression can foster the development of a positive therapeutic relationship whilst improving cognitive and attitudinal changes related to recidivism (Beech & Hamilton, 2005; Kenny et al., 2001; Marshall et al., 2002; Nunes et al., 2013). However, contrasting findings also report the therapeutic relationship did not show to directly impact recidivism rates (DeSorcy et al., 2014; 2017). The selectiveness of findings provides a sound rationale for future research to explore the stability of treatment-induced changes related to dynamic risk factors across time. Nonetheless, the findings can suggest that desirable effects are driven by sex offenders' perception of being genuinely cared for, whether it's by the therapist or by peers.

Furthermore, the current review explored characteristics of the therapist that contribute to the development of successful therapeutic relationships and desirable treatment gains. Empathy was a reoccurring factor; however, it has previously been described as an emotion regulation strategy when exposed to the trauma of another (Eisenberg & Eggum, 2009). This suggests that although the client may benefit from the expression of empathy, the therapist may be using it as a coping mechanism to deal with the psychological demands of their job. Moreover, previous literature has identified further therapist characteristics that contribute to the therapeutic rapport, such as the therapists' attitudes and perceptions of their clients (Nelson et al., 2002; Sandhu & Rose, 2012). The next chapter is a critical review of a psychometric measure designed to assess perceptions of sex offenders. A thorough

understanding of the concept and measure informs the design of the research study described in chapter four which explores the psychological well-being of forensic healthcare workers without professional qualifications working with sex offenders.

CHAPTER THREE

Critique of a Psychometric Measure

Perceptions of Sex Offenders Scale (PSO; Harper & Hogue, 2015a)

Introduction

The current chapter aimed to provide a critique of the Perceptions of Sex Offenders Scale (PSO; Harper & Hogue, 2015a); this was done by assessing the scale's validity and reliability and how it compared to its counterparts. Psychometric tests have been used to assess psychological differences in mental capacities such as intelligence and personality (Oxford Reference, 2022). Psychometrics have been utilised in various fields such as, but not limited to, advertisement, education, employment and psychology. Concerning the latter, the field of psychology has employed the use of psychometric tests within quantitative research to investigate relationships between variables; such findings are commonly used to enhance knowledge of real-world problems. Human behaviour has been a central focus of such studies in conjunction with attitudes, perceptions and personalities (Cripps, 2017).

This review focused on a psychometric test measuring *perceptions* of sex offenders, whereas similar other measures are available, which explore *attitudes* towards sex offenders. Attitudes and perceptions have been defined as mental shortcuts that humans have developed to process and understand their environment at a quicker rate, however, they are two differing constructs. Attitudes are an affective process that naturally occurs in response to one's experience of the world around them (Cacioppo et al., 1999; Maio & Haddock, 2010). Perceptions are beliefs developed through cognitive processes after being presented with information (Cacioppo et al., 1999). Although these processes are essential, they have been found to lead to bias and stereotypes. Stereotyping is the process of attributing particular characteristics to all people of the same group (Pickens, 2005). The use of psychometric testing in behavioural research has demonstrated that both attitudes and perceptions can influence behaviour (Amodio & Devine, 2006).

The Perceptions of Sex Offenders (PSO) scale explores perceptions held of sex offenders (Harper & Hogue, 2015a). There is an increasing scientific and applied interest in measuring the perceptions of and attitudes towards this specific population. Levenson et al. (2007) proposed that the general public can strongly influence the development of public policy around the treatment and reintegration of sex offenders into the community. Furthermore, Harper et al. (2017) proposed that attitudes held by the general public and professionals as well as paraprofessionals involved in treating sex offenders have strong social and clinical implications. Similar to Levenson et al. (2007), Harper et al. (2017) discussed the impact of this on public policy and suggested that strong negative attitudes could influence decision-making related to reintegration within society. Furthermore, on a clinical level, it has been suggested that attitudes held by healthcare professionals could subsequently impact the therapeutic environment, treatment outcomes, and risk judgements (Harper et al., 2017).

Historical Development of the Perceptions of Sex Offenders Scale

In response to the implications mentioned above and the growing body of scientific literature concerning sex offending, several measures have been developed to assess the attitudes towards and perceptions of this population. The most widely used measure has been the Attitudes Towards Sex Offenders scale (ATS; Hogue, 1993), a 36-item measure adapted from the Attitudes Towards Prisoners scale (Melvin et al., 1985), designed to assess affective judgements towards sex offenders. The ATS (Hogue, 1993) has been most commonly used to compare the attitudes of forensic staff involved in treating this population with those with no prior experience or exposure (Hogue & Harper, 2019). In recent years, a shortened adaption of the ATS, the Attitude Towards Sex Offenders – 21 scale (Hogue & Harper, 2019), was developed. The scale includes 21 items that explore the three core components of attitudes: affect-based judgement, cognition, and behaviour. Harper and Hogue (2019) argued that the length of the original ATS made it a cumbersome measure and wanted to develop a more usable

version of the initial ATS that is more theoretically anchored. The ATS-21 has since been widely used with populations such as the general public and professionals and non-professionals working within the criminal justice system. The ATS-21 has been found to have excellent reliability and validity across several contexts (Hogue & Harper, 2019).

Another scale developed to measure the attitudes towards this population is the Community Attitudes Towards Sex Offenders scale (CATSO) (Church et al., 2008). Church et al. (2008) proposed that as other scales, such as the ATS and ATS-21, were adapted from previous measures focusing on prisoners and mentally ill offenders, their individual questions were unable to capture a true reflection of the misconceptions held specifically of sex offenders. This notion emphasised the need to develop the CATSO. The CATSO (Church et al., 2008) is an 18-item measure with an underlying four-factor structure measuring attitudes held towards sex offenders. The CATSO has been used on a variety of population samples, reporting stronger negative perceptions amongst the general public when compared to professionals (Malinen et al., 2014; Shackley et al., 2013), with findings demonstrating that attitudes were significantly influenced by the experience of working with this population.

Nonetheless, the CATSO (Church et al., 2008) has been criticised for its items measuring perceptions rather than attitudes (Shackley et al., 2014; Harper & Hogue, 2019). This was also reported within Harper and Hogue's (2015) review of the CATSO, following a face validity analysis which reported that three knowledge-based factors (perceptions), rather than affect based factors (attitudes), underlie the measure. Additionally, the generalisability and validity of the scale have been questioned, with Conley et al. (2011) having reported that only eight out of the eighteen items could reliably measure the distinct constructs within the measure. Furthermore, within Conley et al.'s (2011) analysis, two items were removed due to their influence on significantly skewing the data. Therefore, Harper and Hogue (2015a) proposed the reinvention of the CATSO due to the importance of having a tool to measure

perceptions of sex offenders. To achieve this, Harper and Hogue (2015a) developed a survey comprised of the CATSO (Church et al., 2008), ATS Scale (Hogue, 1993), General Punitiveness Scale (Maruna & King, 2009), and Rational-Experiential Inventory (Pacini & Epstein, 1999). However, the CATSO was adapted, to include eight additional items exploring participants' views on the risks posed by sex offenders and their views on sentencing and management. Furthermore, four items were removed based on Conley et al.'s (2011) critical analysis of the scale. The adapted CATSO reported strong correlations with the other measures included within the survey study. Thus, this endeavour resulted in the formation of the Perceptions of Sex Offenders Scale.

Overview of the Scale

The Perceptions of Sex Offenders Scale (Harper & Hogue, 2015) is the reinvented version of Church et al.'s (2008) CATSO scale. The revised scale has been designed to measure beliefs about sex offenders and their practical treatment. The measure consists of 20 questions utilising a 6-point Likert scale to provide a response: 1 = Strongly Disagree, 2 = Disagree, 3 = Somewhat Disagree, 4 = Somewhat Agree, 5 = Agree, and 6 = Strongly Agree. Instructions for a participant completing the scale are as follows: "Please respond to each of the following statements by indicating the extent to which you agree with it. To answer, please place the appropriate number next to the question, in the space provided."

The scale is comprised of three subscales: sentencing and management, risk perception and stereotype endorsement. The subscale related to sentencing and management measures an individual's views of a punitive response to a sex offender's crimes. The subscale includes ten items and item one is reverse-scored. An example item for this subscale includes: "With support and therapy, someone who committed a sexual offence can learn to change their behaviour". The subscale named stereotype endorsement measures a respondent's stereotypical beliefs about sex offenders. The subscale includes five questions, for example: "Most sex offenders do not have close friends". The risk perception subscale measures an individual's views of the level of risk posed by sex offenders and the response required to manage such risk. The subscale has five items, and each item is reverse-scored. An example item includes: "People are far too on edge about the risks posed by sex offenders".

A manual on how to administer the PSO is not available. However, scorer's guidelines have been developed. The guidelines advise scorers to subtract a total of one from the score of each item, leaving the scoring range from 0-5. A rationale for this guidance has not been provided within the scoring instructions. However, it could be assumed from the pilot study

that the scoring instructions were based on the scoring range of other measures within this area, such as the Attitudes Towards Sex Offenders Scale (Hogue, 1993). The scorer's guidelines also highlight the reversed items within the measure and advise scorers to rate them as 5-0 instead of 0-5 for the non-reversed items.

Within the scorer's guidelines, Harper and Hogue (2015a) presented subscales with the associated item numbers from the scale. An interpretation guide for the results has been provided, stipulating that the higher the score, the stronger the perception. For example, the sentencing and management subscale has a scoring range of 0-50, which suggests that the higher the score, the stronger the respondent perceives that sex offenders should be punished harshly. For stereotype endorsement, with a scoring range of 0-25, the higher the score, the more stereotypical judgements the respondent is likely to endorse. Finally, for risk perception, with a scoring range of 0-25, a higher score indicates the respondent perceives sex offenders as having an increased risk of committing further offences. It is important to note that there is no reference within the guidelines as to whether scorers should compute or avoid providing a total score (out of 100) for the scale. Rather, higher scores indicate the respondent endorses negative and stereotype-driven perceptions of sex offenders.

The creation of the scale, as described by Harper and Hogue (2015), was based on a sample of four hundred members of the British public. The majority were female (248 female vs. 112 male), and 40 declined to indicate their biological sex. The participant sample was representative of Costello and Osborne's (2005) best practice standards for exploratory factor analysis, in that there should be a minimum of five observations (participants) per scale item. This suggested that factor analyses conducted by Harper and Hogue (2015a) produced reliable findings in relation to the overall efficacy of the scale. These findings were also replicated in a later study conducted by Harper and Hogue (2017).

Reliability

Internal consistency is the correlation observed between subscales of a single measure, and it is desirable that each subscale produces similar scores when measuring the same construct (Tang et al., 2014). When reporting internal consistency, a Cronbach alpha (α) greater than .80 is considered good (George & Mallery, 2019). Harper and Hogue (2015) reported a Cronbach alpha coefficient of .92 for the overall scale, demonstrating excellent internal consistency between the scale's items. The internal consistency for the individual subscales was also high. For the sentencing and management subscale, it was excellent ($\alpha = .92$). The subscale of stereotype endorsement and the subscale of risk perception achieved good internal consistency ($\alpha = .85$ and $\alpha = .81$, respectively). Overall, the internal consistency has been found to be strong and indicated that items on the scale measure similar perceptions. Harper and Hogue (2017) also reported excellent internal consistency in a later study with a larger sample ($N = 528$; 139 male, 347 female and 42 who did not declare their gender). The overall internal consistency for the scale was found to be excellent ($\alpha = .92$). The Cronbach alpha of the subscales was also excellent to good: sentencing and management having achieved $\alpha = .93$, stereotype endorsement having achieved $\alpha = .84$, and risk perception having achieved $\alpha = .80$. Similarly, Harper and Bartels (2017) reported an internal consistency of $\alpha = .90$ in their study of 252 community members.

Harper and Hogue (2015) reported the three subscales based on three factors extracted during the factor analysis. Bakhtiari et al. (2021) also reported a three-factor structure. Additionally, Friestad et al. (2021) replicated the results with a sample of student prison officers and conducted a series of principal component analyses which reported similar Cronbach's alpha levels as Harper and Hogue (2015). The internal consistency of the stereotype endorsement and risk perception subscales were lower than those reported in the original study, however, the authors noted this was likely due to the sample being more homogenous than in

the original study due to the variance in age and education level. Bakhtari et al. (2021) reported a good reliability coefficient (.61-.85) in their sample from Tehran, Turkey. Together, these findings demonstrate that across cultures and participant samples, the PSO (and its subscales) is a reliable measure.

Validity

Face Validity

Face validity concerns whether a psychometric test measures what it is intended to (Johnson, 2021). The items in each subscale aim to measure knowledge-based judgements of sex offenders rather than affective-based judgements, which was specifically assessed during the development of the PSO (see historical development section). Therefore, the Perceptions of Sex Offenders scale can be viewed as measuring the concept it purports to measure. However, the subscale stereotype endorsement focuses on social isolation, for example: “Most sex offenders do not have close friends” and “Most sex offenders keep to themselves”. For sex offenders who are convicted and residing in prison or another criminal justice context, these behaviours may be adaptive in keeping themselves safe from victimisation and stigma. Therefore, rather than reflecting stereotypical personality traits or generalised behaviours of sex offenders, the items of this subscale may measure behaviours which are situational.

Construct Validity

Construct validity assesses whether items and factors of a scale correlate with one another to accurately measure what it is supposed to (Cronbach & Meehl, 1995). All three subscales of the PSO correlated highly with each other ($p < .001$), which suggests that each factor of the PSO reflects and measures the concept of perceptions of sex offenders (Lyons-Thomas, 2014). For example, the subscales of sentencing and management and risk perception had a correlation coefficient of Pearson’s $r = .7$ (Harper & Hogue, 2015a), suggesting that as responders indicated higher perceived risk from sexual offenders, they were more likely to

endorse harsher sentencing and management strategies. However, it is important to note, that high levels of correlation between subscales may also suggest an overlap between items, creating *bloated specifics* (Kline, 2015; Lyons-Thomas, 2014). Therefore, the highly correlating subscales of the PSO should be treated with caution, in that there may be an excessive overlap between the factors.

Convergent Validity

Convergent validity is how well a test is related to other tests measuring the same theoretical construct (Lyons-Thomas, 2014). In terms of other scales used to measure people's perceptions of sex offenders, including their sentencing and management, Harper and Hogue (2015a) conducted an inter-scale correlation analysis. The Perceptions of Sex Offenders Scale was found to correlate significantly with other similar scales. It correlated significantly with the Attitudes to Sexual Offenders Scale (ATS-21; Hogue, 1993) ($r = -.84, p < .001$). The PSO sentencing and management subscale correlated significantly with the General Punitiveness Scale (Maruna & King, 2009), an 8-item scale measuring attitudes towards crime and punishment ($r = -.78, p < .001$). Harper and Hicks (2021) also demonstrated a strong relationship between ATS-21 scores and the Perceptions of Sex Offenders scale scores. As aforementioned, attitudes and perceptions are two separate psychological processes, and therefore, the strong relationship between the PSO and ATS would suggest that they can both be used in a complimentary manner to accurately explore affect-based and knowledge-based judgements towards sex offenders (Harper & Hogue, 2015a).

Other studies using the scale have reported similar findings. For example, Leon and Rollero (2021) reported that the Perceptions of Sex Offenders subscales correlated with the General Punitiveness Scale. This suggests that supporting a punitive criminal justice system is connected to endorsing harsher sentencing and management strategies for sex offenders. These findings further highlight the validity of the PSO.

Predictive Validity

Predictive validity is defined as a scales' ability to predict an outcome relevant to the concept measured (Cronbach & Meehl, 1955). Harper and Hicks's (2021) examined the predictive validity of the Perceptions of Sex Offenders scale for clinical risk judgements of 186 forensic professionals and 341 students. Participants were asked to make risk judgements after reading hypothetical sexual offence scenarios. The study reported that the severity of risk judgements was significantly impacted by the perceptions participants had of sex offenders as measured with the PSO and ATS-21. This provided evidence of the PSO's ability to predict an outcome relevant to the concept measured. This is meaningful when considering that professional perceptions of risk for sexual offenders have been found to influence sentencing and risk management decisions, such as early release and parole (Blumenthal et al., 2010; Harper et al., 2017). Nonetheless, the risk vignettes used in Harper and Hicks (2021) study were for a specific sexual offence related to the internet grooming of a 10-year-old child. Future research could consider replicating this study with scenarios depicting other sexual crimes to explore how this affects perceptions of the offenders.

Harper and Hogue (2017) reported that the Perceptions of Sex Offenders scale scores could be impacted by newspaper readership, particularly tabloid articles. In their study, tabloid readers had higher scores on all three subscales when compared with broadsheet readers. Therefore, tabloid readers were more likely to endorse punitive sentences and restrictions for sex offenders. A significant main effect of newspaper readership was found for all three subscales; subscale stereotype endorsement: ($F(3, 515) = 2.20, p = .044$, partial eta squared = 0.01), subscale risk perception ($F(3, 515) = 2.35, p = .036$, partial eta squared = 0.01) and subscale sentencing and management ($F(3, 515) = 3.13, p = .011$, partial eta squared = 0.02). Post hoc comparisons (with Bonferroni correction) found the effect was due to a significant difference between tabloid and broadsheet readers for the three subscales. In this study, the

effects were present even when generalised attitudes towards sexual offenders were controlled for using the ATS-21; a significant MANCOVA was reported (Wilk's $\lambda = .961$; $F(9, 1530) = 2.26$, $p = .008$, partial eta squared = 0.01). It is concluded that the Perceptions of Sex Offenders scale could be used to support a review of press reporting practices in relation to sexual offences due to the impact it can have on public attitudes, policy, legislation and professional risk judgements.

The Perceptions of Sexual Offenders scale has also been demonstrated to be a useful measure when assessing change in judgements following training on sex offenders delivered to prison officer students (Friestad et al., 2021). Their perceptions were measured during their theoretical education and 1-year practical training. The students held less punitive views about sex offenders, their sentencing and punishment at the end of their education. However, their endorsement of risk did not change, perhaps reflecting the nature of their roles being to contain and manage prisoners and consider issues of risk. Their practical training also took place within a high-security prison, perhaps exposing them to sex offenders who had committed more serious and/or violent crimes. In addition to this, endorsing stereotypical views of sex offenders increased during training. This highlighted how simple exposure to sex offenders and actual prison officer education and training did not reduce the endorsement of stereotypical perceptions of sex offenders (Sanghara & Wilson, 2006). The scale may have utility in identifying those with stereotypical perceptions of sex offenders in pre-training forensic professionals to highlight the need to reduce this. The scale may also be useful in identifying where education and practical training for forensic professionals need to focus more on reducing stereotypical beliefs of sexual offenders. However, some concerns remain about this subscale and its use to test perceptions of forensic professionals, which are discussed next.

Limitations

Harper and Hogue (2015a) addressed that their study was conducted entirely within Britain, and some of the newer items that have been included in the scale may not be applicable to other countries. For example, an item within the scale mentions the death penalty being reintroduced; however, this practice is already present in some non-UK countries. The authors suggested a modification could be to write that the death penalty should always be an option when sentencing sex offenders, however, with the caveat that using this modification would require the reliability coefficients to be re-analysed. Nonetheless, Bakhtiari et al. (2021) reported having successfully used the Perceptions of Sex Offenders scale in Tehran, which suggests its applicability in other countries despite contrasts in sentencing and management practices of sex offenders.

Friestad et al. (2021) conducted a study in Norway which highlighted the contextual nature of the stereotype endorsement subscale, focusing on items describing social isolation (see Face Validity). The study was conducted with prison officers as participants and they were more likely to see sex offenders keep to themselves in order to protect themselves from unwanted attention in prison due to the stigma associated with their offending (Van den Berg et al., 2018). Some research has suggested prison staff may even advise sex offenders to have a cover story prepared to avoid sharing their convictions with peers in prison (Kruse, 2020). Rather than reflecting actual sex offender personality traits or stereotypes, the subscale (when used with forensic professionals) may reflect behaviours sex offenders engage in to avoid being victimised in a prison context.

Research has demonstrated that members of the general public and professionals can have varying opinions on different sex offender groups (e.g., online child sex offenders vs. contact child sex offenders). It would be helpful for the scale to be used to consider differences in perceptions of sexual offences. By using the term sex offender, the scale ignores the

heterogeneity between individuals convicted of sexual offences. Studies have demonstrated that labelling of this nature can increase punitive attitudes (Imhoff, 2015) and increase endorsement of punitive sentencing and policies for sex offenders (Harris & Socia, 2016) when compared to neutral descriptions, for example, ‘individuals convicted of a sexual offence’. Lowe and Willis (2022) demonstrated that when changing the language in the CATSO to be written in the person-first language, scores were significantly lower, indicating that labelling can impact attitude endorsement. It is likely these results would be similar for the Perceptions of Sex Offenders scale.

A limitation of the scale is that it relies purely on self-report to assess a sensitive topic. In addition, some of the questions are political, which increases the sensitivity of the topic. This could lead to socially desirable responses (Harper et al., 2017) and may be particularly present in certain groups, such as forensic professionals as they are responsible for the treatment and risk reduction of sex offenders (Fortney et al., 2009; Levenson et al., 2010). Despite this, research has suggested other similar scales, such as the ATS-21, were found not to correlate with scores of social desirability. Therefore, this is likely the case for the Perceptions of Sex Offenders scale, but it is suggested that future research considers exploring socially desirable responses amongst certain populations, such as those working with sex offenders.

Conclusions

The Perceptions of Sex Offenders scale has been found to be a more appropriate measure of perceptions of sex offenders than the original CATSO (Church et al., 2008). The scale adequately measures perceptions and judgements of sex offenders rather than attitudes towards sex offenders. The scale has demonstrated utility in being used alongside scales measuring attitudes, punitiveness and sexist perceptions, and an ability to predict risk judgements in professionals (Harper & Hicks, 2021; Harper & Hogue, 2015a; Leon & Rollero, 2021). Therefore, it could be helpful to use the scale in research and practice to identify areas to consider when educating the public or considering the development of policy and legislation in this area. The scale also has implications when considering bias in clinical risk judgements when risk assessing sexual offenders, mainly where there are implications for restrictions on a person, such as at sentencing or parole hearings (Blumenthal et al., 2010; Harper et al., 2017; Harper & Hicks, 2021). Additionally, as attitudes and perceptions can influence the therapeutic process (Nelson et al., 2002; Sandhu & Rose, 2012), the scale could support professionals to be more aware of the presence of their negative perceptions of sex offenders so they can take the appropriate steps to address this before attempting to therapeutically engage this patient population. Furthermore, the scale has been used amongst a variety of professionals and paraprofessionals involved in the care of sex offenders, however, it is noted by the author of the current thesis, that the participant samples have not included healthcare and support workers. Therefore, the proceeding chapter utilises the scale within an empirical paper exploring the attitudes and perceptions of forensic healthcare workers without professional qualifications working with sex offenders as predictors of workplace well-being.

CHAPTER FOUR
Quantitative Research Project

Predictors of Well-being in Healthcare Workers Working with Sex Offenders

Abstract

Background

Those supporting individuals within forensic mental health settings have been reported to experience emotional exhaustion, burnout and vicarious trauma (Jaafarpour & Khani, 2012; Munger et al., 2015; Sandhu et al., 2012). Different workplace factors have been identified to moderate the relationship between working with sex offenders and well-being (Hatcher & Noakes, 2010); however, limited attention has been dedicated to the underlying psychological processes within this relationship. The current study aimed to explore potential predictive factors of workplace well-being amongst forensic healthcare workers without professional qualifications who currently care for sex offenders.

Methods

Workplace well-being was defined by three components: compassion satisfaction, burnout, and secondary traumatic stress. Predictive factors included attitudes and perceptions towards sex offenders as well as workplace variables (i.e., environmental safety, co-worker support, and quality of supervision). Participants (N = 91) recruited for the study included forensic healthcare workers without professional qualifications employed within UK privatised mental health settings. Participants completed an online questionnaire including four scales exploring the study's variables.

Results

Multiple regression analysis was conducted to explore predictive effects on workplace well-being. The predictions of the study were partially supported by workplace factors and favourable attitudes predicting increased well-being. Contrastingly, negative perceptions also predicted increased well-being.

Conclusion

The current findings highlight the importance of employers maintaining adequate levels of environmental safety and providing good quality supervision to ensure the well-being of forensic healthcare workers. Conflicting findings were also observed in that favourable attitudes and negative perceptions predict workplace well-being; therefore, future research should explore the discrepancy between perceptions (cognitive process) and attitudes (affective process).

Introduction

Due to the breadth of literature on the current topic, a number of job roles are explored and discussed throughout, such as healthcare professionals, healthcare workers, and paraprofessionals, including prison officers. When referring to the intended sample for the current study, they will be referred to as forensic healthcare workers without professional qualifications.

Working with clients within the mental healthcare industry has been shown to have a number of psychological and physical consequences (De Hert, 2020; Peterson et al., 2008). Research has identified that those working within healthcare are at an increased risk of experiencing high levels of work-related mental and physical exhaustion (De Hert, 2020; Jenkins & Elliott, 2004). Collectively, these experiences are termed *burnout syndrome* (Maslach et al., 2001). The main symptoms of burnout syndrome have been clustered into three components: emotional exhaustion, depersonalization and cynicism, and reduced personal accomplishment and professional efficacy (Maslach et al., 2001). However, burnout can lead to various psychological symptoms.

It has been proposed that the burnout experienced by those working within healthcare has contributed to a number of personal issues such as substance misuse, relationship difficulties and further mental health problems (Awan et al., 2022; Dutheil et al., 2019; Monhanty et al., 2019). There are also a number of professional implications as it has been suspected that high levels of burnout contribute to impaired quality of care, high staff turnover, and cynicism within their job role (Poghosyan et al., 2010; Scanlan & Still, 2019; Willard-Grace et al., 2019). Therefore, burnout can negatively affect people's lives in significant ways.

Burnout has been observed in a number of professions, but arguably those working in forensic mental health, a specialist division of healthcare, are particularly affected (Coffey, 1999; De Looft et al., 2019; Dickinson & Wright, 2013). Forensic mental health settings are dedicated to supporting individuals who have a previous criminal conviction, may display violent behaviour, and have one or more mental health diagnoses that prevent them from residing in the community or serving a prison sentence. Forensic mental health staff such as mental health nurses have reported high levels of burnout within their job role (Newman et al., 2020). Exposure to high levels of client aggression and the resulting increased stress levels have been found as significant factors contributing towards the development of burnout. High workload, interpersonal work-related conflict, and lack of involvement in decision-making also seemed to be contributing factors in the emergence of burnout (De Looft et al., 2019; Dickinson & Wright, 2013). Therefore, forensic healthcare workers are exposed to multiple risk factors that can contribute to the development of burnout.

Individuals convicted of sex offences are one of many client populations who are supported within forensic mental health settings. To date, there has been conflicting evidence on the psychological impact of working with this client group (Hatcher & Noakes, 2010; Munger et al., 2015; Steed & Bicknell, 2001). Higher levels of burnout have been observed amongst qualified practitioners providing sex offender treatment within inpatient settings in comparison to outpatient settings (Mivshek & Schriver, 2022; Shelby et al., 2001). However, no meaningful difference in well-being has been observed between those treating sex offenders and those treating the general clinical population (Hatcher & Noakes, 2010). Nonetheless, the research knowledge base related to this particular group of healthcare workers is sparse. Hence, further research is required to enhance the existing literature exploring the psychological impact of working with sex offenders.

Workplace Well-being Within Healthcare

Workplace well-being has been described as the overall psychological, physical, and emotional health of an employee within their employment (Thompson & Bates, 2009). The concept has been well explored with literature focusing on increasing job performance, satisfaction and productivity (Isham et al., 2020; Wright et al., 2007). Furthermore, several phenomena are focused upon when exploring well-being within healthcare, such as *compassion fatigue*, which has been used interchangeably with the term *secondary traumatisation* (Figley 1995; Singh et al., 2020). The terms have frequently been used in published literature to describe people working with individuals who may have ill mental health, disabilities, behave in challenging ways, or have participated in a traumatic event (Bride et al., 2007; Stamm, 1995). Furthermore, findings of various research have proposed that workers who care for such individuals are at risk of developing symptoms associated with Post Traumatic Stress Disorder (PTSD; Bride et al., 2007; Figley 1995). Therefore, exposure to caring for those with mental health difficulties can have a negative psychological toll on healthcare workers.

Internal and external resources within the workplace have been shown to affect the relationship between caring for clients and workers' well-being (Cooper, 2016; Singh et al., 2020). The job-demands resource model discusses how an increase in job demands (such as workload, therapeutic engagement, and exposure to challenging behaviour) and limited employment resources (such as organisational support and supervision) increases a worker's burnout and compassion fatigue (Bakker & Demerouti, 2014; Singh et al., 2020). A review conducted by Singh et al. (2020) demonstrated how job demands, such as the empathy required to support clients and low job resources, such as limited supervision, increased compassion fatigue among healthcare professionals. The findings highlighted that working

therapeutically with mental health clients can deplete the healthcare workers' emotional resources, but that this relationship can be mitigated by increasing job resources.

Furthermore, the conservation of resource theory (Hobfoll, 1989) proposes that employees are at risk of developing chronic stress when resources are at threat within the workplace. Four resources are identified within the theory: object, condition, personal characteristics and energy (Hobfoll & Freedy, 2017). Within forensic healthcare, there are high job demands due to the challenging nature of patients' behaviour (Cooper, 2016), expending the recourses of energy and personal characteristics. When these resources are at threat, then stress and burnout are reported to occur, subsequently impairing treatment outcomes which has been observed through medication errors and treatment mistakes (Trujillo, 2022). Therefore, due to the high job demands associated with working within forensic healthcare, employment resources are important to focus upon for the benefit of healthcare workers' well-being and the quality of treatment provided to clients.

Workplace Well-being and Working with Sex Offenders

In this study, sex offenders were a client population of particular interest when exploring staff well-being. Sex offenders are individuals who have committed an illegal sexual act against another person, often with the use of force, threat or coercion (Sexual Offences Act, 2003). Different typologies have been developed to describe sex offenders. These typologies are often based on the victim's age or type of crime, for example, child sex offender, rapist or exhibitionist (Robertiello & Terry, 2007; Simons, 2015). Once an individual has been convicted of a sexual offence they are often incarcerated in prison, or if they have ill mental health or a learning disability, they can be cared for within an inpatient healthcare setting (Sentencing Council, 2023). The latter commonly involves being cared for by a nursing team with access to a range of professionals such as, but not limited to, psychiatrists, psychologists, occupational therapists and social workers. Forensic healthcare

workers without professional qualifications are a staff population who are reported to experience high levels of burnout (De Hert, 2020; Jenkins & Elliott, 2004) and would ordinarily also have direct, close, and lengthy contact with this client population to provide care.

As mentioned earlier, reduced well-being amongst those working within healthcare has been found to negatively impact the treatment and care provided to clients within forensic inpatient settings (Delgadillo et al., 2018; Salyers et al., 2015). Research conducted by Salyers et al. (2015) has demonstrated that forensic healthcare workers with and without professional qualifications report lower quality of care when staff burnout levels are higher. Furthermore, Delgadillo et al. (2018) reported that higher levels of burnout among therapists could lead to poorer treatment outcomes, specifically higher rates of anxiety and depression among clients. Therefore, an enhanced understanding of the mechanisms involved in the well-being of the care group may also indirectly lead to improved treatment outcomes for sex offenders.

To date, there is no clear picture of the impact on the well-being of those working with sex offenders. In keeping with this, Munger et al.'s (2015) study concluded that there is a high prevalence of vicarious trauma amongst prison nurses when working with sex offenders, whereas Hatcher and Noakes (2010) contrastingly reported low levels of vicarious trauma and no significant difference in well-being when comparing those who work with sex offenders with those who work with the general clinical population. However, Hatcher and Noakes (2010) identified that work-related factors such as physical safety and regular supervision predicted increased work-related well-being. These findings further demonstrate the effect of workplace resources on staff well-being as highlighted within the job-demands resource model and the conservation of resource theory. Additionally, research conducted by Ennis and Horne (2003) demonstrated that perceived peer support among therapists working

with sex offenders predicted lower levels of psychological distress. Therefore, work-related factors can be expected to be intertwined in the relationship between well-being and working with a sex offender population.

Concerning psychological factors, those working with sex offenders have been reported to adjust their attitudes to protect their well-being (Farrenkopf, 1992; Sandhu et al., 2012; Scheela, 2001). A qualitative analysis conducted by Scheela (2001) reported that over time, those working with sex offenders adjusted their attitudes to seeing them as human beings rather than monsters. Furthermore, Farrenkopf (1992), reported high levels of burnout among a third of therapists working with sex offenders, however, those with lower levels of burnout reported more neutral rather than negative attitudes towards this client population. Therefore, there appears to be a relationship between the attitudes adopted towards a job role and the client group and workplace well-being.

Attitudes and Perceptions

How one interacts and experiences the world around them has been found to be partly influenced by their attitudes and perceptions (Pickens, 2005). Attitudes are formed in response to everyday experiences and are based on the emotional appraisal of an entity, whereas perceptions are a cognitive thought process that mirrors one's understanding and knowledge of the world (Cacioppo et al., 1999; Maio et al., 2010; Pickens, 2005). Attitudes are formed while encountering situations that require the engagement of emotional processes to understand or to respond to a situation in a fast-paced manner; they can be negatively or positively balanced depending on individual experience (Maio et al., 2010). Concerning perceptions, humans have developed mental shortcuts to facilitate the processing and understanding of their environment at a fast pace. Although these shortcuts can be helpful, they have been found to also lead to biased and stereotypical thinking. Stereotyping is the

process of attributing particular characteristics to all people of the same group (Pickens, 2005).

Another distinction between the two psychological processes of attitudes and perceptions involves how they influence behaviour. A study conducted by Amodio and Devine (2006) demonstrated this distinction by measuring participants' attitudes and perceptions towards a specific group of people. Findings from the study demonstrated that those who endorsed stereotypes (perception), rather than negative attitudes, were more likely to make judgments about work performance. People who held negative attitudes were more likely to socially distance themselves from their fictitious working group. Sex offenders have commonly been found the subject of negative attitudes and perceptions expressed by the general population (Levenson et al., 2007). However, when exploring the attitudes and perceptions of those working with this stigmatised population, the findings have generally been mixed (Higgins & Ireland, 2009). This is important to explore considering that attitudes and perceptions can influence behaviour.

Attitudes and Perceptions Towards Sex Offenders

In response to the growing body of literature exploring attitudes towards sex offenders, several measures have been developed. The Attitudes Towards Sex Offenders (ATS; Hogue, 1993) scale has been widely referenced within the relevant literature. The scale is a 36-item measure that expands on the Attitudes Towards Prisoners scale (Melvin et al., 1985) designed to assess affective judgments towards sex offenders. In recent years, a 21-item version of the ATS was developed (ATS-21; Hogue & Harper, 2019). The authors of the ATS-21 have utilised Breckler's (1984) ABC model (affect, behaviour, and cognition) of forming attitudes when developing the three subscales of the ATS-21.

The subscales of the ATS-21 include intent, trust, and social distancing. The subscale of intent reflects the cognitive component of Breckler's (1984) model, measuring an

individual's cognitive evaluations and stereotypical thinking towards sex offenders. The subscale of trust is the affective component of the ABC model, measuring an individual's affective judgement and automatic emotional response to sex offenders. The subscale of social distancing is the behavioural component, measuring an individual's behavioural attitudes towards interacting with sex offenders. The ATS-21 has been used to collect data in large-scale studies, recruited from the general public as well as professionals and non-professionals working within the criminal justice system (Calobrisi & Knight, 2023; Harper et al., 2021; Harper & Hicks, 2021). Hence, the scale is ideal for testing the attitudes and perceptions of forensic healthcare workers.

As previously stated, attitudes and perceptions have been found to be two separate psychological processes with differing consequences for behaviour (Amodio & Devine, 2006; Pickens, 2005). In the process of developing the ATS-21, Harper and Hogue (2015a) reinvented the Community Attitudes Towards Sex Offenders scale (CATSO; Church et al., 2008), a scale designed to measure attitudes towards sex offenders. The authors critically observed that the CATSO consisted of cognitive-based items synonymous with stereotype endorsement rather than affect-based judgements. In response to this observation, Harper and Hogue (2015a) devised an updated measure and called it the Perceptions of Sex Offenders Scale (PSO). The PSO is a 20-item scale exploring perceptions held towards sex offenders, comprising three subscales: sentencing and management, stereotype endorsement, and risk perception. The sentencing and management subscale measures the respondents' views towards a punitive response to a sex offender's crimes. The subscale of stereotype endorsement is an index of stereotypical beliefs about sex offenders. The subscale of risk perception measures views around the level of risk posed by sex offenders and the response to such risk. The authors proposed that the PSO and ATS-21 are complimentary scales with one exploring attitudes and the other exploring perceptions (Harper & Hogue, 2015a).

Professionals' and Paraprofessionals' Attitudes and Perceptions

The populations that research has focused on when exploring attitudes and perceptions of sex offenders have frequently consisted of forensic professionals and paraprofessionals (mainly prison officers and treatment facilitators such as therapists), the general population and university students (Levenson et al., 2007; Higgins & Ireland, 2009; Fuselier et al., 2002). Prison officers have been a focal point within this body of literature due to their extensive contact hours with this population (Sanghara & Wilson, 2006), whereas university student samples are relatively accessible to researchers. Concerning the general population, Levenson et al. (2007) proposed that they were of great significance as they could heavily influence public policy around the treatment of sex offenders. Students have also been reported to hold more negative perceptions related to the restrictions placed upon sex offenders and the benefits of such restrictions on recidivism (Levenson et al., 2007; Schiavone & Jeglic, 2009).

Harper et al. (2017) proposed there are meaningful implications for exploring attitudes towards sex offenders. The attitudes held by healthcare professionals, prison officers, and others involved in their care, could subsequently impact the therapeutic environment, treatment outcomes as well as risk judgements. Whereas the attitudes of the general public could impact public policy and the reintegration of sex offenders into society. This suggests that various sample characteristics such as job role and contact time with sex offenders can somewhat influence the practical implications of attitudes held towards sex offenders.

Generally, members of the general public and professionals involved in the care of sex offenders demonstrated differing attitudes and perceptions towards sex offenders (Calobrisi & Knight, 2023; Fuselier et al., 2002; Higgins & Ireland, 2009; Levenson et al., 2007; Sanghara

& Wilson, 2005). For example, when comparing the attitudes of professionals who were caring for sex offenders to the attitudes of teachers, professionals held more favourable attitudes (Sanghara & Wilson, 2006). Sanghara and Wilson (2006) explained that as the teachers had little exposure to sex offenders in comparison to the professionals who cared for them, they were more likely to rely on the media's "dangerous" portrayal of sex offenders (Greer, 2003, p. 2). Furthermore, when exploring attitudes and perceptions among professionals such as therapists and paraprofessionals (e.g., prison or police officers), further differences have been demonstrated (Day et al., 2014; Higgins & Ireland, 2009). Higgins and Ireland's (2009) findings reported that healthcare professionals who were anticipated to spend several hours a week (on average) of direct contact time with sex offenders, endorsed more favourable attitudes towards them as compared to prison officers who typically spent 12-hour shifts, several days a week with them. Moreover, prison officers are frequently exposed to violence and other forms of challenging behaviour within their job role, negatively impacting their well-being (Isenhardt & Hostettler, 2020; Muzavazi, 2016). Therefore, due to prison officers' long contact hours with sex offenders, they are exposed and thus aware of ongoing risks this client population may pose, which may impact their attitudes. These findings challenge the idea that longer exposure to sex offenders improves attitudes towards the group.

An alternative consideration to the discrepancy in professionals' and paraprofessionals' attitudes and perceptions towards sex offenders could be the psychological process of cognitive dissonance. Cognitive dissonance is the psychological discomfort experienced when behaviour or realities are conflicting with one's beliefs, attitudes, and values (Festinger, 1957). In response to cognitive dissonance, one may alter their attitudes and perceptions to reduce or better cope with the psychological discomfort (Festinger, 2000). On the one hand, healthcare professionals such as therapists are responsible for the treatment

and risk reduction of sex offenders' behaviours, therefore, it has been proposed that they may be more likely to experience favourable attitudes about risk and the suspected benefits of treatment to avoid cognitive dissonance (Fortney et al., 2009; Levenson et al., 2010). Conversely, it has been suggested that criminal justice professionals or those working within prisons, such as prison officers, who arguably hold a more punitive job role, may hold more negative views towards sex offenders (Levenson et al., 2010; Marshall, 2015). Therefore, the role of staff in the treatment of sex offenders may have an impact on the formation of their attitudes and perceptions.

Furthermore, the staff's level of understanding and education could be another contributing factor to the observed difference in attitudes among those who work with sex offenders. Research has shown that cognitive psychoeducation (an intervention that aims to correct stereotypical thinking) has been found to reduce the general public's negative attitudes towards sex offenders (Kleban & Jeglic, 2011). Similar findings have been found when the training was delivered to prison officers (Ware et al., 2012). Furthermore, a qualitative analysis conducted by Lea et al. (1999) reported little difference in the attitudes of paraprofessionals and professionals who had received specific training when working with this population; rather, those without sufficient training endorsed more negative attitudes. These findings further suggested that exposure and experience of working with sex offenders was not the sole factor in shaping attitudes when working with this population and that the level of training and job responsibilities also informed an individual's perception and attitudes towards sex offenders. However, literature focusing on the attitudes and perceptions towards this population has not included forensic healthcare workers without professional qualifications.

Summary of the Background and Research Aims

Workplace burnout is substantial and prevalent within caring professions, partly because of the large mental burden associated with these roles. Incidences of workplace burnout have been linked to employees' poor well-being and reduced client treatment outcomes. However, limited findings have been reported concerning the influence of psychological factors impacting the well-being of those involved in the care of sex offenders, particularly among forensic healthcare workers with no professional qualifications. Furthermore, considering the vast amount of research dedicated to exploring negative attitudes towards sex offenders, very little attention has been given to exploring the well-being of forensic healthcare workers without professional qualifications. The role of a healthcare worker is typically to support clients with their daily living needs and to provide high-quality care. More specifically, healthcare workers within forensic mental health settings often support other healthcare professionals in the treatment provided to clients as well as in managing the clients' risk to themselves and others. Forensic healthcare workers without professional qualifications are in the unique position of receiving little training, like prison officers, but have more contact hours with sex offenders and the same duty of care as other healthcare professionals. It was surprising to the author that this population has been arguably neglected within extant research.

Therefore, the current research aimed to build on the existing literature by exploring whether there is a predictive relationship between attitudes towards and punitive perceptions of sex offenders and workplace well-being amongst forensic healthcare workers without professional qualifications providing care to sex offenders. Additionally, previously published literature has identified a substantial role of workplace factors on workplace well-being (Hatcher & Noakes, 2010). Therefore, the current study also aimed to investigate the influence of such factors.

Hypotheses

Several predictions are explored within the current study. It is hypothesised that workplace factors, namely quality of supervision, co-worker support, and environmental safety will positively predict workplace well-being through an increase in compassion satisfaction and a decrease in burnout and secondary traumatic stress. Secondly, it is hypothesised that negative attitudes towards sex offenders will negatively predict workplace well-being through a decrease in compassion satisfaction and an increase in burnout and secondary traumatic stress. The third hypothesis predicts that negative perceptions towards sex offenders will negatively predict workplace well-being through a decrease in compassion satisfaction and an increase in burnout and secondary traumatic stress.

Methodology

Participants

Overall, 91 participants (43 females and 46 males) were recruited for the study. Participants' age ranged from 19 to 55 ($M_{age} = 30$, $SD = 9.11$). Out of the 91 participants, 11 reported having professional qualifications, however, these qualifications did not meet the exclusion criteria of professional qualifications relating to their job role, for example, that of a psychologist or psychiatrist. Furthermore, 13 participants reported to have received training when working with sex offenders. However, the training descriptions provided suggested that they did not address attitudes towards sex offenders. Out of the 87 participants who provided their nationality, 72 were British, four were African, eight were Asian, and three were Romanian. The average length of employment when working with sex offenders was 31 months (two years and five months; $M = 31.03$, $SD = 22.16$) with a range of five months to 132 months (11 years). From the demographic questionnaire, all 91 participants indicated that at the time of completing the study, they were directly working with sex offenders.

Overall, the recruited participant sample was reflective of the intended study sample. Participants were healthcare workers without professional qualifications (related to their current job role), currently working within a UK-based private mental health service with sex offenders as part of the client population. Additionally, participants were over the age of 18 and had been working within the service for a minimum of three months.

Design

The study employed a quantitative, cross-sectional design, using three multiple regression analyses to test for predictive effects amongst variables. The dependent variables were three indexes of workplace well-being, namely compassion satisfaction, secondary traumatic stress, and burnout. Nine predictors were measured within the study which included five concepts such as attitudes towards sex offenders, perception of sex offenders, co-worker

support, quality of supervision, and environmental safety. In total, the study included nine predictors.

Power Analysis

Power analysis was conducted using G*Power version 3.1.9.7 (Faul et al., 2007) to assess whether the number of recruited participants ($N = 91$) was sufficient for the number of predictive variables ($N = \text{nine}$) used within the study. As multiple tests were conducted, the alpha level was adjusted to 0.02. The results of the post hoc power analysis showed that the achieved statistical power for detecting the observed effect size in the study's model was 1. This suggests the study had a sufficient sample size to detect the effect size of interest, and our analysis was adequately powered.

Measures

Demographic Questionnaire

A demographic questionnaire was developed to extract relevant data from the recruited participants. General information such as the participants' age, gender, and nationality were included. Questions specific to the study and its exclusion criteria were also included, such as whether the participants currently work with sex offenders, their length of employment within the service, their relevant training and whether they have relevant professional qualifications.

Perception of Sex Offenders

The Perception of Sex Offenders (PSO; Harper & Hogue, 2015) scale is a 6-point scale comprising of 20 items. The PSO measures an individual's punitiveness towards sex offenders as well as their stereotypical thinking. The PSO reports good internal consistency and reliability ($\alpha > .92$). The scale is comprised of three subscales including stereotype endorsement, reporting good internal consistency and reliability ($\alpha = .85$); sentencing and management, reporting good internal consistency and reliability ($\alpha = .92$); and risk perception, reporting good internal consistency and reliability ($\alpha = .80$). Throughout the scale, participants are required to respond using a Likert scale from one (Strongly Disagree) to six (Strongly Agree). Instructions for the participants completing the scale include: "Please respond to each of the following statements by indicating the extent to which you agree with it. To answer, please place the appropriate number next to the question, in the space provided". Definitions of the subscales can be found in the introduction.

Professional Quality of Life Scale – Version 5

The Professional Quality of Life Scale – Version 5 (Stamm, 2009) is a 5-point scale with 30 items. The scale has been designed with the aim of gaining insight into the negative and positive effects of providing specialised care to those who have experienced trauma or are suffering physically or mentally (ProQOL, 2021). The scale is comprised of three subscales including compassion satisfaction, reporting good internal consistency and reliability ($\alpha = .88$); burnout, reporting acceptable internal consistency and reliability ($\alpha = .75$), and secondary traumatic stress, reporting good internal consistency and reliability ($\alpha = .81$). The subscale of compassion satisfaction measures how positively an individual feels towards helping others in their job role. The subscale of burnout measures an individual's difficulties or feelings of hopelessness when doing their job. The subscale of secondary

traumatic stress measures the impact of secondary exposure to stressful events. Throughout the measure, participants are required to respond using a Likert scale from one (Never) to five (Very Often). Instructions for the participants completing the scale include:

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days. (Stamm, 2009)

The Quality of Work Life Survey

The Quality of Work Life Survey (QWLS; Armstrong & Griffin, 2004) is comprised of eight subscales which are rated using a 5-point system. The aim of the survey is to measure an individual's quality of life within the workplace, focusing on eight different areas. For the purpose of this study, only three subscales were included which were deemed as the most relevant to the background literature. Across the three subscales, there are a total of 17 items. The subscales include environmental safety, perceived co-worker support, and quality of supervision. Environmental safety reports acceptable internal consistency and reliability ($\alpha = .61$); this item measures an employee's feeling of safety relating to the provisions in place for them to complete their job role. Perceived co-worker support reports acceptable internal consistency and reliability ($\alpha = .76$); this item measures the employee's perception of the support they receive from their co-workers within their job role. Quality of supervision reports good internal consistency and validity ($\alpha = .81$); this measures the employees' satisfaction with the supervision they receive relating to their job role. Participants rate each item using a 5-point Likert Scale from one (Strongly Agree) to five (Strongly Disagree).

Instructions for the participants completing the scale include: “Please rate each item from 1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree nor Disagree, 4 = Agree, 5 = Strongly Agree”.

Attitudes Towards Sex Offenders – 21

The Attitudes Towards Sex Offenders – 21 scale (Hogue & Harper, 2019) is a 5-point scale with 21 items, measuring an individual’s attitude towards sex offenders. The ATS-21 reports strong internal consistency ($\alpha = .94$). The scale is comprised of three subscales including intent, reporting good internal consistency and reliability ($\alpha = .84$); social distancing reporting acceptable internal consistency and reliability ($\alpha = .79$), and trust reporting good internal consistency and reliability ($\alpha = .83$). Throughout the measure, participants are required to respond using a Likert scale from zero (strongly disagree) to four (strongly agree). Instructions for participants completing the scale include: “Please respond to each of the following items using the scale provided. Please be as honest as possible in your responding. There are no right or wrong answers.” Definitions of the subscales can be found in the introduction.

Procedure

Recruitment

Participants were recruited via a study advert (Appendix D) accessible either through their workplace email following authorisation from their service manager or advertised on social media platforms such as Facebook, WhatsApp, and LinkedIn. Additionally, the snowball method was used whereby participants were encouraged to recruit their colleagues. The study advert included a link to a separate website whereby participants could complete the questionnaires through Qualtrics (Qualtrics, Provo, UT). Qualtrics is a web-based

software that is used to develop online surveys and distribute them to targeted populations through the use of a website link.

Study Procedure

When directed to the study, participants were presented with an information sheet (Appendix E) and a consent form (Appendix F). If participants consented to participate in the study, they were then encouraged to complete a demographic questionnaire (Appendix G). Following this, participants were asked to complete four scales in the following order: Perception of Sex Offenders Scale (Appendix H), Professional Quality of Life Scale – Version 5 (Appendix I), The Quality of Work Life Survey (Appendix J) and The Attitudes Towards Sex Offenders Scale – 21 (Appendix K). The design of the study ensured that participants could not progress to the next scale without having provided an answer for each item to ensure all the required data was collected. Once the questionnaires were completed, participants were provided with the opportunity to provide their email address to be enrolled on a participant raffle (Appendix L) before being presented with a debrief form (Appendix M) and a unique participant ID code. It was anticipated that the study would take 30 minutes to complete. Analysis of the actual time taken to complete the study averaged 18 minutes.

Ethical Considerations

Within the information sheet, participants were provided with a brief overview of the topic of the study, so they were informed of its context before deciding whether they wished to engage. As the study encouraged participants to consciously think about sensitive topics such as their attitudes towards sex offenders as well as to reflect on their level of burnout and well-being, participants were reminded of their right to withdraw at the beginning of the study. Additionally, as a precautionary measure, participants were provided with a phone number for the Samaritans in case they were adversely affected by the content of the questionnaires. All participants were provided with a unique participant code to maintain

pseudo-anonymity and were advised their data would be kept confidential. Finally, upon completion of the study, participants were presented with a debrief form, thanking them for their participation, reminding them of their right to withdraw as well as restating the researchers' contact information. Ethical approval (reference ERN_21-1594) for this research was granted by the University of Birmingham's ethics committee.

Results

Statistical Analysis

Data was exported from Qualtrics in an Excel format and then exported into IBM SPSS statistical software, Version 27.0 (Armonk, NY: IBM Corp). Prior to transcription into SPSS, all incomplete responses (N = 40) were removed from the Excel spreadsheet. This included deleting participant data for those who had not completed the entirety of the study (i.e., all four psychometric scales).

To test the hypotheses, three separate enter multiple regression analyses were conducted, one per each subscale of the Professional Quality of Life Scale – Version 5 (PQLS; Stamm, 2009), namely compassion satisfaction, burnout, and secondary traumatic stress acting as dependent variables. Each of the regressions used the same set of predictors entered simultaneously in a single step. These predictors were attitudes towards sex offenders as measured by ATS-21 - Trust, ATS-21 - Social Distancing, and ATS-21 – Intent; perceptions of sex offenders as measured by PSO – Sentencing Management, PSO – Risk Perceptions, and PSO – Stereotype Endorsement, and workplace variables including environmental safety, perceived peer support, and quality of supervision. It is important to bear in mind that higher scores for the PQLS subscale of compassion satisfaction indicate more desirable levels of workplace well-being, whereas higher scores for burnout and secondary traumatic stress indicate less desirable levels of workplace well-being (i.e., the direction of the desirable effect varies between the variables).

To test the aforementioned relationships, several assumptions were tested (Appendix N, O, P). Each subscale of the dependent variable (PQLS; Stamm, 2009) demonstrated a linear relationship between the independent variables as well as reported normal distribution. Multivariate normality was also observed as the normal distribution of the residuals was

shown on the normal probability plot. The analysis of variance inflation factor (VIF) for each analysis did not report scores higher than 10, suggesting there was not a high correlation between variables, thus it can be assumed there is no multicollinearity within the data. Finally, homoscedasticity was observed within each scatterplot as there was no clear pattern of distribution among the residuals. Therefore, each assumption was met, and standard multiple regression was conducted. Regarding correlations between the dependent and independent variables (refer to Appendix N, O, P), relationships were in the expected direction.

Concerning demographic variables, none of the participants had received any training specific to working with sex offenders and did not hold relevant professional qualifications. Therefore, as the data was homogeneous there was no rationale to conduct further analyses.

Compassion Satisfaction

The model exploring whether attitudes and perceptions towards sex offenders as well as workplace variables predicted compassion satisfaction was a good fit ($F(9, 81) = 21.731$, $p < .001$) and explained 70% of the variance in compassion satisfaction within the workplace.

Table 4 lists all of the predictors and their significance in relation to the dependent variable (compassion satisfaction). Concerning the predictors that demonstrated significant results, this included: ATS-21 - Trust ($\beta = -.354$, $p = .009$), ATS-21 - Social Distancing ($\beta = .530$, $p < .001$), ATS-21 - Intent ($\beta = .609$, $p < .001$), environmental safety ($\beta = .1.190$, $p < .001$), and co-worker support ($\beta = -.484$, $p = .03$). Variables including PSOS - Sentencing Management, PSOS - Stereotype Endorsement, PSOS - Risk Perception, and quality of supervision did not report significant effects.

These results suggested that increased positive attitudes relating to how healthcare workers viewed interactions with sex offenders (ATS-21 - Social Distancing) as well as the

workers' cognitive evaluations of offenders (ATS-21 - Intent) predicted increased compassion satisfaction. However, attitudes related to trusting sex offenders (ATS-21 -Trust) demonstrated that more positive attitudes predicted reduced well-being, in that healthcare workers who trusted sex offenders were less likely to experience greater pleasure in helping and caring for them. Furthermore, workplace factors such as higher levels of environmental safety, as well as perceived co-worker support, predicted increased levels of compassion satisfaction.

Table 4*Psychological and Workplace Variables Predict Compassion Satisfaction*

	Unstandardized Coefficients				95% CI	
Variable	B	Std. Error	Standardized Coefficients Beta	Sig.	Lower Bound	Upper Bound
<i>PSOS</i>						
Sentencing Management	.143	.095	.247	.134	-.045	.332
Stereotype Endorsement	.138	.136	.100	.314	-.133	.409
Risk Perception	-.058	.142	-.038	.684	-.340	.224
<i>ATS-21</i>						
Trust	-.354	.131	-.288	.009	-.616	-.093
Social Distancing	.530	.160	.395	.001	.211	.849
Intent	.609	.146	.597	<.001	.318	.900
<i>QWLS</i>						
Environmental Safety	1.190	.183	.612	<.001	.826	1.555
Quality of Supervision	.223	.133	.144	.097	-.041	.488
Co-worker Support	-.484	.229	-.208	.038	-.940	-.029

Note. * $p < .05$; Multiple Regression analysing the following predictors: Perception of Sex Offenders Scale (PSOS), Attitudes Towards Sex Offenders (ATS-21), Quality of Worklife Survey (QWLS).

Secondary Traumatic Stress

The model exploring whether attitudes and perceptions towards sex offenders as well as workplace variables predicted secondary traumatic stress was a good fit ($F(9, 81) = 10.645, p < .001$) and explained 55% of variance in secondary traumatic stress within the workplace.

Table 5 reports all the potential predictors and their significance in relation to the dependent variable (secondary traumatic stress). Concerning the predictors that demonstrated significant results, this included PSOS - Sentencing Management ($\beta = -.273, p = .01$), PSOS - Risk Perception ($\beta = -.441, p = .007$), ATS-21 - Intent ($\beta = -.950, p < .001$), Quality of Supervision ($\beta = -.169, p = .002$) and Environmental Safety ($\beta = -.659, p = .001$). Variables including PSOS - Stereotype Endorsement, ATS-21 – Trust, ATS-21 – Social Distancing, and co-worker support did not report significant effects.

The current results suggested that healthcare workers who perceived that sex offenders should be treated more harshly (PSOS; Sentencing Management) and viewed them as a high risk of committing further offences (PSOS; Risk Perception) had lower scores on secondary traumatic stress, in that they were less likely to experience psychological difficulties when working with this population. Concerning healthcare workers' cognitive evaluation of sex offenders (ATS-21 - Intent), more positive attitudes predicted lower levels of secondary traumatic stress. Furthermore, the workplace factor of environmental safety and quality of supervision reported that higher levels predicted a reduction in secondary traumatic stress.

Table 5*Psychological and Workplace Variables Predict Secondary Traumatic Stress*

	Unstandardized Coefficients				95% CI	
Variable	B	Std. Error	Standardized Coefficients Beta	Sig.	Lower Bound	Upper Bound
<i>PSOS</i>						
Sentencing Management	-.273	.106	-.527	<.001	-.483	-.063
Stereotype Endorsement	.132	.152	.107	.012	-.170	.435
Risk Perception	-.441	.158	-.323	.387	-.755	-.126
<i>ATS-21</i>						
Trust	.123	.147	.112	.007	-.169	.414
Social Distancing	.073	.179	.061	.405	-.283	.429
Intent	-.950	.163	-1.043	.685	-1.275	-.626
<i>QWLS</i>						
Environmental Safety	-.659	.204	-.380	<.001	-1.066	-.252
Quality of Supervision	-.169	.148	-.122	.002	-.464	.126
Co-worker Support	.242	.255	.117	.258	-.266	.751

Note. * $p < .05$; Multiple Regression analysing the following predictors: Perception of Sex Offenders Scale (PSOS), Attitudes Towards Sex Offenders (ATS-21), Quality of Worklife Survey (QWLS).

Burnout

The model exploring whether attitudes and perceptions towards sex offenders as well as workplace variables predicted burnout was a good fit ($F(9, 81) = 16.750, p < .001$) and explained 65% of the variance in burnout within the workplace.

Table 6 reports all the potential predictors and their significance in relation to the dependent variable (burnout). Concerning the predictors that demonstrated significant results, this included Sentencing Management (beta = $-.400, p < .001$), ATS-21 - Intent (beta = $-.867, p < .001$), Environmental Safety (beta = $-.783, p < .001$), and Quality of Supervision (beta = $-.347, p = .003$). Variables including PSOS - Stereotype Endorsement, PSOS – Risk Perception, ATS-21 – Trust, ATS-21 – Social Distancing, and co-worker support did not report significant effects.

The current results suggested that healthcare workers who believed that sex offenders should be treated more harshly (PSOS; Sentencing Management) had lower scores on burnout, in that they were less likely to, for example, experience feelings of hopelessness when working with this population. Concerning healthcare workers' cognitive evaluation of sex offenders (ATS-21 - Intent), more positive attitudes predicted lower levels of burnout. Furthermore, higher environmental safety and better quality of supervision predicted a reduced level of burnout.

Table 6*Psychological and Workplace Variables Predict Burnout*

	Unstandardized Coefficients				95% CI	
Variable	B	Std. Error	Standardized Coefficients Beta	Sig.	Lower Bound	Upper Bound
<i>PSOS</i>						
Sentencing Management	-.400	.080	-.892	<.001	-.559	-.241
Stereotype Endorsement	.062	.115	.058	.594	-.167	.291
Risk Perception	.072	.120	.061	.550	-.166	.310
<i>ATS-21</i>						
Trust	.170	.111	.179	.129	-.050	.391
Social Distancing	-.211	.136	-.203	.123	-.481	.059
Intent	-.867	.124	-1.097	<.001	-1.112	-.621
<i>QWLS</i>						
Environmental Safety	-.783	.155	-.521	<.001	-1.091	-.475
Quality of Supervision	-.347	.112	-.289	.003	-.570	-.123
Co-worker Support	.337	.194	.187	.086	-.049	.722

Note. * $p < .05$; Multiple Regression analysing the following predictors: Perception of Sex Offenders Scale (PSOS), Attitudes Towards Sex Offenders (ATS-21), Quality of Worklife Survey (QWLS).

Discussion

The current research aimed to explore if attitudes, perceptions, and workplace variables influenced the well-being of forensic healthcare workers without professional qualifications who provide care to sex offenders. The hypotheses for the study proposed that negative attitudes and perceptions would negatively predict workplace well-being and that workplace factors would positively predict workplace well-being; this was partially supported. Overall, results indicated that more favourable attitudes towards sex offenders predicted increased well-being through higher levels of compassion satisfaction and a reduction in secondary traumatic stress and burnout. However, in contrast to the hypotheses, negative perceptions supportive of harsher punishments and increased risks predicted higher levels of well-being through a reduction in secondary traumatic stress and burnout. Furthermore, higher scores on each of the workplace factors (i.e., environmental safety, quality of supervision, and co-worker support) predicted increased levels of workplace well-being, which was also supportive of the hypotheses.

Attitudes and Perceptions

The findings from the study have contributed to the existing literature by exploring forensic healthcare workers without professional qualifications' attitudes and perceptions of sex offenders, a population that to the author's knowledge, has previously been overlooked. Several interesting and unexpected results have been reported, such as attitudes and perceptions providing differing directions of predictive effects on workplace well-being. As aforementioned, attitudes and perceptions are two separate, multifactorial psychological processes; attitudes relate to one's emotional and behavioural responses, whereas perceptions reflect one's understanding and knowledge of the world (Cacioppo et al., 1999). The current findings also reinforce Harper's and Hogue's (2015a) suggestion, that the ATS-21 and PSO

are complimentary measures within this topic of research. Hence, the differing directions have various clinical implications and knowledge-based implications.

A predictive relationship that was supportive of the current hypotheses was the interaction observed between favourable attitudes and increased workplace well-being. It is plausible that, as described within previous literature, forensic healthcare workers adjusted their attitudes to be more favourable as a subconscious coping strategy, which has been found to help reduce psychological distress such as burnout (Farrenkopf, 1992). However, it could also be argued that the longer forensic healthcare workers spent directly working with this client population, the more likely they were to humanise sex offenders as observed within Scheela's (2001) study, consequently freeing themselves of psychological discomfort when caring for this client group. Employing a humane and compassionate approach is one that has been previously encouraged when treating sex offenders to optimise treatment outcomes (Blanchard, 1995), however, it also appears to have positive psychological benefits for those providing the care and treatment.

A relationship that was not supportive of the hypotheses was the contrast between the ATS-21 subscales (Hogue & Harper, 2019). Positive attitudes that predicted increased well-being were related to the subscales of intent and social distancing, whereas positive attitudes related to trust, predicted a reduction in well-being. Breckler's (1984) ABC model of attitudes has been reported to have inspired the components of the ATS-21, with intent and social distancing reflecting the cognitive and behavioural components of the formation of attitudes and the subscale of trust being related to our automatic emotional response. This meant that the more likely the forensic healthcare workers were to trust the sex offenders they cared for, the less likely they gained pleasure from helping them. Following the notion outlined by the job-demands resource model and the conservation of resource theory, which states that when resources are depleted or under threat, staff well-being is negatively impacted, for example,

increasing compassion fatigue (Bakker & Demerouti, 2014; Hobfoll & Freedy, 2017; Singh et al., 2020). Therefore, as trusting sex offender clients was an automatic emotional response, this may have exhausted the forensic healthcare workers' emotional resources, subsequently diminishing their well-being. However, this relationship is not clear, and the different components of forming attitudes would benefit from being individually explored within this topic.

Moreover, the current findings reported contrasts in the predictive effects of attitudes and perceptions, as negative perceptions also predicted increased well-being. The concept of cognitive dissonance may contribute to this discrepancy, as unlike prison officers, forensic healthcare workers without professional qualifications are in a position of care and are not required to enforce punitive measures (Levenson et al., 2010; Marshall, 2015), suggesting their favourable attitudes related to how they interact with sex offenders as measured by the ATS-21, may have been altered to reduce psychological discomfort (Festinger, 2006; Festinger & Carlsmith, 1959). Moreover, unlike qualified healthcare professionals, they do not have a responsibility to provide treatment or reduce risk, therefore, their perceptions relating to risk and harsher sentencing may not have been adjusted in response to cognitive dissonance and were more similar to that of the general public's perceptions (Levenson et al., 2007; 2010; Schiavone, & Jeglic, 2009). Further research exploring the formation of attitudes and perceptions amongst forensic healthcare workers without professional qualifications working with sex offenders is suggested.

Workplace Factors

Workplace factors measured within the current study were supportive of the hypotheses and were also in line with previous literature (Ennis & Horner, 2003; Hatcher & Noakes, 2010). Environmental safety demonstrated positive predictive effects across all three

components of workplace well-being. As discussed in Hatcher and Noakes's (2010) study, it has been suspected that there is a greater concern for environmental safety when working with this population within inpatient settings due to a greater level of relational risk. Mivshek and Schriver (2022) found higher levels of burnout and the use of depersonalisation as a maladaptive coping strategy among professionals working within prison settings when compared to those working in the community. Therefore, it has been suggested that provisions provided by employers to maintain the safety of their employees are particularly important within inpatient settings to increase well-being and reduce the development of maladaptive coping strategies (Mivshek & Shriver, 2022).

Concerning the quality of supervision, this predicted a reduction in forensic healthcare workers' level of burnout. When working with sex offenders, supervision was shown to be an effective coping strategy among healthcare professionals (Hatcher & Noakes, 2010). Supervision has been used for debriefs and to reflect on the experiences of working with sex offenders, a process that has been linked to resilience amongst staff (Hatcher & Noakes, 2010; White et al., 2008). Similarly, co-worker support also showed a positive predictive effect on well-being through an increase in compassion satisfaction. These results are in line with Ennis and Horne's (2003) findings, as professional peer support predicted lower levels of psychological distress and PTSD-related symptoms amongst professionals working with sex offenders. Thus, supervision and peer support appear to be a highly valued space to discuss and process the experience of working with this client population, subsequently increasing well-being through resilience and positive coping strategies.

By implication, it is proposed that as forensic healthcare workers receive a good quality of supervision, peer support, and environmental safety, there will be a positive effect on the quality of care provided to the sex offenders they care for (Delgadillo et al., 2018; Salyers et al., 2015; Teoh et al., 2023). Additionally, as proposed by the job-demands

resource model and the conservation of resource theory, the maintenance of such workplace resources will likely mitigate staff well-being being negatively impacted by high job demands such as the emotional resources required to care for this client population. Furthermore, this effect may also reduce high levels of staff turnover as well as cynicism within their job role (Poghosyan et al., 2010; Scanlan & Still, 2019; Willard-Grace et al., 2019). Personal issues such as substance misuse, relationship difficulties and further mental health problems are also likely to reduce (Awan et al., 2022; Dutheil et al., 2019; Monhanty et al., 2019). In summary, workplace variables have meaningful implications for the service, forensic healthcare workers without professional qualifications and sex offenders.

Implications for Practice

The current findings further reinforce the importance of exploring attitudes and perceptions held towards sex offenders as two separate psychological processes (Cacioppo et al., 1999). This can also be said for exploring the attitudes and perceptions of different populations (not just forensic healthcare workers without professional qualifications), particularly those who have contact time with sex offenders and are responsible for their care and treatment. Favourable attitudes and negative perceptions towards sex offenders predicted increased well-being, which indicates a need to manage suspected cognitive dissonance when working with this population. To do so, it is recommended that employers consider providing relevant training focusing on the benefits of therapeutic interventions in reducing risk (Fortney et al., 2009; Lea et al., 1999; Levenson et al., 2010; Ware et al., 2012). Moreover, as the subscale of trust, the closest related scale to the affective process of attitudes reported a negative prediction on compassion satisfaction, it is recommended that employers encourage the appropriate use of supervision as a coping strategy and a means to develop resilience (Hatcher & Noakes, 2010; White et al., 2008).

Additionally, the current study has highlighted the importance of maintaining adequate levels of environmental safety, supervision and support provided by co-workers to ensure workplace well-being, particularly when working with sex offenders (Hatcher & Noakes, 2010; Munger et al., 2015; Sandhu et al., 2012). If employers are considerate of workplace factors and their employees' attitudes with aims to optimise well-being, this would likely lead to an increase in the quality of care that is provided to the service users (Delgadillo et al., 2018; Salyers et al., 2015; Teoh et al., 2023).

Limitations and Strengths

The author of this work has personal experience of working within privatised settings, thus, being more familiar with the measured work-related factors in private healthcare settings as opposed to NHS settings. Whilst the study design and interpretation of the findings may have been guided by the researcher's personal experience, it is argued that the unique, personal insights may have enriched as much as biased aspects of this study. Nonetheless, the impact of bias has been mitigated through the supervision process provided by the research supervisor. Furthermore, it is anticipated that the current findings are of great contribution to existing literature, however, it is recommended that future research on the current topic include those employed within the NHS, particularly when accounting for work-related factors, to identify potential implications for non-private healthcare workplace well-being. Additionally, each of the measures included in the study achieved good levels of internal consistency and reliability.

Another limitation of the current study is the uncertainty around the influence of participants' contact time with other clients who do not have a sexual offence conviction on workplace well-being. It remains to be explored to what extent this variable interacts with the participants' workplace well-being. Staff working in forensic mental health services typically support individuals with a variety of offences, including those of a sexually violent nature;

however, this drastically varies across services. Other clients without a sexual offence may present with challenging behaviours or have complex histories that also elicit psychological distress amongst those supporting them (De Looft et al., 2019; Dickinson & Wright, 2013). Therefore, it is plausible that the exposure to clients without a sexual offence may have influenced the data collected relating to well-being. Nonetheless, the measures exploring attitudes and perceptions exclusively focus on that of sex offenders which strengthens the methodology used within the current study to obtain results reflective of the experience of working with sex offenders. Additionally, within the demographic questionnaire, it was identified that the average participant had spent two years and five months working with sex offenders as part of the client population they cared for, further increasing the likelihood that the well-being results are reflective of their time spent caring for sex offenders.

Future Research

The results suggest that favourable emotional responses to sex offenders, as measured within the ATS-21 trust subscale, can negatively impact the well-being of forensic healthcare workers without professional qualifications. Therefore, future literature should explore potential moderating variables that can mitigate this from occurring. Additionally, the process of cognitive dissonance may also relate to the discrepancies that have been reported between attitudes and perceptions when predicting well-being. Therefore, future research should continue to explore this concept and other variables that influence the process.

Furthermore, as professionals and paraprofessionals have previously reported discrepancies in their attitudes towards sex offenders (Higgins & Ireland, 2009; Day et al., 2014) and findings remain unclear on the psychological impact of working with this population (Ennis & Horne, 2003; Hatcher & Noakes, 2010; Kadambi & Truscott, 2003; Munger et al., 2015; Steed & Bicknell, 2001), future research should also explore whether attitudes and perceptions can account for these inconsistencies.

Additionally, as none of the participants in the current study had received training or further education relevant to working with sex offenders, it was not reasonable to incorporate these demographic variables within the analysis. However, as training and participants' profession have reported effects on the attitudes and perceptions towards this client population (Day et al., 2014; Higgins & Ireland, 2009; Ware et al., 2012), future research exploring the well-being of forensic healthcare workers should consider including demographic variables such as gender, training, and level of education within data analysis.

Conclusion

To summarise, this study provides insight into the predictors of well-being amongst forensic healthcare workers without professional qualifications working with sex offenders. As stated above, this is an important population to explore due to their unique contact with the offender group and because they receive minimal training but are expected to provide the same quality of care as qualified healthcare professionals. The findings clearly demonstrate that favourable attitudes related to the participants' behavioural responses to sex offenders, increase workplace well-being, and negative perceptions related to harsher sentencing and risk also improve well-being. Therefore, training for forensic healthcare workers without professional qualifications should consider these findings. Furthermore, these findings reinforce the notion that cognitions (perceptions) and emotions (attitudes) should be considered as two separate psychological processes that have differing effects on well-being, particularly amongst those working with sex offenders. It is also suggested that employers would benefit from maintaining adequate levels of environmental safety as well as providing good quality supervision to ensure the well-being of forensic healthcare workers. Through further exploration and practical application of the aforementioned findings, employers will have a healthier workforce. This in turn can anticipate improved treatment outcomes for people sentenced for sex offences.

CHAPTER FIVE

General Discussion

Discussion

Restatement of Aims

The aim of the current thesis was twofold. Firstly, the thesis explored how various aspects of the therapeutic treatment of sex offenders impact treatment outcomes. The results of the exploration informed the aims of the research, which focused on the well-being of forensic healthcare workers without professional qualifications providing care to sex offenders. The aims were achieved through careful consideration of four overarching concepts, namely the therapeutic relationship, attitudes and perceptions, workplace characteristics, and employee well-being. A thorough report of all findings has been detailed in chapters two, three, and four. Brief overviews of chapters one to four are presented next.

Chapter one highlighted that some sex offenders have tendencies to reoffend and that it is essential to explore factors linked to their therapeutic rehabilitation (Darkness to Light, 2020; Master, 1986; RAINN, 2023; Tomasula et al., 2012; Ullman & Najdowski, 2009; Van Egmond et al., 1993). The chapter also emphasised that the workers involved in sex offender treatment and management also required attention as they have a strong influence on the treatment outcomes obtained (Marshall et al., 2003; Sandhu & Rose, 2012). Conflicting research findings have been reported relating to the psychological impact on staff working with sex offenders (Ennis & Horne, 2003; Hatcher & Noakes, 2010; Kadambi & Truscott, 2003; Munger et al., 2015; Steed & Bicknell, 2001). However, limited attention has been dedicated to the well-being of forensic healthcare workers without professional qualifications. Therefore, the review of the existing literature provided a rationale for conducting further review and research on the therapeutic process of treating sex offenders and the psychological impact on forensic healthcare workers without professional qualifications, which was communicated in the remaining chapters.

The aim of chapter two was to provide a systematic review of the literature exploring the factors contributing towards the quality of the therapeutic relationship between a therapist and a sex offender, and the influence that this relationship has on treatment outcomes. Following a systematic search, screening process, and dual coding quality assessment, seven studies were included in the review (Aylwin, 2010; Beech et al., 2005; DeSorcy et al., 2014; 2017; Fenske, 2007; Marshall et al., 2002; Rothman, 2007). Results from the studies were extracted and synthesised utilising a narrative approach to provide an overall view of the findings within this area of research.

Chapter three aimed to provide a critique of the Perception of Sex Offenders Scale (PSO; Harper & Hogue, 2015a), a measure designed to assess the perceptions held towards sex offenders. This scale was then used within the empirical research project discussed in chapter four.

Chapter four explored the well-being of forensic healthcare workers without professional qualifications directly working with sex offenders. This empirical paper employed a quantitative study design measuring well-being and psychological processes such as attitudes and perceptions towards sex offenders, as well as workplace variables including environmental safety, quality of supervision, and co-worker support. Well-being was explored through measuring compassion satisfaction, burnout, and secondary traumatic stress.

Summary of Findings

Chapter Two

As aforementioned, chapter two provided a systematic review of the extant literature exploring the influence of the therapeutic relationship on treatment outcomes amongst sex offenders. Treatment gains, as reported in the included studies, were most frequently assessed through pre- and post-treatment measures (Aylwin, 2010; Beech et al., 2005; Fenske, 2007;

Rothman, 2007); this involved measuring behavioural, cognitive, and attitudinal changes. Two studies explored treatment outcomes by measuring the rate of recidivism over a ten-year period (DeSorcy et al., 2014; 2017). The therapeutic relationship was defined by the clients' perceptions of the relationship, with the exception of one observational study (Marshall et al., 2002).

The review concluded with seven themes, which reflected the processes of the therapeutic relationship and how this impacted treatment outcomes. Theme one (the impact of the quality of the therapeutic relationship on short-term cognitive treatment outcomes) highlighted that the therapeutic relationship accounted for positive short-term treatment outcomes, such as changes to the sex offender's cognition, behaviour, and attitudes (Aylwin, 2010; Fenske, 2007; Rothman, 2007). More specifically, a reduction in interpersonal difficulties, as well as an improvement in responsibility, offender functioning, and goal attainment (Aylwin, 2010; Fenske, 2007; Rothman, 2007). Contrastingly, theme two (the quality of the therapeutic relationship does not reduce recidivism rates) demonstrated no meaningful relationship between the therapeutic relationship and recidivism rates (DeSorcy et al., 2014; 2017). This suggested that the therapeutic relationship did not contribute to a reduction of the risk of recidivism amongst this client group. However, it is important to note that the findings relating to an improvement in interpersonal difficulties are reflective of intimate and non-intimate relationships, a dynamic risk factor that is predictive of recidivism and the onset of harmful sexual behaviour (Kruttschnitt et al., 2000; Marshall et al., 1993). Therefore, the therapeutic relationship has been shown to induce changes consistent with treatment goals as well as improve dynamic risk factors predictive of recidivism.

Furthermore, the third theme (therapist characteristics influence the quality of the therapeutic alliance) reinforced the importance of the therapist's characteristics when developing the therapeutic relationship and inducing treatment change (Beech et al., 2005;

Fenske, 2007; Marshall et al., 2002; Rothman, 2007). Having empathy was reported as contributing to a significant increase in the perceived working alliance, whilst reducing harmful cognitive processes such as victim blaming, denial of harm, and denial of responsibility (Marshall et al., 2002). It has also been shown to improve dynamic risk factors such as social and occupational functioning (Craig et al., 2005; Rothman, 2007). It was proposed that the process and characteristics of a positive therapeutic relationship can role model valuable social skills, influencing the change observed within the reported findings.

Theme four (PCL-R scores report conflicting interactions with the therapeutic relationship) reviewed the effects of the client's (sex offender's) PCL-R score on the development of the therapeutic relationship. This highlighted a contrast in findings with Aylwin (2010) reporting that the therapeutic relationship was independent of all client's characteristics including the PCL-R and DeSorcy et al. (2017) providing results that show specific facets of the PCL-R were related to lower scores of the working alliance. The findings from DeSorcy et al. (2017) demonstrated that specific facets of the PCL-R likely impair the sex offender's ability to respond to the mechanisms involved in developing a therapeutic rapport and reducing the risk of recidivism.

Theme five (peer relationships facilitate desirable treatment outcomes) was an unexpected but valuable finding, which was that perceived peer support facilitated positive treatment outcomes (Beech & Hamilton, 2005; Aylwin, 2010). Interestingly, Aylwin (2010) reported that perceived peer support was more influential, as compared to the relationship with the therapist, inducing improvements in interpersonal problems. Therefore, it was concluded that the role of peer support may demonstrate a similar (if not better) effect on the therapeutic relationship in relation to role-modelling healthy interpersonal skills.

The sixth theme (mandated treatment may not hinder the formation of the therapeutic relationship) reported that mandating treatment engagement did not affect the therapeutic relationship. Fenske (2007) was the only empirical paper to comment on whether or not clients were mandated to take part in the treatment, and therefore, it was assumed that the remaining participant groups engaged voluntarily. Fenske's (2007) findings were consistent with other included papers, in that the therapeutic relationship facilitated favourable treatment outcomes, suggesting that the mandating of treatment does not hinder this process.

The seventh and final theme (aspects of intervention design) found that other aspects of the intervention design did not interfere with the effects found between the therapeutic relationship and treatment outcomes. Treatment location and intervention, category of sex offender, the profession of the therapist, and whether group-led interventions were supplemented, were not reported to impact the process of the therapeutic relationship or its relationship with treatment outcomes.

Chapter Three

Chapter three critiqued a measure that has been employed within research exploring topics related to the current thesis; the Perception of Sex Offenders Scale (PSO; Harper & Hogue, 2015a). The critique concluded that the PSO is a reliable and valid measure in capturing an individual's perceptions and judgements of sex offenders. Each subscale demonstrated strong internal consistency, in that each component (sentencing management, stereotype endorsement, and risk perception) produced similar scores. This was also the case for a participant sample from Tehran (Bakhtari et al., 2021). Furthermore, the scale's predictive validity has also performed well throughout research exploring forensic professionals' risk judgements after reading relevant hypothetical scenarios (Harper & Hicks,

2021). The findings reported that risk judgements were significantly impacted by the perception of sex offenders as measured through the PSO.

However, a limitation of the scale is that the scale's items may be reflective of perceptions relevant to British laws and legislation. For example, referring to the reintroduction of the death penalty, which in some non-UK countries is already a legal practice. The PSO was used within the fourth chapter of the current thesis, with a participant sample of healthcare workers employed within inpatient hospitals within the UK. Therefore, although the scale may have application limitations if used within different countries, this limitation did not apply to the current thesis.

Overall, the PSO has proven to be a highly reliable and valid measure with good face validity, in that it measures the concept it sets out to measure. The PSO has provided significant contributions to research relevant to the topic of treating and managing sex offenders. It is also likely to have valuable applications in supporting professionals to be more aware of the potential presence of their negative perceptions of sex offenders.

Chapter Four

It was identified within chapters one and two that the therapist's well-being and relationship with their client group contributed to treatment outcomes, and that the psychological characteristics of the therapist potentially impacted both processes (Delgadillo et al., 2018; Hatcher & Noakes, 2010; Nelson et al., 2002; Salyers et al., 2015; Sandhu & Rose, 2012). Therefore, the study described in chapter four investigated attitudes and perceptions as well as workplace variables as predictors of well-being amongst forensic healthcare workers without professional qualifications, who at the time of data collection worked with sex offenders.

Results of the multiple regression analysis demonstrated that favourable attitudes concerning social distancing and intent predicted increased well-being through higher levels of compassion satisfaction and lower levels of burnout and secondary traumatic stress amongst forensic healthcare workers. This suggested that when forensic healthcare workers had less of a desire to socially distance from the client and held more favourable views about a sex offender's cognitions, they were more likely to gain satisfaction from their job and were less likely to experience negative psychological consequences. Conversely, favourable attitudes related to trust demonstrated a negative predictive effect on compassion satisfaction. The subscale of trust is described to be the most closely related to the affective process of attitudes (Hogue & Harper, 2019), suggesting that the more positive their affect was towards sex offenders, the less likely they were to enjoy their jobs.

Negative perceptions related to sentencing management and risk perceptions predicted a reduction in secondary traumatic stress and burnout. Therefore, forensic healthcare workers who perceived sex offenders as riskier, and that they should therefore be treated more harshly, were less likely to experience negative psychological consequences when working with this population.

Overall, favourable attitudes and, conversely, negative perceptions were positively related to an employee's well-being. Collectively, these findings reinforced the notion that these processes are not interchangeable and raised the importance of measuring attitudes and perceptions as separate psychological processes. Additionally, these findings may account for the inconsistencies observed in past literature exploring the psychological health of staff who worked with sex offenders (Ennis & Horne, 2003; Hatcher & Noakes, 2010; Kadambi & Truscott, 2003; Munger et al., 2015; Steed & Bicknell, 2001), as different professional groups involved in the treatment of sex offenders have reported differing attitudes and perceptions (Higgins & Ireland, 2009; Day et al., 2014).

Furthermore, higher scores for workplace factors including environmental safety, quality of supervision, and co-worker support predicted increased well-being through higher levels of compassion satisfaction and lower levels of burnout and secondary traumatic stress. Therefore, when forensic healthcare workers were provided with adequate training, received good quality supervision and received support from their co-workers, they were more likely to gain satisfaction from their job supporting sex offenders and were less likely to experience negative psychological consequences. The current findings were in accordance with previous literature that reported the powerful influence of workplace factors on staff well-being when working with this population (Ennis & Horne, 2010; Hatcher & Noakes, 2010).

To conclude, the study demonstrated that psychological processes such as attitudes and perceptions as well as workplace variables impacted treatment outcomes when working with sex offenders. These findings expanded on the existing literature by providing valuable insights into the circumstances of forensic healthcare workers without professional qualifications, a population that has been overlooked in previous literature.

Implications for Practice

Several implications for practice are put forward based on the findings of this thesis. All suggestions are directed at those either directly involved in the treatment of sex offenders, or those employing the staff that are. These suggestions are hoped to provide positive effects for both sex offender treatment outcomes and the well-being of those caring for them, such as treatment facilitators and forensic healthcare workers without professional qualifications.

First, the current thesis highlights the important role professionals have in the treatment outcomes of sex offenders. Similar to the general clinical population, the therapeutic relationship has demonstrated strong positive effects on short-term treatment outcomes. Other psychological factors such as empathy have also been shown to mediate this

relationship. Therefore, professionals involved in the therapeutic process of treating sex offenders are encouraged to consider the relationships they have with their clients with such offences and to consider how they can embody and demonstrate qualities such as empathy and warmth to optimise treatment outcomes. It is also recommended that appropriate training and supervision be encouraged by employers to ensure that professionals are sufficiently supported and educated on the process of developing positive therapeutic relationships.

Second, the review also reported that perceived peer support produces similar, if not stronger effects on positive treatment outcomes amongst this population (Aylwin, 2010; Beech & Hamilton, 2005). Therefore, it is recommended that treatment facilitators explore how to assist group cohesion and positive relationships amongst peers to further encourage positive treatment outcomes.

Third, the Perception of Sex Offenders Scale (POS; Harper & Hogue, 2015a) demonstrated good levels of reliability and efficacy. Forensic healthcare workers' perceptions towards sex offenders were shown to influence workplace well-being. Therefore, it was concluded that the PSO can be used within forensic settings to inform training needs. Additionally, as perceptions towards this population have been found to influence the therapeutic process, the scale can be used in practice to support therapists in identifying their perceptions of sex offenders (Nelson et al., 2002; Sandhu & Rose, 2012).

Fourth, the empirical study highlighted the importance of workplace factors such as environmental safety, peer support, and quality of supervision to ensure the well-being of those working with sex offenders. Burnout and reduced well-being have been reported to result in a number of professional implications, such as impaired quality of care, high staff turnover and cynicism within the job role (Poghosyan et al., 2010; Scanlan & Still, 2019; Willard-Grace et al., 2019). Therefore, employers are encouraged to maintain high standards

of each variable to ensure the well-being of the forensic healthcare workers they employ and to mitigate negative professional implications.

Fifth, attitudes and perceptions showed strong predictive effects on the well-being of those working with sex offenders. As aforementioned, cognitive psychoeducation (i.e., training) has previously been found to improve attitudes towards this forensic population (Ware et al., 2012). Therefore, employers are encouraged to further consider the use of appropriate training to help improve attitudes towards sex offenders amongst forensic healthcare workers without professional qualifications.

Recommendations for Future Research

The following research recommendations are presented in order of the thesis chapters.

Chapter Two

The quality of the therapeutic relationship has been shown to influence positive treatment gains amongst sex offenders through behavioural, cognitive and attitudinal changes. However, no meaningful findings were observed when considering the therapeutic relationship and its link to recidivism. Data for the latter effect (i.e., recidivism) were recorded over a ten-year period (DeSorcy et al., 2014; DeSorcy et al., 2017), whereas data for the former effect (i.e., treatment outcomes) were measured through psychometrics shortly after completion of the treatment intervention (Aylwin, 2010; Beech et al., 2005; Fenske, 2007; Marshall et al., 2002; Rothman, 2007). Therefore, future research exploring behavioural, cognitive, and attitudinal changes consistent with dynamic risk factors should consider taking a longitudinal approach in line with existing recidivism research. Moreover, research should consider designing advice on how to further explore the impact that the therapeutic relationship may have on recidivism.

The sex offender samples reported on within the systematic review consisted exclusively of male sex offenders. Men are overrepresented amongst sexual offenders as they are estimated to account for 98% of the prison population (Office for National Statistics, 2021), which was reflected in the reviewed research. Therefore, the current findings provided valuable and relevant contributions to the current topic. However, as biological sex differences of the treatment facilitators impacted the process of the therapeutic relationship and treatment outcomes (Aylwin, 2010; Sandhu & Rose, 2012), it is recommended that sex differences amongst sex offenders are also explored in subsequent research.

Chapter Three

The PSO (Harper & Hogue, 2015a) demonstrated applicability in measuring punitiveness and sexist perceptions, and an ability to predict risk judgements in professionals (Harper & Hicks, 2021). This is meaningful when considering that professional perceptions of risk for sexual offenders can influence sentencing and risk management decisions, such as early release and parole decisions (Blumenthal et al., 2010; Harper et al., 2017). Additionally, as cognitive psychoeducation (i.e., training) has been shown to improve the attitudes and perceptions of those working with this population (Ware et al., 2012), it may be helpful for further research to consider using the scale as a pre-and post-training measure to identify whether training impacts on risk judgements made by professionals.

Chapter Four

As attitudes and perceptions towards sex offenders have reported differing predictive effects on well-being, it is recommended that future research continue to consider these two concepts as distinct psychological processes. Additionally, as professionals and paraprofessionals have previously reported discrepancies in their attitudes towards sex offenders (Higgins & Ireland, 2009; Day et al., 2014), and findings remain unclear on the

psychological impact of working with this population (Ennis & Horne, 2003; Hatcher & Noakes, 2010; Kadambi & Truscott, 2003; Munger et al., 2015; Steed & Bicknell, 2001), future research should also explore whether such psychological processes can account for these inconsistencies.

General Interpretations and Conclusions

Overall, this thesis provided beneficial contributions to psychological knowledge and practice by highlighting that the quality of treatment processes can have a powerful effect on treatment outcomes for sex offenders. Similar to findings observed in studies recruiting from the general clinical population, a positive therapeutic relationship was proven to elicit desirable treatment outcomes amongst sex offenders (Aylwin, 2010; Beech et al., 2005; Fenske, 2007; Marshall et al., 2002; Rothman, 2007). These outcomes concerned behavioural, cognitive, and attitudinal changes consistent with dynamic risk factors predictive of recidivism rates (Aylwin, 2010; Kruttschnitt et al., 2000; Rothman, 2007). Furthermore, the critique of the Perception of Sex Offenders Scale (Harper & Hogue, 2015a) showed to be a valid and reliable measure when exploring the perceptions held towards sex offenders with strong predictive effects. The scale was used alongside the Attitudes Towards Sex Offenders Scale-21 (Harper & Hogue, 2019), in the study discussed in chapter four, to explore attitudes and perceptions as well as workplace factors as predictors of well-being amongst staff working with sex offenders. Results demonstrated that attitudes, perceptions and workplace variables have strong predictive effects on the well-being of forensic healthcare workers.

Findings from this thesis supported the notion that to obtain desirable treatment outcomes, those providing sex offender treatment should work towards establishing positive therapeutic relationships. The PSO scale could be used throughout this process to support therapists in identifying underlying perceptions, which may impair the therapeutic process. Furthermore, employers of forensic healthcare workers are encouraged to ensure that relevant training and supervision are provided to promote favourable attitudes towards sex offenders and ensure workplace well-being.

Furthermore, the collective findings of chapters two and four suggested that psychological characteristics are deeply meaningful in the care and treatment process of sex offenders. Most notably, empathy, attitudes, and perceptions held by forensic staff have been identified as qualities important for the psychological health of both the facilitator and the recipient. This is in strong contrast to the beliefs held by the general population, where a lack of empathy and negative attitudes towards those who sexually offend are frequently encouraged (Levenson et al., 2007). Understandably, such stark contrasts can contribute towards cognitive dissonance experienced by forensic employees. Nonetheless, they are still expected to perform their role to the best of their abilities, that is, to ensure a reduction in offending. Arguably, opinions relating to recidivism, risk, and the benefits of treatment, held by some members of the public are inaccurate and may be counterproductive (Levenson et al., 2007). Therefore, it seems plausible to suggest that mid-scale, government, or employee-based initiatives are the most appropriate avenues of support relevant for forensic staff.

List of References

- Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training*, 38(2), 171.
- Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical psychology review*, 23(1), 1-33.
- Amodio, D. M., & Devine, P. G. (2006). Stereotyping and evaluation in implicit race bias: evidence for independent constructs and unique effects on behavior. *Journal of personality and social psychology*, 91(4), 652.
- Armstrong, G.S., & Griffin, M.L. (2004). Does the job matter? Comparing correlates of stress among treatment and correctional staff in prisons. *Journal of Criminal Justice*, 32, 577-592.
- Aylwin, A. S. (2010). The therapeutic alliance in sex offender treatment: The juxtaposition of violence and care. [Doctoral dissertation, University of Alberta]. The University of Alberta Education and Research Archive.
https://era.library.ualberta.ca/items/54cac317-d8d4-446e-9d5d-2c68e6699361/view/d5fb02d2-bdd9-4580-8881-f704b7af197b/Aylwin_Scott_Spring2010.pdf
- Awan, S., Diwan, M. N., Aamir, A., Allahuddin, Z., Irfan, M., Carano, A., Vellante, F., Ventriglio, A., Fornaro, M., Valchera, A., Pettorruso, M., Martinotti, G., Di Giannantonio, M., Ullah, I., & De Berardis, D. (2022). Suicide in healthcare workers: determinants, challenges, and the impact of COVID-19. *Frontiers in psychiatry*, 12, 792925.

- Bakhtiari, M., Sohrabzadeh, A., Bazani, M., & Hosseini, A. (2021). An investigation of the validity of two self-report questionnaires about attitudes and perceptions towards sex offenders.
- Bakker, A., & Demerouti, E. (2013). Job demands-resources model. *Revista de Psicologia del Trabajo y de las Organizaciones*, 29(3), 107-115.
- Barrett-Lennard, G. T. (1962). Dimensions of the client's experience of his therapist associated with personality change. *Genetic Psychology Monographs*, 76, 43.
- Barrett-Lennard, G. T. (1986). The relationship inventory now: Issues and advances in theory, method and use. In *The psychotherapeutic process: A research handbook* (pp. 439-476). Guilford Press.
- Baum, N., & Moyal, S. (2020). Impact on therapists working with sex offenders: A systematic review of gender findings. *Trauma, Violence, & Abuse*, 21(1), 193-205.
- Beckett, R. C. (1987). The children and sex questionnaire. *Unpublished manuscript*.
- Beckett, R. C., & Fisher, D. (1994, November). Assessing victim empathy: A new measure. In *13th annual conference of the Association for the Treatment of Sexual Abusers, San Francisco*.
- Bedi, R. P., Davis, M. D., & Williams, M. (2005). Critical Incidents in the Formation of the Therapeutic Alliance from the Client's Perspective. *Psychotherapy: Theory, research, practice, training*, 42(3), 311.
- Beech A. R., Hamilton-Giachritsis C. E. (2005). Relationship between therapeutic climate and treatment outcome in group-based sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment*, 17(2), 127–140.

- Beech, A., Friendship, C., Erikson, M., & Hanson, R. K. (2002). The relationship between static and dynamic risk factors and reconviction in a sample of UK child abusers. *Sexual Abuse: A journal of research and treatment*, 14(2), 155-167.
- Bickley, J., & Beech, A. R. (2001). Classifying child abusers: Its relevance to theory and clinical practice. *International Journal of Offender Therapy and Comparative Criminology*, 45(1), 51-69.
- Black, R. S., Curran, D., & Dyer, K. F. (2013). The impact of shame on the therapeutic alliance and intimate relationships. *Journal of clinical psychology*, 69(6), 646-654.
- Blanchard, G. T. (1995). *The difficult connection: The therapeutic relationship in sex offender treatment*. Safer Society Press.
- Blasko, B. L., & Jeglic, E. L. (2016). Sexual offenders' perceptions of the client–therapist relationship: The role of risk. *Sexual Abuse*, 28(4), 271-290.
- Boland, A., Dickson, R., & Cherry, G. (2017). Doing a systematic review: A student's guide. *Doing a Systematic Review*, 1-304.
- Blumenthal S., Huckle C., Czornyj R., Craissati J., Richardson P. (2010). The role of affect in the estimation of risk. *Journal of Mental Health*, 19(5), 444–451.
- Bressington, D., Stewart, B., Beer, D., & MacInnes, D. (2011). Levels of service user satisfaction in secure settings—A survey of the association between perceived social climate, perceived therapeutic relationship and satisfaction with forensic services. *International journal of nursing studies*, 48(11), 1349-1356.
- Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical social work journal*, 35, 155-163.

- Brown, D. (2020). A review of the PubMed PICO tool: using evidence-based practice in health education. *Health Promotion Practice, 21*(4), 496-498.
- Brown, J., & Singh, J. P. (2014). Forensic risk assessment: A beginner's guide. *Archives of Forensic Psychology, 1*(1), 49-59.
- Buhrmester, D., & Furman, W. (2008). The network of relationships inventory: Relationship qualities version. *Unpublished measure, University of Texas at Dallas*.
- Bumby, K. M. (1996). Assessing the cognitive distortions of child molesters and rapists: Development and validation of the MOLEST and RAPE scales. *Sexual Abuse: A Journal of Research and Treatment, 8*, 37-54.
- Cacioppo, J. T., Gardner, W. L., & Berntson, G. G. (1999). The affect system has parallel and integrative processing components: Form follows function. *Journal of personality and Social Psychology, 76*(5), 839.
- Calobrisi, E. A., & Knight, R. A. (2023). Comparison of community and expert samples in the perceived risk of individuals who have sexually offended. *Sexual abuse, 35*(5), 568-595.
- Carl, L. C., & Lösel, F. (2021). When sexual offender treatment in prison-based social-therapeutic treatment is not completed: Relationship to risk factors and recidivism after release. *Criminal Behaviour and Mental Health, 31*(6), 421-435.
- Carr, D. L. (2011). *An exploratory study of the association between the static variables of the static-99 and successful or unsuccessful treatment completion* (Doctoral dissertation, Capella University).

- Church, W. T., Wakeman, E. E., Miller, S. L., Clements, C. B., & Sun, F. (2008). The community attitudes toward sex offenders scale: The development of a psychometric assessment instrument. *Research on Social Work Practice, 18*(3), 251-259.
- Cicchetti, D., & Lynch, M. (1995). Failures in the expectable environment and their impact on individual development: The case of child maltreatment. In D. Cicchetti & D.J. Cohen (Eds.), *Developmental Psychopathology, Volume 2: Risk, Disorder, and Adaptation* (pp. 32–71). New York: John Wiley.
- Cloitre, M., Chase Stovall-McClough, K., Miranda, R., & Chemtob, C. M. (2004). Therapeutic alliance, negative mood regulation, and treatment outcome in child abuse-related posttraumatic stress disorder. *Journal of consulting and clinical psychology, 72*(3), 411.
- Coffey, M. (1999). Stress and burnout in forensic community mental health nurses: an investigation of its causes and effects. *Journal of psychiatric and mental health nursing, 6*(6), 433-443.
- College of Policing. (2023). *Offenders with mental health issues*.
<https://www.college.police.uk/app/major-investigation-and-public-protection/managing-sexual-offenders-and-violent-offenders/offenders-mental-health-issues>
- Conley, T., Hill, K., Church, W. T., Stoeckel, E., & Allen, H. (2011). Assessing probation and community corrections workers' attitudes toward sex offenders using the attitudes toward sex offenders (CATSO) scale in a rural state. *Sexual Addiction & Compulsivity, 18*, 75–85.
- Cooper, A. (2016). Working in a demanding environment: employee wellbeing in secure forensic settings. [Doctoral Dissertation, The University of Edinburgh]. ERA Digital

Repository.

<https://era.ed.ac.uk/bitstream/handle/1842/25501/Cooper2016.pdf?sequence=2&isAllowed=y>

Couture, S. M., Roberts, D. L., Penn, D. L., Cather, C., Otto, M. W., & Goff, D. (2006). Do baseline client characteristics predict the therapeutic alliance in the treatment of schizophrenia?. *The Journal of nervous and mental disease*, 194(1), 10-14.

Craig, L. A. (2005). The impact of training on attitudes towards sex offenders. *Journal of Sexual Aggression*, 11(2), 197–207.

Craig, L. A., Browne, K. D., Stringer, I., & Beech, A. (2005). Sexual recidivism: A review of static, dynamic and actuarial predictors. *Journal of Sexual Aggression*, 11(1), 65-84.

Craissati, J., & Beech, A.R. (2006). The role of key developmental variables in identifying sex offenders likely to fail in the community: An enhanced risk prediction model. *Child Abuse & Neglect*, 30, 327–339.

Cripps, B. (Ed.). (2017). *Psychometric testing: Critical perspectives*. John Wiley & Sons.

Cronbach, L. J., & Meehl, P. E. (1955). Construct validity in psychological tests. *Psychological bulletin*, 52(4), 281.

Darkness to Light. (2020). *Long-term consequences of child sexual abuse*.

<https://www.d2l.org/wp-content/uploads/2020/01/Long-Term-Consequences-of-ChildSexualAbuse-2020.pdf>

Day, A., Boni, N., Hobbs, G., Carson, E., Whitting, L., & Powell, M. (2014). Professional attitudes to sex offenders: Implications for multiagency and collaborative working. *Sexual Abuse in Australia and New Zealand*, 6(1), 12-19.

- De Hert, S. (2020). Burnout in healthcare workers: prevalence, impact and preventative strategies. *Local and regional anesthesia*, 171-183.
- De Looff, P., Didden, R., Embregts, P., & Nijman, H. (2019). Burnout symptoms in forensic mental health nurses: Results from a longitudinal study. *International journal of mental health nursing*, 28(1), 306-317.
- DeSorcy, D. R., Olver, M. E., & Wormith, J. S. (2017). Working alliance and psychopathy: Linkages to treatment outcome in a sample of treated sexual offenders. *Journal of Interpersonal Violence*, 35(7-8), 1739-1760.
- DeSorcy, D.R., Olver, M.E., & Wormith, J.S. (2014). Working alliance and its relationship with treatment outcome in a sample of aboriginal and non-aboriginal sexual offenders. *Sexual Abuse: Journal of Research and Treatment*, 28(4), 291-313.
- Devon Rape Crisis. (2022). *Myths, facts and statistics*. <https://devonrapecrisis.org.uk/about-us/myths-facts-and-statistics/>
- Delgadillo, J., Saxon, D., & Barkham, M. (2018). Associations between therapists' occupational burnout and their patients' depression and anxiety treatment outcomes. *Depression and Anxiety*, 35(9), 844-850.
- Dickinson, T., & Wright, K. M. (2008). Stress and burnout in forensic mental health nursing: a literature review. *British Journal of Nursing*, 17(2), 82-87.
- Digby, R., Winton-Brown, T., Finlayson, F., Dobson, H., & Bucknall, T. (2021). Hospital staff well-being during the first wave of COVID-19: Staff perspectives. *International journal of mental health nursing*, 30(2), 440-450.

- Dolev, T., & Zilcha-Mano, S. (2019). The role of the therapeutic relationship in the association between interpersonal behaviors and outcome: Comparison of two competing models. *Psychotherapy Research*, 29(5), 553-564.
- Dutheil, F., Aubert, C., Pereira, B., Dambrun, M., Moustafa, F., Mermillod, M., ... & Navel, V. (2019). Suicide among physicians and health-care workers: A systematic review and meta-analysis. *PloS one*, 14(12), e0226361.
- Eagley, A. H. (1987). Sex differences in social behaviour: A social-role interpretation. Hillsdale, NJ: Erlbaum.
- Eisenberg, N., & Eggum, N. D. (2009). Empathic responding: Sympathy and personal distress. *The social neuroscience of empathy*, 6, 71-830.
- Ennis, L., & Horne, S. (2003). Predicting psychological distress in sex offender therapists. *Sexual Abuse: A Journal of Research and Treatment*, 15, 149-157.
- Ellerby, L. (1997). Impact on clinicians: Stressors and providers of sex-offender treatment. *Impact: Working with sexual abusers*, 51-60.
- Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy*, 48(1), 43.
- Elliott, R., Bohart, A. C., Watson, J. C., & Murphy, D. (2018). Therapist empathy and client outcome: An updated meta-analysis. *Psychotherapy*, 55(4), 399.
- Eriksen, M. B., & Frandsen, T. F. (2018). The impact of patient, intervention, comparison, outcome (PICO) as a search strategy tool on literature search quality: a systematic review. *Journal of the Medical Library Association: JMLA*, 106(4), 420.
- Farmer, M., McAlinden, A. M., & Maruna, S. (2015). Understanding desistance from sexual offending: A thematic review of research findings. *Probation Journal*, 62(4), 320-335.

- Farrenkopf, T. (1992). What happens to therapists who work with sex offenders?. *Journal of Offender Rehabilitation*, 18(3-4), 217-224.
- Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G* Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior research methods*, 39(2), 175-191.
- Festinger, L. (1957). *A theory of cognitive dissonance*. Evanstone, IL: Row, Peterson.
- Festinger's cognitive dissonance theory. (2006). In J. Roenneklein (Ed.), *Elsevier's dictionary of psychological theories*. Oxford, United Kingdom: Elsevier Science & Technology.
- Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring.
- Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of clinical psychology*, 58(11), 1433-1441.
- Finkelhor, D. (1984). *Child Sexual Abuse: New Theory and Research*. New York: Free Press.
- Fleeman, N., & Dunder, Y. (2014). Data Extraction: Where Do I Begin? In A. Boland, M. G. Cherry, & R. Dickson (Eds.), *Doing A Systematic Review: A Student's Guide* (Pp. 85-98). London, UK: Sage.
- Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, 55(4), 316.
- Forster, C., Berthollier, N., & Rawlinson, D. (2014). A systematic review of potential mechanisms of change in psychotherapeutic interventions for Personality Disorder. *Journal of Psychology and Psychotherapy*, 4, 133.
- Fortney, T., Baker, J. N., & Levenson, J. (2009). A look in the mirror: Sexual abuse professionals' perceptions about sex offenders. *Victims and Offenders*, 4(1), 42-57.

- Frandsen, T. F., Nielsen, M. F. B., Lindhardt, C. L., & Eriksen, M. B. (2020). Using the full PICO model as a search tool for systematic reviews resulted in lower recall for some PICO elements. *Journal of clinical epidemiology*, 127, 69-75.
- Friestad, C., Mjåland, K., & Pape, H. (2021). Prison officer students' perceptions of persons convicted of sexual crimes. *European journal of criminology*, 14773708211038538.
- Fuselier, D. A., Durham, R. L., & Wurtele, S. K. (2002). The child sexual abuser: Perceptions of college students and professionals. *Sexual Abuse: A Journal of Research & Treatment*, 14(3), 267–276.
- Gannon, T. A., Olver, M. E., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical psychology review*, 73, 101752.
- Gilbert, P. (1998). What is shame? Some core issues and controversies.
- Geoffrion, S., Lamothe, J., Morizot, J., & Giguère, C. É. (2019). Construct validity of the professional quality of life (ProQoL) scale in a sample of child protection workers. *Journal of Traumatic Stress*, 32(4), 566-576.
- George, D., & Mallery, P. (2019). *IBM SPSS statistics 26 step by step: A simple guide and reference*. Routledge.
- Gibson S. (2021). Social climate and hope amongst staff and prisoners in a high security male prison. *The Journal of Forensic Practice*, 23(1), 26–38.
- Graves, T. A., Tabri, N., Thompson-Brenner, H., Franko, D. L., Eddy, K. T., Bourion-Bedes, S., ... & Thomas, J. J. (2017). A meta-analysis of the relation between therapeutic

- alliance and treatment outcome in eating disorders. *International Journal of Eating Disorders*, 50(4), 323-340.
- Greer, C. (2003). Media representations of dangerousness.
- Groth, A. N. (1983). Treatment of the sexual offender in a correctional institution. The sexual aggressor: Current perspectives on treatment, 160-176.
- Grubin, D., & Thornton, D. (1994). A national program for the assessment and treatment of sex offenders in the English prison system. *Criminal Justice and Behavior*, 21(1), 55-71.
- Hanson, R. K., & Morton-Bourgon, K. E. (2019). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. In *Clinical forensic psychology and law* (pp. 67-76). Routledge.
- Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and behavior*, 36(9), 865-891.
- Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare staff well-being, burnout, and patient safety: a systematic review. *PloS one*, 11(7), e0159015.
- Hanson, R. K., & Thornton, D. (1999). *Static 99: Improving actuarial risk assessments for sex offenders* (Vol. 2). Ottawa, Ontario: Solicitor General Canada.
- Harper, C. A., & Hogue, T. E. (2015a). Measuring public perceptions of sex offenders: reimagining the Community Attitudes Toward Sex Offenders (CATSO) scale. *Psychology, Crime & Law*, 21(5), 452-470.
- Hatcher, R., & Noakes, S. (2010). Working with sex offenders: The impact on Australian treatment providers. *Psychology, Crime & Law*, 16(1-2), 145-167.

- Harper C. A., Hogue T. E., Bartels R. M. (2017). Attitudes towards sexual offenders: What do we know, and why are they important? *Aggression and Violent Behavior, 34*, 201–213.
- Harper, C. A., & Hogue, T. E. (2015a). Measuring public perceptions of sex offenders: reimagining the Community Attitudes Toward Sex Offenders (CATSO) scale. *Psychology, Crime & Law, 21*(5), 452-470.
- Harper C. A., Hogue T. E. (2015. b). The emotional representation of sexual crime in the national British press. *Journal of Language and Social Psychology, 34*(1), 3–24.
- Harper, C. A., & Hicks, R. A. (2021). The effect of attitudes towards individuals with sexual convictions on professional and student risk judgments. *Sexual Abuse*, 10790632211070799.
- Harper, C. A., & Bartels, R. M. (2017). The influence of implicit theories and offender characteristics on judgements of sexual offenders: A moderated mediation analysis. *Journal of sexual aggression, 23*(2), 139-150.
- Harper C. A., Hogue T. E. (2017). Press coverage as a heuristic guide for social decision-making about sexual offenders. *Psychology, Crime & Law, 23*(2), 118–134.
- Harper, C. A., Lievesley, R., Blagden, N. J., & Hocken, K. (2021). Humanizing pedophilia as stigma reduction: A large-scale intervention study. *Archives of sexual behavior*, 1-16.
- Hart, S. D., Hare, R. D., & Harpur, T. J. (1992). The Psychopathy Checklist—Revised (PCL-R) An Overview for Researchers and Clinicians. *Advances in psychological assessment*, 103-130.
- Hersoug, A. G., Høglend, P., Monsen, J. T., & Havik, O. E. (2001). Quality of working alliance in psychotherapy: Therapist variables and patient/therapist similarity as predictors. *The Journal of psychotherapy practice and research, 10*(4), 205.

- Higgins, C., & Ireland, C. (2009). Attitudes towards male and female sex offenders: A comparison of forensic staff, prison officers and the general public in Northern Ireland. *The British Journal of Forensic Practice*, 11, 14-19.
- Hinderer, K. A., VonRueden, K. T., Friedmann, E., McQuillan, K. A., Gilmore, R., Kramer, B., & Murray, M. (2014). Burnout, compassion fatigue, compassion satisfaction, and secondary traumatic stress in trauma nurses. *Journal of Trauma Nursing| JTN*, 21(4), 160-169.
- Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American psychologist*, 44(3), 513.
- Hobfoll, S. E., & Freedy, J. (2017). Conservation of resources: A general stress theory applied to burnout. In *Professional burnout* (pp. 115-129). Routledge.
- Hogue, T. E. (1993). Attitudes towards prisoners and sex offenders. In N. C. Clark and G. Stephenson (Eds.), *DCLP occasional papers: Sexual offenders* (pp. 27-32). Leicester, UK: British Psychological Society.
- Hogue, T. E., & Harper, C. A. (2019). Development of a 21-item short form of the Attitudes to Sexual Offenders (ATS) Scale. *Law and human behavior*, 43(1), 117.
- Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., & Villaseñor, V. S. (1988). Inventory of interpersonal problems: psychometric properties and clinical applications. *Journal of consulting and clinical psychology*, 56(6), 885.
- Horvath, A. O., & Greenberg, L. (1986). The development of the Working Alliance Inventory: A research handbook. *Psychotherapeutic processes: A research handbook*, 529-556.

- Howard, M. V. A. (2016). Process evaluation of the Custody Based Intensive (CUBIT) programs for sex offenders: Factors associated with program completion. *Research Bulletin*, (55).
- Howard M. V. A., de Almeida Neto A. C., Galouzis J. J. (2019). Relationships between treatment delivery, program attrition, and reoffending outcomes in an intensive custodial sex offender program. *Sexual Abuse*, 31(4), 477–499.
- IBM Corp. Released 2020. IBM SPSS Statistics for Windows, Version 27.0. Armonk, NY: IBM Corp
- Isenhardt, A., & Hostettler, U. (2020). Inmate violence and correctional staff burnout: The role of sense of security, gender, and job characteristics. *Journal of interpersonal violence*, 35(1-2), 173-207.
- Isham, A., Mair, S., & Jackson, T. (2020). Well-being and productivity: a review of the literature.
- Jaafarpour, M., & Khani, A. (2012). Evaluation of the nurses' job satisfaction, and its association with their moral sensitivities and well-being. *Journal of clinical and diagnostic research: JCDR*, 6(10), 1761.
- Jackson, D. N. (1989). *Personality Research Form – English*. Port Huron, MI: Sigma Assessment Systems.
- Jackson, D. N. (1994). *Jackson personality inventory-revised*. Sigma Assessment Systems, Research Psychologists Press Division.
- Jenkins, R., & Elliott, P. (2004). Stressors, burnout and social support: nurses in acute mental health settings. *Journal of advanced nursing*, 48(6), 622-631.

- Johnson, E. (2021). Face validity. In *Encyclopedia of autism spectrum disorders* (pp. 1957-1957). Cham: Springer International Publishing.
- Jong, G., & Schout, G. (2013). Breaking through marginalisation in public mental health care with Family Group Conferencing: Shame as risk and protective factor. *British Journal of Social Work*, 43(7), 1439-1454.
- Jonson-Reid, M., & Way, I. (2001). Adolescent sexual offenders: Incidence of childhood maltreatment, serious emotional disturbance, and prior offences. *American Journal of Orthopsychiatry*, 71(1), 120-130.
- Jordan, J. V. (1997). Relational development: Therapeutic implications of empathy and shame. *Women's growth in diversity*, 138-161.
- Kadambi, M. A., & Truscott, D. (2003). Vicarious traumatization and burnout among therapists working with sex offenders. *Traumatology*, 9(4), 216-230.
- Kenny, D. T., Keogh, T., & Seidler, K. (2001). Predictors of recidivism in Australian juvenile sex offenders: Implications for treatment. *Sexual abuse: a journal of research and treatment*, 13, 131-148.
- Kiresuk, T. J., & Sherman, R. E. (1968). Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. *Community mental health journal*, 4, 443-453.
- Kleban, H., & Jeglic, E. (2012). Dispelling the myths: Can psychoeducation change public attitudes towards sex offenders?. *Journal of sexual aggression*, 18(2), 179-193.
- Kline, P. (2015). *A handbook of test construction (psychology revivals): introduction to psychometric design*. Routledge.

- Kruse AE (2020) The Why, the Who and the Wherefore. Explanations, self-change and social friction in men's narratives of sexual violations. PhD Thesis. University of Oslo, Norway.
- Kruttschnitt, C., Uggen, C., & Shelton, K. (2000). Predictors of desistance among sex offenders: The interaction of formal and informal social controls. *Justice Quarterly*, 17(1), 61-87.
- Lambert, M. J., Hansen, N. B., Umphress, V., Lunnen, K., Okiishi, J., Burlingame, G. M., & Reisinger, C. W. (1996). Administration and scoring manual for the Outcome Questionnaire (OQ-45.2). *Wilmington, DE: American Professional Credentialing Services*, 35.
- Lambert, M. J., & Hill, C. E. (1994). Assessing psychotherapy outcomes and processes.
- Lea, S., Auburn, T., & Kibblewhite, K. (1999). Working with sex offenders: The perceptions and experiences of professionals and paraprofessionals. *International Journal of Offender Therapy and Comparative Criminology*, 43(1), 103-119.
- Legislation.gov.uk. (n.d). *Sexual Offences Act 2003*.
<https://www.legislation.gov.uk/ukpga/2003/42/notes>
- Leon, C. M., & Rollero, C. (2021). The role of ambivalent sexism, punitiveness, and ability to recognise violence in the perception of sex offenders: a gender-perspective analysis. *Sexes*, 2(4), 495-508.
- Levenson, J. S., Brannon, Y. N., Fortney, T., & Baker, J. (2007). Public perceptions about sex offenders and community protection policies. *Analyses of Social Issues and Public Policy*, 7(1), 137-161.

- Levenson, J. S., Fortney, T., & Baker, J. N. (2010). Views of sexual abuse professionals about sex offender notification policies. *International Journal of Offender Therapy and Comparative Criminology*, 54(2), 150-168.
- Levenson, J. S., & Prescott, D. S. (2009). Treatment experiences of civilly committed sex offenders: A consumer satisfaction survey. *Sexual Abuse*, 21(1), 6-20.
- Lorenzo-Luaces, L., DeRubeis, R. J., & Webb, C. A. (2014). Client characteristics as moderators of the relation between the therapeutic alliance and outcome in cognitive therapy for depression. *Journal of Consulting and Clinical Psychology*, 82(2), 368.
- Lösel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology*, 1(1), 117-146.
- Lowe, G. T., & Willis, G. M. (2022). Do popular attitudinal scales perpetuate negative attitudes towards persons who have sexually offended?. *Journal of Sexual Aggression*, 1-13.
- Luborsky, L., Barber, J. P., Siqueland, L., Johnson, S., Najavitz, L. M., Frank, A. & Daley, D. (1996). The revised helping alliance questionnaire-II (HAQ-II). Psychometric properties. *Journal of psychotherapy research and practice*, 5, 260-271.
- Lyons-Thomas, J. (2014). Interscale correlations. *Encyclopedia of quality of life and well-being research*, 3352-3353.
- Maio, G. R., Haddock, G., Manstead, A. S., & Spears, R. (2010). Attitudes and intergroup relations. *The SAGE handbook of prejudice, stereotyping, and discrimination*, 261-275.

- Malinen, S., Willis, G. W., & Johnston, L. (2014). Might informative media reporting of sexual offending influence community members' attitudes towards sex offenders? *Psychology, Crime & Law*, 20, 535–552.
- Marsa, F., O'Reilly, G., Carr, A., Murphy, P., O'Sullivan, M., Cotter, A., & Hevey, D. (2004). Attachment styles and psychological profiles of child sex offenders in Ireland. *Journal of Interpersonal Violence*, 19, 228–251.
- Marshall, P. J. (2015). *Working with sex offenders: Factors that influence attitudes of correctional officers* (Doctoral dissertation, Capella University).
- Marshall, W. L. (2010). The role of attachments, intimacy, and loneliness in the etiology and maintenance of sexual offending. *Sexual and Relationship Therapy*, 25(1), 73-85.
- Marshall, W. L. (2010). The role of attachments, intimacy, and loneliness in the etiology and maintenance of sexual offending. *Sexual and Relationship Therapy*, 25(1), 73-85.
- Marshall, W.L., & Barbaree, H.E. (1990). An integrated theory of sexual offending. In W.L. Marshall, D.R. Laws, & H.E. Barbaree (Eds.), *Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender* (pp. 257–275). New York: Plenum.
- Marshall, W. L., Fernandez, Y. M., Serran, G. A., Mulloy, R., Thornton, D., Mann, R. E., & Anderson, D. (2003). Process variables in the treatment of sexual offenders: A review of the relevant literature. *Aggression and violent behavior*, 8(2), 205-234.
- Marshall, W. L., & Hollin, C. (2015). Historical developments in sex offender treatment. *Journal of Sexual Aggression*, 21(2), 125-135.
- Marshall, W. L., Marshall, L. E., Serran, G. A., & O'Brien, M. D. (2009). Self-esteem, shame, cognitive distortions and empathy in sexual offenders: Their integration and treatment implications. *Psychology, crime & law*, 15(2-3), 217-234.

- Marshall W., Serran G., Fernandez Y., Mulloy R., Mann R., Thornton D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. *Journal of Sexual Aggression*, 9(1), 25–30.
- Marshall, W. L., Serran, G., Moulden, H., Mulloy, R., Fernandez, Y. M., Mann, R., & Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behaviour change. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, 9(6), 395-405.
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of consulting and clinical psychology*, 68(3), 438.
- Martínez-Catena, A., Redondo, S., Frerich, N., & Beech, A. R. (2017). A dynamic risk factors–based typology of sexual offenders. *International journal of offender therapy and comparative criminology*, 61(14), 1623-1647.
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual review of psychology*, 52(1), 397-422.
- Masters, W. H. (1986). Sexual dysfunction as an aftermath of sexual assault of men by women. *Journal of Sex & Marital Therapy*, 12(1), 35-45.
- Marziali, E., & Alexander, L. (1991). The power of the therapeutic relationship. *American Journal of orthopsychiatry*, 61(3), 383-391.
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of traumatic stress*, 3, 131-149.

- McCartan, K. F., & Prescott, D. (2017). Bring me the Horizon!(and Kaizen). *Journal of Sexual Abuse Blog*.
- Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature. *Addiction*, 100(3), 304-316.
- Melvin, K. B., Gramling, L. K., & Gardner, W. M. (1985). A scale to measure attitudes toward prisoners. *Criminal Justice and Behavior*, 12(2), 241-253.
- Mews, A., Di Bella, L., & Purver, M. (2017). *Impact evaluation of the prison-based core sex offender treatment programme*. London: Ministry of Justice.
- Mikulincer, M., Shaver, P. R., & Berant, E. (2013). An attachment perspective on therapeutic processes and outcomes. *Journal of personality*, 81(6), 606-616.
- Mivshek, M. E., & Schriver, J. L. (2022). Attitudes toward treatment among sex offender treatment providers affect burnout and empathy. *Journal of Sexual Aggression*, 1-12.
- Mohanty, A., Kabi, A., & Mohanty, A. P. (2019). Health problems in healthcare workers: A review. *Journal of family medicine and primary care*, 8(8), 2568.
- Moos, R. H. (1986). *Group environment scale manual*. Consulting Psychologists Press.
- Moulden, H. M., & Firestone, P. (2007). Vicarious traumatization: The impact on therapists who work with sexual offenders. *Trauma, Violence, & Abuse*, 8(1), 67-83.
- Munger, T., Savage, T., & Panosky, D. M. (2015). When caring for perpetrators becomes a sentence: Recognizing vicarious trauma. *Journal of Correctional Health Care*, 21(4), 365-374.

- Muller, R. T., & Rosenkranz, S. E. (2009). Attachment and treatment response among adults in inpatient treatment for posttraumatic stress disorder. *Psychotherapy: Theory, Research, Practice, Training*, 46(1), 82.
- Muzavazi, C. (2016). Violence at work in prison establishments: A preliminary study. *Journal of Criminological Research, Policy and Practice*, 2(4), 250-259.
- Nelson, M., Herlihy, B., & Oescher, J. (2002). A survey of counselor attitudes towards sex offenders. *Journal of Mental Health Counseling*, 24(1).
- Newman, C., Jackson, J., Macleod, S., & Eason, M. (2020). A survey of stress and burnout in forensic mental health nursing. *Journal of Forensic Nursing*, 16(3), 161-168.
- NIH. (2021). *Study Quality Assessment Tools*. <https://www.nlm.nih.gov/health-topics/study-quality-assessment-tools>
- Nunes, K. L., & Jung, S. (2013). Are cognitive distortions associated with denial and minimization among sex offenders?. *Sexual Abuse*, 25(2), 166-188.
- Office for National Statistic. (2021, March 8). *Nature of sexual assaults by rape or penetration, England and Wales: Year ending March 2020*.
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/natureofsexualassaultbyrapeorpenetrationenglandandwales/yearendingmarch2020>
- Office for National Statistics. (2023). *Sexual offences prevalence and trends, England and Wales: year ending March 2022*.
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/sexualoffencesprevalenceandtrendsenglandandwales/yearendingmarch2022#:~:text=The%20police%20recorded%20193%2C566%20sexual,the%20year%20ending%20March%202020>

Olver, M. E., & Wong, S. (2011). Predictors of sex offender treatment dropout: Psychopathy, sex offender risk, and responsivity implications. *Psychology, Crime & Law*, 17(5), 457-471.

Oxford Reference. (2022). *Psychometrics*.

<https://www.oxfordreference.com/view/10.1093/oi/authority.20110803100352815>

Pacini, R., & Epstein, S. (1999). Rational-Experiential Inventory--Revised. *Journal of personality and social psychology*.

Peterson, U., Demerouti, E., Bergström, G., Samuelsson, M., Åsberg, M., & Nygren, Å. (2008). Burnout and physical and mental health among Swedish healthcare workers. *Journal of advanced nursing*, 62(1), 84-95.

Petrella, A. R., Hughes, L., Fern, L. A., Monaghan, L., Hannon, B., Waters, A., & Taylor, R. M. (2021). Healthcare staff well-being and use of support services during COVID-19: a UK perspective. *General Psychiatry*, 34(3).

Pickens, J. (2005). Attitudes and perceptions. *Organizational behavior in health care*, 4(7), 43-76.

Poghosyan, L., Clarke, S. P., Finlayson, M., & Aiken, L. H. (2010). Nurse burnout and quality of care: Cross-national investigation in six countries. *Research in nursing & health*, 33(4), 288-298.

Powell, J. T., & Koelemay, M. J. (2022, January). Systematic reviews of the literature are not always either useful or the best way to add to science. In *EJVES Vascular Forum* (Vol. 54, pp. 2-6). Elsevier.

Proeve, M., & Howells, K. (2002). Shame and guilt in child sexual offenders. *International journal of offender therapy and comparative criminology*, 46(6), 657-667.

Przybylski, R. (2015). Recidivism of adult sexual offenders. *SOMAPI-Research Brief Sex Offender Management Assessment and Planning Initiative. US Department of Justice of Office of Justice Programs Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering and Tracking, Washington, DC.*

RAINN. (2023). *Victims of sexual violence: Statistics.*

<https://www.rainn.org/statistics/victims-sexual-violence/>

RAINN. (2023). *Effects of sexual violence.* <https://www.rainn.org/effects-sexual-violence>.

Rape Crisis. (n.d.). *Statistics about rape, sexual assault and sexual abuse.*

<https://rapecrisis.org.uk/get-informed/statistics-sexual-violence/>

Richardson, W. S., Wilson, M. C., Nishikawa, J., & Hayward, R. S. (1995). The well-built clinical question: a key to evidence-based decisions. *ACP journal club*, 123(3), A12-A13.

Robertiello, G., & Terry, K. J. (2007). Can we profile sex offenders? A review of sex offender typologies. *Aggression and violent behavior*, 12(5), 508-518.

Rothman, D. B. (2007). The role of the therapeutic alliance in psychotherapy with sexual offenders.

Russell, D., Peplau, L. A., & Cutrona, C. E. (1980). The revised UCLA Loneliness Scale: concurrent and discriminant validity evidence. *Journal of personality and social psychology*, 39(3), 472.

Salyers, M. P., Fukui, S., Rollins, A. L., Firmin, R., Gearhart, T., Noll, J. P., ... & Davis, C. J. (2015). Burnout and self-reported quality of care in community mental health. *Administration and Policy in Mental Health and Mental Health Services Research*, 42(1), 61-69.

- Sandhu, D. K., & Rose, J. (2012). How do therapists contribute to therapeutic change in sex offender treatment: An integration of the literature. *Journal of Sexual Aggression, 18*(3), 269-283.
- Sandhu, D. K., Rose, J., Rostill-Brookes, H. J., & Thrift, S. (2012). 'It's intense, to an extent': A qualitative study of the Emotional challenges faced by staff working on a treatment programme for intellectually disabled Sex offenders. *Journal of Applied Research in Intellectual Disabilities, 25*(4), 308–318.
- Sanghara, K. K., & Wilson, C. D. J. (2006). Stereotypes and attitudes about child sexual abusers: A comparison of experienced and inexperienced professionals in sex offender treatment. *Legal and Criminological Psychology, 11*(2), 229-244.
- Scanlan, J. N., & Still, M. (2019). Relationships between burnout, turnover intention, job satisfaction, job demands and job resources for mental health personnel in an Australian mental health service. *BMC health services research, 19*(1), 1-11.
- Shaver, P. R., & Mikulincer, M. A. R. I. O. (2008). Augmenting the sense of security in romantic, leader-follower, therapeutic, and group relationships: A relational model of psychological change. *Social relationships: Cognitive, affective, and motivational processes, 55-74*.
- Schiavone, S. K., & Jeglic, E. L. (2009). Public perception of sex offender social policies and the impact on sex offenders. *International journal of offender therapy and comparative criminology, 53*(6), 679-695.
- Schmucker, M., & Lösel, F. (2017). Sexual offender treatment for reducing recidivism among convicted sex offenders: A systematic review and meta-analysis. *Campbell Systematic Reviews, 13*(1), 1–75.

- Sanghara, K. K., & Wilson, C. D. J. (2006). Stereotypes and attitudes about child sexual abusers: A comparison of experienced and inexperienced professionals in sex offender treatment. *Legal and Criminological Psychology, 11*(2), 229-244.
- Scanlan, J. N., & Still, M. (2019). Relationships between burnout, turnover intention, job satisfaction, job demands and job resources for mental health personnel in an Australian mental health service. *BMC health services research, 19*(1), 1-11.
- Scheela, R. A. (2001). Sex offender treatment: therapists' experiences and perceptions. *Issues in Mental Health Nursing, 22*(8), 749-767.
- Schiavone, S. K., & Jeglic, E. L. (2009). Public perception of sex offender social policies and the impact on sex offenders. *International journal of offender therapy and comparative criminology, 53*(6), 679-69.
- Sentencing Council. (2023). *Sentencing offenders with mental disorders, developmental disorders, or neurological impairments*.
<https://www.sentencingcouncil.org.uk/overarching-guides/magistrates-court/item/sentencing-offenders-with-mental-disorders-developmental-disorders-or-neurological-impairments/>
- Serran, G., & Marshall, W. (2010). Therapeutic process in the treatment of sexual offenders: A review article. *The British Journal of Forensic Practice*.
- Sewall, L. A., & Olver, M. E. (2019). Psychopathy and treatment outcome: Results from a sexual violence reduction program. *Personality Disorders: Theory, Research, and Treatment, 10*(1), 59.

- Shackley, M., Weiner, C., Day, A., & Willis, G. M. (2014). Assessment of public attitudes towards sex offenders in an Australian population. *Psychology, Crime & Law*, 20(6), 553-572.
- Shelby, R. A., Stoddart, R. M., & Taylor, K. L. (2001). Factors contributing to levels of burnout among sex offender treatment providers. *Journal of Interpersonal Violence*, 16(11), 1205-1217.
- Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: a meta-analytic review. *Journal of consulting and clinical psychology*, 71(3), 452.
- Simon, L.M.J. (1997). Do criminal offenders specialize in crime types? *Applied and Preventative Psychology*, 6, 35–53.
- Simons, D. A. (2015). Sex offender typologies. *Sex offender management and planning initiative*, 55-75.
- Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., & Smith-MacDonald, L. (2017). Compassion fatigue: A meta-narrative review of the healthcare literature. *International journal of nursing studies*, 69, 9-24.
- Singh, J., Karanika-Murray, M., Baguley, T., & Hudson, J. (2020). A systematic review of job demands and resources associated with compassion fatigue in mental health professionals. *International Journal of Environmental Research and Public Health*, 17(19), 6987.
- Skourteli, M. C., & Lennie, C. (2010). The therapeutic relationship from an attachment theory perspective. *Counselling psychology review*, 26(1), 20-33.

- Sorenson, C., Bolick, B., Wright, K., & Hamilton, R. (2016). Understanding compassion fatigue in healthcare providers: A review of current literature. *Journal of Nursing Scholarship*, 48(5), 456-465.
- Sowden, J. N., & Olver, M. E. (2017). Sexual offender treatment readiness, responsivity, and change: Linkages to treatment completion and recidivism. *Journal of forensic nursing*, 13(3), 97-108.
- Stamm, B. (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. The Sidran Press.
- Stamm, B. (2009). Professional quality of life measure: Compassion, satisfaction, and fatigue version 5 (ProQOL).
- Stasch J., Yoon D., Sauter J., Hausam J., Dahle K. (2018). Prison climate and its role in reducing dynamic risk factors during offender treatment. *International Journal of Offender Therapy and Comparative Criminology*, 62(14), 4609–4621.
- Steed, L., & Bicknell, J. (2001). Trauma and the therapist: The experience of therapists working with the perpetrators of sexual abuse. *The Australasian Journal of Disaster and Trauma Studies*, 1(5), 527-540.
- Stück, E., Briken, P., & Brunner, F. (2022). Changes in the risk of sexual reoffending: the role and relevance of perceived self-efficacy and adult attachment styles in correctional treatment. *Sexual Abuse*, 34(8), 891-922.
- Stumpf, B. C. (2022). *Predicting Sexual Offence Treatment Completion through Specific Responsivity Factors* (Doctoral dissertation, George Fox University).
- Tang, W., Cui, Y., & Babenko, O. (2014). Internal consistency: Do we really know what it is and how to assess it. *Journal of Psychology and Behavioral Science*, 2(2), 205-220.

- Teoh, K., Singh, J., Medisauskaite, A., & Hassard, J. (2023). Doctors' perceived working conditions, psychological health and patient care: a meta-analysis of longitudinal studies. *Occupational and Environmental Medicine*, 80(2), 61-69.
- Thompson, N., & Bates, J. (Eds.). (2009). *Promoting workplace well-being*. Springer.
- Tomasula, J. L., Anderson, L. M., Littleton, H. L., & Riley-Tillman, T. C. (2012). The association between sexual assault and suicidal activity in a national sample. *School psychology quarterly*, 27(2), 109.
- Trujillo, A. (2022). Nursing Burnout in Perspective: Conservation of Resources Theory and the Nurse Worklife Model. [Dissertation, The University of New Mexico]. The University of New Mexico Digital Repository. [Nursing Burnout in Perspective: Conservation of Resources Theory and the Nurse Worklife Model \(unm.edu\)](https://unm.edu/digital-repository/nursing-burnout-in-perspective-conservation-of-resources-theory-and-the-nurse-worklife-model)
- Ullman, S. E., & Najdowski, C. J. (2009). Correlates of serious suicidal ideation and attempts in female adult sexual assault survivors. *Suicide and Life-Threatening Behavior*, 39(1), 47-57.
- Van den Berg C, Beijersbergen K, Nieuwbeerta P, et al. (2018) Sex offenders in prison: Are they socially isolated? *Sexual Abuse*, 30(7): 828–845.
- Van Egmond, M., Garnefski, N., Jonker, D., & Kerkhof, A. (1993). " The relationship between sexual abuse and female suicidal behavior": Erratum.
- Ward, T., & Hudson, S.M. (1998). A model of the relapse process in sexual offenders. *Journal of Interpersonal Violence*, 13, 700–725.
- Ware, J., Galouzis, J., Hart, R., & Allen, R. (2012). Training correctional staff in the management of sex offenders: Increasing knowledge and positive attitudes. *Sexual Abuse in Australia and New Zealand*, 4(2), 23-30

- Weisberg, R. (2013). Meanings and measures of recidivism. *S. Cal. L. Rev.*, 87, 785.
- White, B., Driver, S., & Warren, A. M. (2008). Considering resilience in the rehabilitation of people with traumatic disabilities. *Rehabilitation Psychology*, 53(1), 9.
- Willard-Grace, R., Knox, M., Huang, B., Hammer, H., Kivlahan, C., & Grumbach, K. (2019). Burnout and health care workforce turnover. *The Annals of Family Medicine*, 17(1), 36-41.
- Wright, T. A., Cropanzano, R., & Bonett, D. G. (2007). The moderating role of employee positive well being on the relation between job satisfaction and job performance. *Journal of occupational health psychology*, 12(2), 93.
- Youssef, C. (2017). The importance of the therapeutic alliance when working with men who have committed a sexual offence. *Journal of Criminal Psychology*.

Appendices

Appendix A: Database Search Table

Database	Search Completed/Terms	Date	No. of Hits
ProQuest (Abstract)	"Sex Offender*" or "sexual offender*" or "child sex offender" or "paedophile*" AND therapeutic* NEAR/1 relationship* OR therapeutic* NEAR/1 rapport* OR working* NEAR/1 relationship* OR professional* NEAR/1 relationship* OR therapeutic* NEAR/1 alliance* OR therapeutic* NEAR/1 process* AND "treatment respons*" or "treatment efficacy" or "efficacy" or "treatment outcome*" or "recidivism rat*" or "behaviour* change*" or "attitude change*" or "risk level"	Initial search: 10/12/2021 Repeated on 16/04/2023 with the publication date adjusted to the initial search (10/12/2021)	Initial Search: 80 Repeat search (date adjusted): 11
Web Of Science (Topic)	"Sex Offender*" or "sexual offender*" or "child sex offender" or "paedophile*" AND therapeutic* NEAR/1 relationship* OR therapeutic* NEAR/1 rapport* OR working* NEAR/1 relationship* OR professional* NEAR/1 relationship* OR therapeutic* NEAR/1 alliance* OR therapeutic* NEAR/1 process* AND "treatment respons*" or "treatment efficacy" or "efficacy" or "treatment outcome*" or "recidivism rat*" or "behaviour* change*" or "attitude change*" or "risk level"	Initial Search: 10/12/2021 Repeated on 16/04/2023 with the publication date adjusted to the initial search (10/12/2021)	50 Repeat search (date adjusted): 6
Ovid: PsycInfo (Subject Heading Mapping)	Initial search terms: Sex Offender AND Therapeutic Relationship AND Treatment Outcome OR Recidivism OR Behaviour Change OR Attitude Change Adjusted search terms: sex offences/ or sexual violence/ or incest/ or rape/ or sexual abuse/ or sexual coercion/ or paraphilias/ or pedophilia/ or pornography/ or sex/ or sexual harassment/ AND Therapeutic Processes/ or exp Therapeutic Alliance/ AND Treatment Outcomes/ or Recidivism/ or Behaviour Change/ or Attitude Change	Initial Search: 10/12/2021 Repeated on 16/04/2023 with the publication date adjusted to the initial search (10/12/2021)	73 Repeat search (date adjusted): 2
Scopus	{Sex Offender} or {Sexual Offender} or {Child sex offender} or paedophile AND {therapeutic relationship} or {therapeutic rapport} or {working relationship} or {professional relationship} or {therapeutic alliance} or {therapeutic process} AND	Initial search: 10/12/2021 Repeated on 16/04/2023 with the publication date adjusted to	5 Repeat search (date adjusted):

	{treatment response} or {treatment efficacy} or efficacy or {treatment outcome} or {recidivism rate} or {behaviour change} or {attitude change} or {risk level}	the initial search (10/12/2021)	0
--	---	---------------------------------	---

Appendix B: Quality Assessments

Criteria	Yes	No	Other (CD, NR, NA)*
Aylwin (2010)			
Pre and Post Study Design			
1. Was the study question or objective clearly stated?	Yes		
2. Were eligibility/selection criteria for the study population prespecified and clearly described?	Yes		
3. Were the participants in the study representative of those who would be eligible for the test/service/intervention in the general or clinical population of interest?	Yes		
4. Were all eligible participants that met the prespecified entry criteria enrolled?	Yes		
5. Was the sample size sufficiently large to provide confidence in the findings?			NR
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?	Yes		
7. Were the exposure and outcome measures prespecified, clearly defined, valid, reliable, and	Yes		

Criteria	Yes	No	Other (CD, NR, NA)*
Aylwin (2010)			
Pre and Post Study Design			
assessed consistently across all study participants?			
8. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?	Yes		
9. Was the loss to follow-up after baseline 20% or less? Were those lost to follow-up accounted for in the analysis?	Yes		
10. Did the statistical methods examine changes in outcome measures from before to after the intervention? Were statistical tests done that provided p values for the pre-to-post changes?	Yes		
11. Were outcome measures of interest taken multiple times before the intervention and multiple times after the intervention (i.e., did they use an interrupted time-series design)?		No	
12. If the intervention was conducted at a group level (e.g., a whole hospital, a community, etc.) did the statistical analysis take into account the	Yes		

Criteria	Yes	No	Other (CD, NR, NA)*
Aylwin (2010)			
Pre and Post Study Design			
use of individual-level data to determine effects at the group level?			
13. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?		No	

Quality Rating = Good: 10/13
Rater #1 Initials: CW
Rater #2 Initials: AS
Additional Comments (If POOR, please state why):

Criteria	Yes	No	Other (CD, NR, NA)*
Beech et al. (2005)			
Pre and Post Study Design			
1. Was the study question or objective clearly stated?	Yes		
2. Were eligibility/selection criteria for the study population prespecified and clearly described?	Yes		
3. Were the participants in the study representative of those who would be eligible for the test/service/intervention in the general or clinical population of interest?	Yes		
4. Were all eligible participants that met the prespecified entry criteria enrolled?			NR
5. Was the sample size sufficiently large to provide confidence in the findings?			NR
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?	Yes		

Criteria	Yes	No	Other (CD, NR, NA)*
Beech et al. (2005)			
Pre and Post Study Design			
7. Were the exposure and outcome measures prespecified, clearly defined, valid, reliable, and assessed consistently across all study participants?	Yes		
8. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?	Yes		
9. Was the loss to follow-up after baseline 20% or less? Were those lost to follow-up accounted for in the analysis?	Yes		
10. Did the statistical methods examine changes in outcome measures from before to after the intervention? Were statistical tests done that provided p values for the pre-to-post changes?	Yes		
11. Were outcome measures of interest taken multiple times before the intervention and multiple times after the intervention (i.e., did they use an interrupted time-series design)?		No	

Criteria	Yes	No	Other (CD, NR, NA)*
Beech et al. (2005)			
Pre and Post Study Design			
12. If the intervention was conducted at a group level (e.g., a whole hospital, a community, etc.) did the statistical analysis take into account the use of individual-level data to determine effects at the group level?	Yes		
13. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?	Yes		

Quality Rating = Good 10/13
Rater #1 Initials: CW
Rater #2 Initials: AS

Quality Rating = Good 10/13

Additional Comments (If POOR, please state why):

Criteria	Yes	No	Other (CD, NR, NA)*
DeSorcy et al. (2014) Correlational Design			
1. Was the study question or objective clearly stated?	Yes		
2. Were eligibility/selection criteria for the study population prespecified and clearly described?	Yes		
3. Were the participants in the study representative of those who would be eligible for the test/service/intervention in the general or clinical population of interest?	Yes		
4. Were all eligible participants that met the prespecified entry criteria enrolled?	Yes		
5. Was the sample size sufficiently large to provide confidence in the findings?			NR

Criteria	Yes	No	Other (CD, NR, NA)*
DeSorcy et al. (2014)			
Correlational Design			
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?	Yes		
7. Were the exposure outcome measures prespecified, clearly defined, valid, reliable, and assessed consistently across all study participants?	Yes		
8. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?	Yes		
9. Was the loss to follow-up after baseline 20% or less? Were those lost to follow-up accounted for in the analysis?	Yes		
10. Did the statistical methods examine changes in outcome measures from before to after the intervention? Were statistical tests done that provided p values for the pre-to-post changes?		No	
11. Were outcome measures of interest taken multiple times before the intervention and		No	

Criteria	Yes	No	Other (CD, NR, NA)*
DeSorcy et al. (2014) Correlational Design			
multiple times after the intervention (i.e., did they use an interrupted time-series design)?			
12. If the intervention was conducted at a group level (e.g., a whole hospital, a community, etc.) did the statistical analysis take into account the use of individual-level data to determine effects at the group level?	Yes		
13. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?	Yes		

Quality Rating = Good: 10/13

Rater #1 Initials: CW

Rater #2 Initials: AS

Quality Rating = Good: 10/13

Additional Comments (If POOR, please state why):

Criteria	Yes	No	Other (CD, NR, NA)*
DeSorcy et al. (2017) Correlational Design			
1. Was the study question or objective clearly stated?	Yes		
2. Were eligibility/selection criteria for the study population prespecified and clearly described?	Yes		
3. Were the participants in the study representative of those who would be eligible for the test/service/intervention in the general or clinical population of interest?	Yes		
4. Were all eligible participants that met the prespecified entry criteria enrolled?		No	
5. Was the sample size sufficiently large to provide confidence in the findings?			NR

Criteria	Yes	No	Other (CD, NR, NA)*
DeSorcy et al. (2017)			
Correlational Design			
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?	Yes		
7. Were the exposure and outcome measures prespecified, clearly defined, valid, reliable, and assessed consistently across all study participants?	Yes		
8. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?	Yes		
9. Was the loss to follow-up after baseline 20% or less? Were those lost to follow-up accounted for in the analysis?	Yes		
10. Did the statistical methods examine changes in outcome measures from before to after the intervention? Were statistical tests done that provided p values for the pre-to-post changes?		No	
11. Were outcome measures of interest taken multiple times before the intervention and		No	

Criteria	Yes	No	Other (CD, NR, NA)*
DeSorcy et al. (2017)			
Correlational Design			
multiple times after the intervention (i.e., did they use an interrupted time-series design)?			
12. If the intervention was conducted at a group level (e.g., a whole hospital, a community, etc.) did the statistical analysis take into account the use of individual-level data to determine effects at the group level?	Yes		
13. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?		No	

Quality Rating = Fair: 8/13

Rater #1 Initials: CW

Rater #2 Initials: AS

Quality Rating = Fair: 8/13

Additional Comments (If POOR, please state why):

Criteria	Yes	No	Other (CD, NR, NA)*
Fenske (2007)			
Pre and Post Study Design			
1. Was the study question or objective clearly stated?	Yes		
2. Were eligibility/selection criteria for the study population prespecified and clearly described?	Yes		
3. Were the participants in the study representative of those who would be eligible for the test/service/intervention in the general or clinical population of interest?	Yes		
4. Were all eligible participants that met the prespecified entry criteria enrolled?			Not clear
5. Was the sample size sufficiently large to provide confidence in the findings?			NR

Criteria	Yes	No	Other (CD, NR, NA)*
Fenske (2007)			
Pre and Post Study Design			
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?	Yes		
7. Were the exposure and outcome measures prespecified, clearly defined, valid, reliable, and assessed consistently across all study participants?	Yes		
8. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?	Yes		
9. Was the loss to follow-up after baseline 20% or less? Were those lost to follow-up accounted for in the analysis?		No	
10. Did the statistical methods examine changes in outcome measures from before to after the intervention? Were statistical tests done that provided p values for the pre-to-post changes?	Yes		
11. Were outcome measures of interest taken multiple times before the intervention and		No	

Criteria	Yes	No	Other (CD, NR, NA)*
Fenske (2007)			
Pre and Post Study Design			
multiple times after the intervention (i.e., did they use an interrupted time-series design)?			
12. If the intervention was conducted at a group level (e.g., a whole hospital, a community, etc.) did the statistical analysis take into account the use of individual-level data to determine effects at the group level?	Yes		
13. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?	Yes		

Quality Rating = Fair: 9/13

Rater #1 Initials: CW

Rater #2 Initials: AS

Quality Rating = Fair: 9/13

Additional Comments (If POOR, please state why):

Criteria	Yes	No	Other (CD, NR, NA)*
Rothman (2007) Pre and Post Study Design			
1. Was the study question or objective clearly stated?	Yes		
2. Were eligibility/selection criteria for the study population prespecified and clearly described?	Yes		
3. Were the participants in the study representative of those who would be eligible for the test/service/intervention in the general or clinical population of interest?	Yes		
4. Were all eligible participants that met the prespecified entry criteria enrolled?		No	
5. Was the sample size sufficiently large to provide confidence in the findings?	Yes		

Criteria	Yes	No	Other (CD, NR, NA)*
Rothman (2007)			
Pre and Post Study Design			
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?		No	
7. Were the exposure and outcome measures prespecified, clearly defined, valid, reliable, and assessed consistently across all study participants?	Yes		
8. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?	Yes		
9. Was the loss to follow-up after baseline 20% or less? Were those lost to follow-up accounted for in the analysis?	Yes		
10. Did the statistical methods examine changes in outcome measures from before to after the intervention? Were statistical tests done that provided p values for the pre-to-post changes?		No	
11. Were outcome measures of interest taken multiple times before the intervention and		No	

Criteria	Yes	No	Other (CD, NR, NA)*
Rothman (2007)			
Pre and Post Study Design			
multiple times after the intervention (i.e., did they use an interrupted time-series design)?			
12. If the intervention was conducted at a group level (e.g., a whole hospital, a community, etc.) did the statistical analysis take into account the use of individual-level data to determine effects at the group level?	Yes		
13. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?	Yes		

Quality Rating = Fair: 9/13

Rater #1 Initials: CW

Rater #2 Initials: AS

Quality Rating = Fair: 9/13

Additional Comments (If POOR, please state why):

Criteria	Yes	No	Other (CD, NR, NA)*
Marshall et al. (2002)			
Observational Study			
1. Was the study question or objective clearly stated?	Yes		
2. Were eligibility/selection criteria for the study population prespecified and clearly described?	Partly		
3. Were the participants in the study representative of those who would be eligible for the test/service/intervention in the general or clinical population of interest?	Yes		
4. Were all eligible participants that met the prespecified entry criteria enrolled?			Not clear
5. Was the sample size sufficiently large to provide confidence in the findings?			NR

Criteria	Yes	No	Other (CD, NR, NA)*
Marshall et al. (2002)			
Observational Study			
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?	Yes		
7. Were the exposure and outcome measures prespecified, clearly defined, valid, reliable, and assessed consistently across all study participants?	Yes		
8. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?	Yes		
9. Was the loss to follow-up after baseline 20% or less? Were those lost to follow-up accounted for in the analysis?			N/A
10. Did the statistical methods examine changes in outcome measures from before to after the intervention? Were statistical tests done that provided p values for the pre-to-post changes?		No	

Criteria	Yes	No	Other (CD, NR, NA)*
Marshall et al. (2002)			
Observational Study			
11. Were outcome measures of interest taken multiple times before the intervention and multiple times after the intervention (i.e., did they use an interrupted time-series design)?			N/A
12. If the intervention was conducted at a group level (e.g., a whole hospital, a community, etc.) did the statistical analysis take into account the use of individual-level data to determine effects at the group level?		No	
13. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?		No	

Quality Rating = Fair: 6.5/11

Rater #1 Initials: CW

Quality Rating = Fair: 6.5/11

Rater #2 Initials: AS

Additional Comments (If POOR, please state why):

Criteria	Yes	No	Other (CD, NR, NA)*
Marshall et al. (2003)			
Observational Study			
1. Was the study question or objective clearly stated?	Yes		
2. Were eligibility/selection criteria for the study population prespecified and clearly described?	Partly		
3. Were the participants in the study representative of those who would be eligible for the test/service/intervention in the general or clinical population of interest?	Yes		
4. Were all eligible participants that met the prespecified entry criteria enrolled?			Not clear

Criteria	Yes	No	Other (CD, NR, NA)*
Marshall et al. (2003)			
Observational Study			
5. Was the sample size sufficiently large to provide confidence in the findings?			NR
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?			Not Clear
7. Were the exposure and outcome measures prespecified, clearly defined, valid, reliable, and assessed consistently across all study participants?	Yes		
8. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?	Yes		
9. Was the loss to follow-up after baseline 20% or less? Were those lost to follow-up accounted for in the analysis?			N/A
10. Did the statistical methods examine changes in outcome measures from before to after the intervention? Were statistical tests		No	

Criteria	Yes	No	Other (CD, NR, NA)*
Marshall et al. (2003)			
Observational Study			
done that provided p values for the pre-to-post changes?			
11. Were outcome measures of interest taken multiple times before the intervention and multiple times after the intervention (i.e., did they use an interrupted time-series design)?			N/A
12. If the intervention was conducted at a group level (e.g., a whole hospital, a community, etc.) did the statistical analysis take into account the use of individual-level data to determine effects at the group level?		No	
13. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?		No	

Quality Rating = Poor: 4.5/11

Rater #1 Initials: CW

Rater #2 Initials: AS

Additional Comments (If POOR, please state why):

The paper failed to clearly state whether pre-treatment measures were conducted and did not provide any analysis to show whether there was a significant change between pre and post scores however, provided analysis to demonstrate whether therapist characteristics were associated with treatment change. Additionally, the study did not acknowledge any confounding variables and reported programme changes rather than on an individual basis.

Appendix C: Data Extraction Table

Study Details	Population and setting	Method of intervention	Method of measuring and recording	Results (Include Mean, P Value, Standard Deviation and Effect Size where appropriate)	Limitations	Additional comments
Authors: Citation: Aim of Study: Design: Observational study Quality score:	Eligible population: Selected population: Categories of sex offenders: Additional identified participant factors: Controlled factors:	Group: Individual: Community: Secure inpatient service: Prison environment:	How was the therapeutic relationship defined?: Who reported on the therapeutic relationship and treatment outcome (Offenders or therapists): Self-report scales: Risk assessment levels: Recidivism rates: Behavioural change:	Risk assessment levels: Recidivism rates: Behavioural change: Attitude change: Participants views (qualitative): Working alliance/therapeutic relationship:	Limitations identified by author(s): Limitations identified by me: -	

			Attitude change:	Overall findings (treatment outcome and working alliance):		
--	--	--	------------------	--	--	--

Appendix D: Advertisement for Healthcare workers



**UNIVERSITY OF
BIRMINGHAM**

Healthcare Workers Required!

We are looking for healthcare workers with experience working with sex offenders in privatised services to participate in a short yet meaningful study exploring the experiences of those that work the most closely with them.

If you are interested in participating, please use this link: https://bhampsiychology.eu.qualtrics.com/jfe/form/SV_etCjaBgnDMkstRY

If you have any questions please feel free to contact the researcher by the details provided below:
Researcher: Chloe Wheeler
Department: Forensic Psychology
Email: [REDACTED]

The study will be conducted online through four short questionnaires which is estimated to take **30 minutes** to complete.

BONUS! With your participation you can chose to enter a prize draw to win a £25 Amazon gift card voucher. There will be two winners and the raffle will be drawn no later than January 2023



Appendix E: Information Sheet

Information Sheet

What is the research about?

The current research aims to explore and understand the experiences of non-professional healthcare workers that work closely with sexual offenders.

Why have I been chosen?

You have been chosen to participate in this study because you are over the age of 18 and you are an healthcare worker, working in a privatised service and are currently working with sex offenders. To meet the participation criteria for the study, it is required that as a healthcare worker you do not have any professional qualifications and are not employed at the service as either a doctor, psychologist, occupational therapist, speech and language therapist nurse or social worker.

What are you asking of me?

By agreeing to take part in the study, you will be asked to complete some demographic information and four questionnaires. The questionnaires will be exploring your opinions of working with sex offenders as well as assessing your well-being at work and work related arrangements. It is estimated that the study will take approximately 30 minutes to complete. Additionally, you will have the opportunity to provide your email address to be entered into a prize draw to win one out of two available £25 Amazon gift cards.

What if I wish to withdraw from the study?

You can withdraw from the study up to three weeks of submitting your responses. During the online study you will be given the option to withdraw after reading the information sheet, and you can stop participating at any point by exiting your internet browser and we will destroy your data. If you finish the study and wish to withdraw at a later stage, you can contact the researcher requesting to withdraw with your unique participant number and your data will be destroyed.

What if I become upset during the study?

We do not expect that the study will cause more distress than experienced during routine daily activities. However, we request that you withdraw by exiting the browser if you become upset whilst responding to the questions. Please note the underneath contact details for Samaritans, who specialise in supporting healthcare workers. When you reach the end of the study, we will provide you with a debrief sheet including more information about the study, the contact details of the researchers, and the Samaritans number once again.

Samaritans

Helpline: 0800 484 0555

Website: www.samaritans.org

Email: jo@samaritans.org

Data Protection and Confidentiality

All of your data will be collected and processed in accordance with the Data Protection Act 2018. No identifiable data will be published or made available to third parties.

Will I be kept anonymous?

Each participant will be requested to develop a randomised participant ID; therefore, your data will not be associated with your name or other personally identifying information. If you wish to take part in the prize draw you will need to provide your email address. This will be stored in a separate file to the data including your responses.

If you wish to withdraw after completing the study (providing this is within 3 weeks of you completing the study) you will be required to email your randomised participant ID number for your data to be destroyed. The email will be deleted at the same time as the submitted data.

About one month after completion of the data collection phase, participant ID numbers will be removed from the data, and the anonymised data may be made available on public repositories to support study replication and further development of knowledge.

Researcher Contact Details:

Doctoral Researcher (main point of contact): Chloe Wheeler [REDACTED]

Principal Investigator: Artur Brzozowski [REDACTED]

University of Birmingham

Complaints

If you have any complaints regarding the research, please feel free to contact the Head of School, Professor Ed Wilding using the details provided below:

Email: hos.psychology@contacts.bham.ac.uk

Telephone: 0121 414 7217

Appendix F: Consent Form

Consent Form

Please read each of the following statements carefully and indicate your response underneath.

- I have read and fully understood the previously displayed *Information Sheet*
- I am over the age of 18, and I have voluntarily agreed to participate in the study
- I understand that participation in the study may cause distress
- I am as a healthcare worker employed by a privatised service overseeing sex offenders
- I understand that my data will be kept confidential and that my anonymised responses will be used for research purposes
- I understand that I can withdraw at any point while completing the study and up to 3 weeks of submitting responses
- I agree to having my anonymised responses shared on public repositories

If you agree with the above and wish to consent to take part in the study, please select 'I agree' and if you do not wish to consent, please select 'I do not consent'. If you select the latter, you will be provided with a debrief sheet and exited from the study.

I agree

I do not consent to this
study

Appendix G: Demographic Questionnaire

Demographic Questionnaire

The following statement will not be included in the study, it is solely for the purpose of the ethics application: When participants are responding to the questions below, if they are to select “No” to any of the inclusion requirements such as working with sex offenders as part of the patient population, the study will be designed on Qualtrics to automatically close the study down so participants will not be able to proceed onto the main questionnaires. Any data collected up to that point will be deleted.

Please select the box that applies to you:

1. *What is your biological sex?*

Male ☐

Female ☐

Non-Binary ☐

Prefer not to say ☐

2. *You identify yourself as:*

Male ☐

Female ☐

Non-Binary ☐

Other ☐

Prefer not to say ☐

3. *How old are you?*

Prefer not to say ☐

4. *What is your country of residence?*

5. *Do you work within a privatised service?*

YES ☐

NO ☐

6. *Are you employed as a healthcare worker/support worker with a patient facing role?*

YES ☐

NO ☐

7. *How long have you worked at the service?*

8. *Do you have any professional qualifications?*

YES ☐

NO ☐

If you selected "YES" to the previous question, please briefly describe your qualification(s).

9. *Can you describe what type of service you work for? (e.g., locked rehabilitation/low secure/forensic community)*

N/A ☐

10. *Do you currently work with sex offender(s) as part of the patient population?*

YES ☐

NO ☐

11. *Are you employed as:*

Fulltime ☐

Parttime ☐

Agency/zero-hour contract ☐

If the latter was selected, please estimate the number of hours you work a week at the service:

12. *Have you had previous training/education on working with sex offenders?*

YES ☐

NO ☐

If you selected “YES” to the previous question, could you briefly describe what type of training you received (e.g., in person, online) and how long ago?

--

Appendix H: The Perceptions of Sex Offenders Scale

The Perceptions of Sex Offenders Scale (PSO)

Please respond to each of the following statements by indicating the extent to which you agree with it. To answer, please place the appropriate number next to the question, in the space provided.

- | | 1 | 2 | 3 | 4 | 5 | 6 |
|-----------|--|----------|----------------------|-------------------|-------|-------------------|
| | Strongly
Disagree | Disagree | Somewhat
Disagree | Somewhat
Agree | Agree | Strongly
Agree |
| _____ 1. | With support and therapy, someone who committed a sexual offence can learn to change their behaviour. | | | | | |
| _____ 2. | People who commit sex offences should lose their civil rights (e.g. voting, privacy). | | | | | |
| _____ 3. | The death penalty should be reintroduced for sex offenders. | | | | | |
| _____ 4. | People are far too on edge about the risks posed by sex offenders. | | | | | |
| _____ 5. | More sex offenders should be given sentences in the community. | | | | | |
| _____ 6. | Sex offenders prefer to stay home alone rather than be around lots of people. | | | | | |
| _____ 7. | Most sex offenders do not have close friends. | | | | | |
| _____ 8. | Sex offenders have difficulty making friends, even if they try real hard. | | | | | |
| _____ 9. | The prison sentences sex offenders receive are much too long when compared to the sentence lengths of other crimes. | | | | | |
| _____ 10. | People who commit sex offences should be subject to harsh restrictions on their liberty for the rest of their lives. | | | | | |
| _____ 11. | Trying to rehabilitate a sex offender is a waste of time. | | | | | |
| _____ 12. | Sex offenders should wear tracking devices so their location can be pinpointed at any time. | | | | | |
| _____ 13. | Only a few sex offenders are dangerous. | | | | | |
| _____ 14. | Most sex offenders are unmarried men. | | | | | |
| _____ 15. | It's not <u>if</u> a sex offender commits another crime, it's <u>when</u> . | | | | | |
| _____ 16. | Most sex offenders keep to themselves. | | | | | |
| _____ 17. | Sex offenders should have all their details announced to local communities. | | | | | |
| _____ 18. | Convicted sex offenders should never be released from prison. | | | | | |
| _____ 19. | Sex offenders will almost always commit further offences. | | | | | |
| _____ 20. | Some sex offenders should be allowed to work in schools. | | | | | |

What type of sex offender were you thinking of? _____

Appendix I: Professional Quality of Life Scale

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue

(ProQOL) Version 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your

compassion for those you [help] can affect you in positive and negative ways. Below are some

questions about your experiences, both positive and negative, as a [helper]. Consider each of the

following questions about you and your current work situation. Select the number that honestly

reflects how frequently you experienced these things in the last 30 days.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I [help].
3. I get satisfaction from being able to [help] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [help].
7. I find it difficult to separate my personal life from my life as a [helper].
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
9. I think that I might have been affected by the traumatic stress of those I [help].
10. I feel trapped by my job as a [helper].
11. Because of my [helping], I have felt "on edge" about various things.
12. I like my work as a [helper].
13. I feel depressed because of the traumatic experiences of the people I [help].
14. I feel as though I am experiencing the trauma of someone I have [helped].
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
17. I am the person I always wanted to be.

18. My work makes me feel satisfied.
19. I feel worn out because of my work as a [helper].
20. I have happy thoughts and feelings about those I [help] and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
24. I am proud of what I can do to [help].
25. As a result of my [helping], I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a [helper].
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

Appendix J: Quality of Work Life Survey

Quality of Work Life Survey (Armstrong & Griffin, 2004)

Please rate each item from 1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree nor Disagree, 4 = Agree, 5 = Strongly Agree

Environmental Safety

1. I feel safe when working among the patients
2. I received the kind of training I need to keep myself safe while working here
3. I have the equipment needed to keep staff from getting hurt by the patients
4. I have the back up support I need if things get rough

Quality of Supervision

1. I often receive feedback on my performance from my supervisor
2. On my job, I know what my supervisor expects of me
3. My supervisor asks my opinion when a work-related problem arises
4. I am free to disagree with my supervisor
5. I can tell my supervisor when things are wrong
6. My supervisor respects my work
7. My supervisor is knowledgeable and competent

Co-worker Support

1. I usually get along very well with my co-workers
2. The people I work with are helpful to me in getting my job done
3. I know I can get help from my co-workers when I need it
4. Co-workers criticize my work to others
5. The people I work with are competent
6. My co-workers respect my work and abilities

Appendix K: Attitudes Towards Sex Offenders – 21

Attitudes Towards Sex Offenders - 21

Instructions

Please respond to each of the following items using the scale provided. Please be as honest as possible in your responding. There are no right or wrong answers.

Response options

- 0 = strongly disagree
- 1 = disagree
- 2 = undecided
- 3 = agree
- 4 = strongly agree

No.	Item	Factor
1	Sex offenders are different from other people (r)	Trust
2	Most sex offenders are victims of circumstances and deserve help	Social Distance
3	Sex offenders have feelings like the rest of us	Social Distance
4	It is not wise to trust a sex offender too far (r)	Trust
5	I think I would like a lot of sex offenders	Social Distance
6	Give a sex offender an inch and they take a mile (r)	Intent
7	Sex offenders need affection and praise just like anybody else	Social Distance
8	Trying to rehabilitate sex offenders is a waste of time and money (r)	Intent
9	Sex offenders are no better or worse than other people	Social Distance
10	You have to be constantly on your guard with sex offenders (r)	Trust
11	If you give a sex offender your respect, he'll give you the same	Social Distance
12	Sex offenders only think about themselves (r)	Intent
13	There are some sex offenders I would trust with my life	Trust
14	Most sex offenders are too lazy to earn an honest living (r)	Intent
15	I wouldn't mind living next door to a treated sex offender	Trust
16	Sex offenders are just plain mean at heart (r)	Intent
17	Sex offenders are always trying to get something out of somebody (r)	Intent
18	Sex offenders are immoral (r)	Trust
19	I would like associating with some sex offenders	Trust
20	Sex offenders respect only brute force (r)	Intent
21	If sex offenders do well in prison/hospital, they should be let out on parole	Social Distance

Appendix L: Raffle Entry

Raffle Entry

If you wish to enter in the Amazon Gift Card Raffle, please provide your email address below:

The raffle is anticipated to be drawn with feedback provided to winners no later than January 2023. This is to ensure that an adequate sample size is collected for the current population.

Appendix M: Debrief Form

Debrief Form

Thank you for participating in the current study, your participation is greatly appreciated.

There are conflicting findings around the impact of working with sex offenders on work related well-being, with some research identifying work related factors such as peer support, supervision and safety measures as protective factors. However, little research has explored the effect psychological factors on well-being, particularly amongst healthcare workers. Therefore, the current research aims to explore whether stereotype endorsement and negative attitudes predict workplace well-being amongst healthcare workers working with sex offenders. It is anticipated that findings of the study will inform training offered to healthcare workers and consequently their well-being.

If you wish to contact the researcher, please refer to the contact details at the bottom of this page. Additionally, if you wish to withdraw from the study, you are able to do so within three weeks of submission of your responses. If you wish to withdraw from the study please contact the researcher at the email address below with your participant ID number requesting withdrawal.

If you feel distressed and would like to talk to someone about your situation, please use the dedicated **Samaritans service**:

Website: www.samaritans.org

Helpline: 0800 484 0555

Email: jo@samaritans.org

Researcher Contact Details:

Doctoral Researcher (main point of contact): Chloe Wheeler [REDACTED]

Principal Investigator: Artur Brzozowski [REDACTED]

University of Birmingham

Complaints

If you have any complaints regarding the research, please feel free to contact the Head of School, Professor Ed Wilding using the details provided below:

Email: hos.psychology@contacts.bham.ac.uk

Telephone: 0121 414 7217

Thank you for taking part!

Please help us find more participants by suggesting this research to colleagues within your profession or by posting the study link on social media and relevant forums.

Appendix N: SPSS Output for Multiple Regression Analysis on Compassion Satisfaction

Descriptive Statistics			
	Mean	Std. Deviation	N
CompSat	38.48	6.997	91
SentManag	29.32	12.069	91
StereoEnd	15.30	5.054	91
RiskPerc	20.90	4.575	91
ATSTrust	18.56	5.683	91
ATSSocDis	23.45	5.214	91
ATSIIntent	23.85	6.851	91
EnviSafety	13.92	3.600	91
QualSuperv	17.01	4.520	91
CoWorkSup	20.93	3.003	91
p			

Correlations

		CompSat	SentManag	StereoEnd	RiskPerc	ATSTrust	ATSSocDis	ATSIIntent	EnviSafety	QualSuper	CoWorkSupp
Pearson Correlation	CompSat	1.000	-.568	-.388	-.418	.449	.630	.573	.733	.360	.440
	SentManaging	-.568	1.000	.710	.464	-.710	-.722	-.892	-.482	-.195	-.326
	StereoEnd	-.388	.710	1.000	.263	-.605	-.537	-.713	-.394	.093	-.186
	RiskPerc	-.418	.464	.263	1.000	-.624	-.573	-.348	-.395	-.311	-.097
	ATSTrust	.449	-.710	-.605	-.624	1.000	.692	.674	.479	.177	.217
	ATSSocial Dis	.630	-.722	-.537	-.573	.692	1.000	.620	.577	.172	.501
	ATSIIntent	.573	-.892	-.713	-.348	.674	.620	1.000	.400	.067	.247
	EnviSafety	.733	-.482	-.394	-.395	.479	.577	.400	1.000	.469	.638
	QualSuper	.360	-.195	.093	-.311	.177	.172	.067	.469	1.000	.488
	CoWorkSupp	.440	-.326	-.186	-.097	.217	.501	.247	.638	.488	1.000
Sig. (1-tailed)	CompSat	.	<.001	<.001	<.001	<.001	<.001	<.001	<.001	<.001	<.001
	SentManaging	.000	.	.000	.000	.000	.000	.000	.000	.032	.001
	StereoEnd	.000	.000	.	.006	.000	.000	.000	.000	.190	.039
	RiskPerc	.000	.000	.006	.	.000	.000	.000	.000	.001	.181
	ATSTrust	.000	.000	.000	.000	.	.000	.000	.000	.047	.019
	ATSSocial Dis	.000	.000	.000	.000	.000	.	.000	.000	.051	.000
	ATSIIntent	.000	.000	.000	.000	.000	.000	.	.000	.264	.009
	EnviSafety	.000	.000	.000	.000	.000	.000	.000	.	.000	.000

	QualSuper v	.000	.032	.190	.001	.047	.051	.264	.000	.	.000
	CoWorkSu pp	.000	.001	.039	.181	.019	.000	.009	.000	.000	.
N	CompSat	91	91	91	91	91	91	91	91	91	91
	SentMana g	91	91	91	91	91	91	91	91	91	91
	StereoEnd	91	91	91	91	91	91	91	91	91	91
	RiskPerc	91	91	91	91	91	91	91	91	91	91
	ATSTrust	91	91	91	91	91	91	91	91	91	91
	ATSSocDi s	91	91	91	91	91	91	91	91	91	91
	ATSIintent	91	91	91	91	91	91	91	91	91	91
	EnviSafety	91	91	91	91	91	91	91	91	91	91
	QualSuper v	91	91	91	91	91	91	91	91	91	91
	CoWorkSu pp	91	91	91	91	91	91	91	91	91	91

Variables Entered/Removed^a

Model	Variables Entered	Variables Removed	Method
1	CoWorkSupp, RiskPerc, StereoEnd, QualSuperv, ATSIIntent, EnviSafety, ATSTrust, ATSSocDis, SentManag ^b	.	Enter

a. Dependent Variable: CompSat

b. All requested variables entered.

Model Summary^b

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.841 ^a	.707	.675	3.992	1.660

a. Predictors: (Constant), CoWorkSupp, RiskPerc, StereoEnd, QualSuperv, ATSIIntent, EnviSafety, ATSTrust, ATSSocDis, SentManag

b. Dependent Variable: CompSat

ANOVA ^a						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	3116.160	9	346.240	21.731	<.001 ^b
	Residual	1290.565	81	15.933		
	Total	4406.725	90			

a. Dependent Variable: CompSat

b. Predictors: (Constant), CoWorkSupp, RiskPerc, StereoEnd, QualSuperv, ATSIIntent, EnviSafety, ATSTrust, ATSSocDis, SentManag

Coefficients ^a													
		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
Model		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	2.757	8.804		.313	.755	-14.759	20.274					
	SentManag	.143	.095	.247	1.514	.134	-.045	.332	-.568	.166	.091	.136	7.372
	StereoEnd	.138	.136	.100	1.013	.314	-.133	.409	-.388	.112	.061	.373	2.678
	RiskPerc	-.058	.142	-.038	-.408	.684	-.340	.224	-.418	-.045	-.025	.421	2.375
	ATSTrust	-.354	.131	-.288	-2.695	.009	-.616	-.093	.449	-.287	-.162	.317	3.150
	ATSSocDis	.530	.160	.395	3.306	.001	.211	.849	.630	.345	.199	.253	3.950
	ATSIIntent	.609	.146	.597	4.168	<.001	.318	.900	.573	.420	.251	.176	5.668
	EnviSafety	1.190	.183	.612	6.496	<.001	.826	1.555	.733	.585	.391	.407	2.459
	QualSuperv	.223	.133	.144	1.678	.097	-.041	.488	.360	.183	.101	.490	2.040
	CoWorkSupp	-.484	.229	-.208	-2.115	.038	-.940	-.029	.440	-.229	-.127	.374	2.671

a. Dependent Variable: CompSat

Collinearity Diagnostics^a

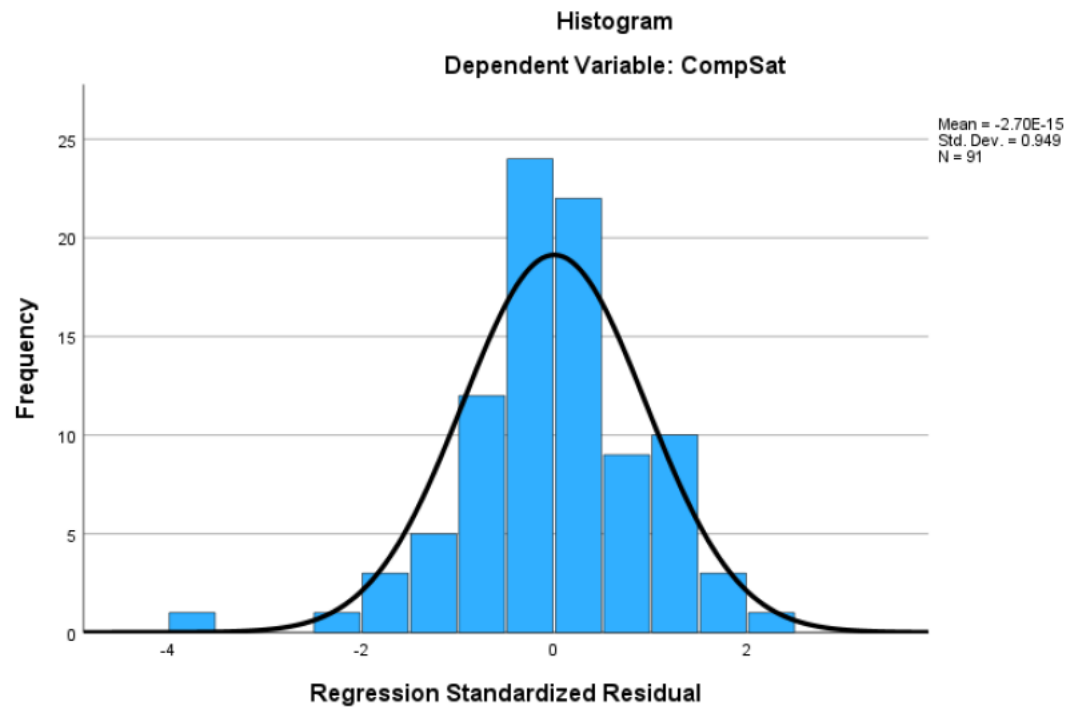
Mod el	Dimensi on	Eigenval ue	Condi on Index	Variance Proportions									
				(Const ant)	SentMa nag	StereoE nd	RiskP erc	ATSTr ust	ATSSoc Dis	ATSI nt ent	EnviSaf ety	QualSup erv	CoWorkS upp
1	1	9.400	1.000	.00	.00	.00	.00	.00	.00	.00	.00	.00	.00
	2	.381	4.967	.00	.02	.02	.00	.01	.00	.00	.00	.00	.00
	3	.077	11.056	.00	.00	.03	.07	.00	.00	.02	.02	.18	.00
	4	.046	14.319	.00	.02	.06	.10	.22	.01	.00	.04	.06	.01
	5	.038	15.634	.00	.10	.26	.00	.00	.00	.05	.19	.05	.00
	6	.025	19.411	.00	.05	.24	.02	.19	.11	.00	.07	.29	.01
	7	.015	25.232	.00	.00	.22	.00	.02	.26	.07	.57	.12	.05
	8	.011	29.018	.01	.28	.12	.40	.46	.00	.39	.00	.02	.01
	9	.005	41.392	.01	.01	.01	.21	.05	.37	.04	.10	.19	.91
	10	.002	70.751	.99	.52	.05	.20	.05	.23	.42	.00	.09	.01

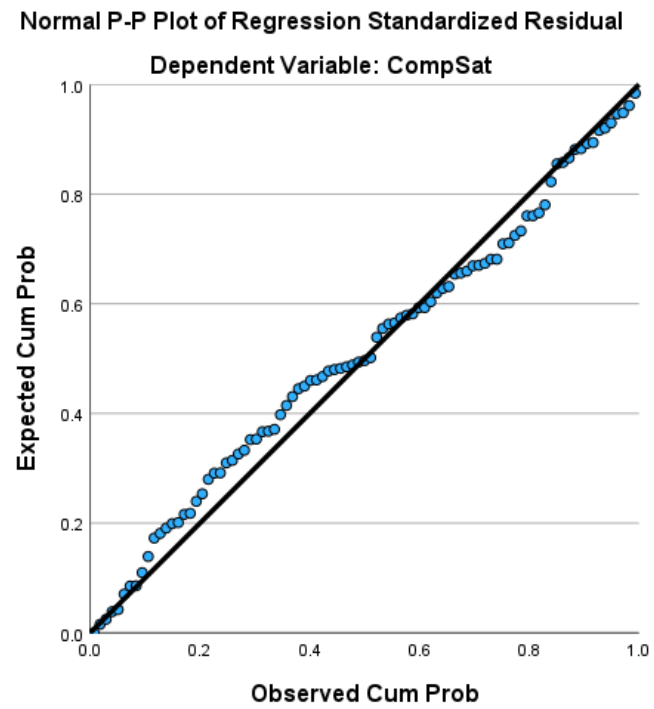
a. Dependent Variable: CompSat

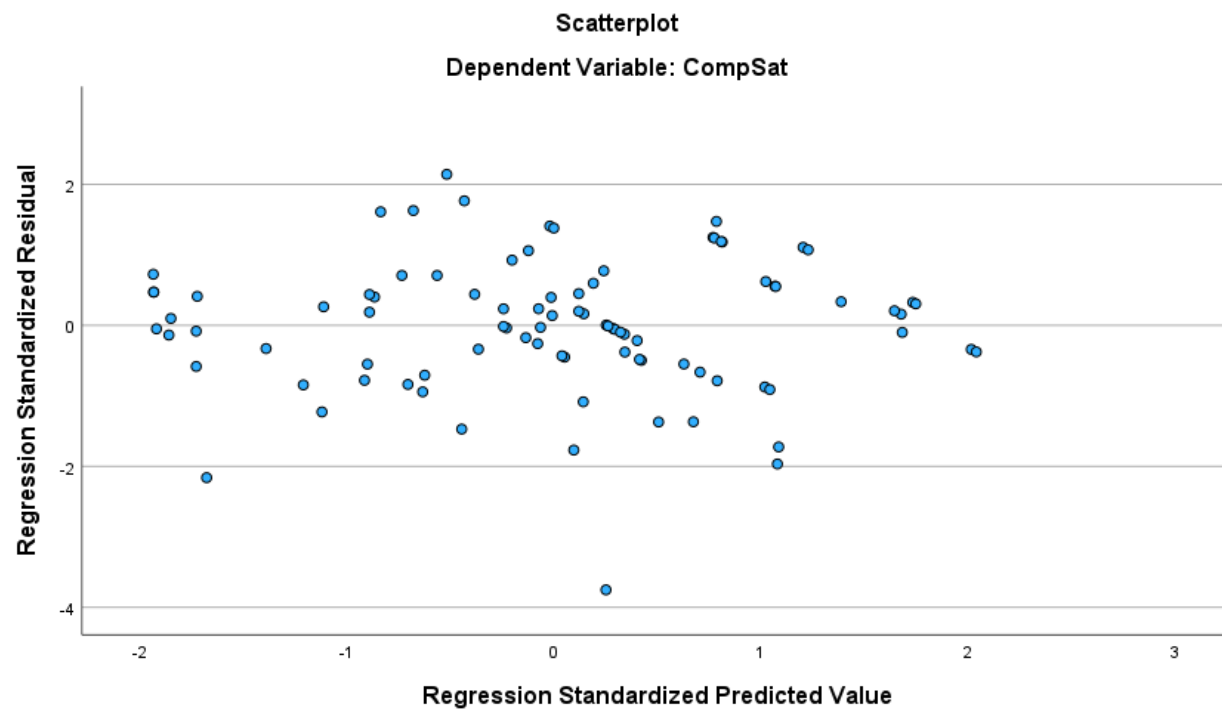
Residuals Statistics^a

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	27.11	50.50	38.48	5.884	91
Residual	-14.976	8.550	.000	3.787	91
Std. Predicted Value	-1.933	2.043	.000	1.000	91
Std. Residual	-3.752	2.142	.000	.949	91

a. Dependent Variable: CompSat







Appendix O: SPSS Output for Multiple Regression Analysis on Secondary Traumatic Stress

Descriptive Statistics			
	Mean	Std. Deviation	N
SecTraumStres	25.63	6.243	91
SentManag	29.32	12.069	91
StereoEnd	15.30	5.054	91
RiskPerc	20.90	4.575	91
ATSTrust	18.56	5.683	91
ATSSocDis	23.45	5.214	91
ATSIintent	23.85	6.851	91
EnviSafety	13.92	3.600	91
QualSuperv	17.01	4.520	91
CoWorkSupp	20.93	3.003	91

Correlations

		SecTraumStr ess	SentMan ag	StereoE nd	RiskPe rc	ATSTr ust	ATSSoc Dis	ATSInte nt	EnviSaf ety	QualSup erv	CoWorkSu pp
Pearson Correlati on	SecTraumStr ess	1.000	.375	.408	-.104	-.216	-.182	-.555	-.352	-.070	-.205
	SentManag	.375	1.000	.710	.464	-.710	-.722	-.892	-.482	-.195	-.326
	StereoEnd	.408	.710	1.000	.263	-.605	-.537	-.713	-.394	.093	-.186
	RiskPerc	-.104	.464	.263	1.000	-.624	-.573	-.348	-.395	-.311	-.097
	ATSTrust	-.216	-.710	-.605	-.624	1.000	.692	.674	.479	.177	.217
	ATSSocDis	-.182	-.722	-.537	-.573	.692	1.000	.620	.577	.172	.501
	ATSIIntent	-.555	-.892	-.713	-.348	.674	.620	1.000	.400	.067	.247
	EnviSafety	-.352	-.482	-.394	-.395	.479	.577	.400	1.000	.469	.638
	QualSuperv	-.070	-.195	.093	-.311	.177	.172	.067	.469	1.000	.488
	CoWorkSupp	-.205	-.326	-.186	-.097	.217	.501	.247	.638	.488	1.000
Sig. (1- tailed)	SecTraumStr ess	.	<.001	<.001	.164	.020	.042	<.001	<.001	.254	.026
	SentManag	.000	.	.000	.000	.000	.000	.000	.000	.032	.001
	StereoEnd	.000	.000	.	.006	.000	.000	.000	.000	.190	.039
	RiskPerc	.164	.000	.006	.	.000	.000	.000	.000	.001	.181
	ATSTrust	.020	.000	.000	.000	.	.000	.000	.000	.047	.019
	ATSSocDis	.042	.000	.000	.000	.000	.	.000	.000	.051	.000
	ATSIIntent	.000	.000	.000	.000	.000	.000	.	.000	.264	.009
	EnviSafety	.000	.000	.000	.000	.000	.000	.000	.	.000	.000
	QualSuperv	.254	.032	.190	.001	.047	.051	.264	.000	.	.000
	CoWorkSupp	.026	.001	.039	.181	.019	.000	.009	.000	.000	.

N	SecTraumStr ess	91	91	91	91	91	91	91	91	91	91
	SentManag	91	91	91	91	91	91	91	91	91	91
	StereoEnd	91	91	91	91	91	91	91	91	91	91
	RiskPerc	91	91	91	91	91	91	91	91	91	91
	ATSTrust	91	91	91	91	91	91	91	91	91	91
	ATSSocDis	91	91	91	91	91	91	91	91	91	91
	ATSIintent	91	91	91	91	91	91	91	91	91	91
	EnviSafety	91	91	91	91	91	91	91	91	91	91
	QualSuperv	91	91	91	91	91	91	91	91	91	91
	CoWorkSupp	91	91	91	91	91	91	91	91	91	91

Variables Entered/Removed^a

Model	Variables Entered	Variables Removed	Method
1	CoWorkSupp, RiskPerc, StereoEnd, QualSuperv, ATSIintent, EnviSafety, ATSTrust, ATSSocDis, SentManag ^b	.	Enter

a. Dependent Variable: SecTraumStress

b. All requested variables entered.

Model Summary^b

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.736 ^a	.542	.491	4.454	1.600

a. Predictors: (Constant), CoWorkSupp, RiskPerc, StereoEnd, QualSuperv, ATSIIntent, EnviSafety, ATSTrust, ATSSocDis, SentManag

b. Dependent Variable: SecTraumStress

ANOVA^a

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1900.527	9	211.170	10.645	<.001 ^b
	Residual	1606.770	81	19.837		
	Total	3507.297	90			

a. Dependent Variable: SecTraumStress

b. Predictors: (Constant), CoWorkSupp, RiskPerc, StereoEnd, QualSuperv, ATSIIntent, EnviSafety, ATSTrust, ATSSocDis, SentManag

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	66.455	9.823		6.765	<.001	46.910	86.000					
	SentManag	-.273	.106	-.527	-2.582	.012	-.483	-.063	.375	-.276	-.194	.136	7.372
	StereoEnd	.132	.152	.107	.871	.387	-.170	.435	.408	.096	.065	.373	2.678
	RiskPerc	-.441	.158	-.323	-2.786	.007	-.755	-.126	-.104	-.296	-.210	.421	2.375
	ATSTrust	.123	.147	.112	.837	.405	-.169	.414	-.216	.093	.063	.317	3.150
	ATSSocDis	.073	.179	.061	.407	.685	-.283	.429	-.182	.045	.031	.253	3.950
	ATSIIntent	-.950	.163	-1.043	-5.825	<.001	-1.275	-.626	-.555	-.543	-.438	.176	5.668
	EnviSafety	-.659	.204	-.380	-3.221	.002	-1.066	-.252	-.352	-.337	-.242	.407	2.459
	QualSuperv	-.169	.148	-.122	-1.139	.258	-.464	.126	-.070	-.126	-.086	.490	2.040
	CoWorkSupp	.242	.255	.117	.949	.346	-.266	.751	-.205	.105	.071	.374	2.671

a. Dependent Variable: SecTraumStress

Collinearity Diagnostics^a

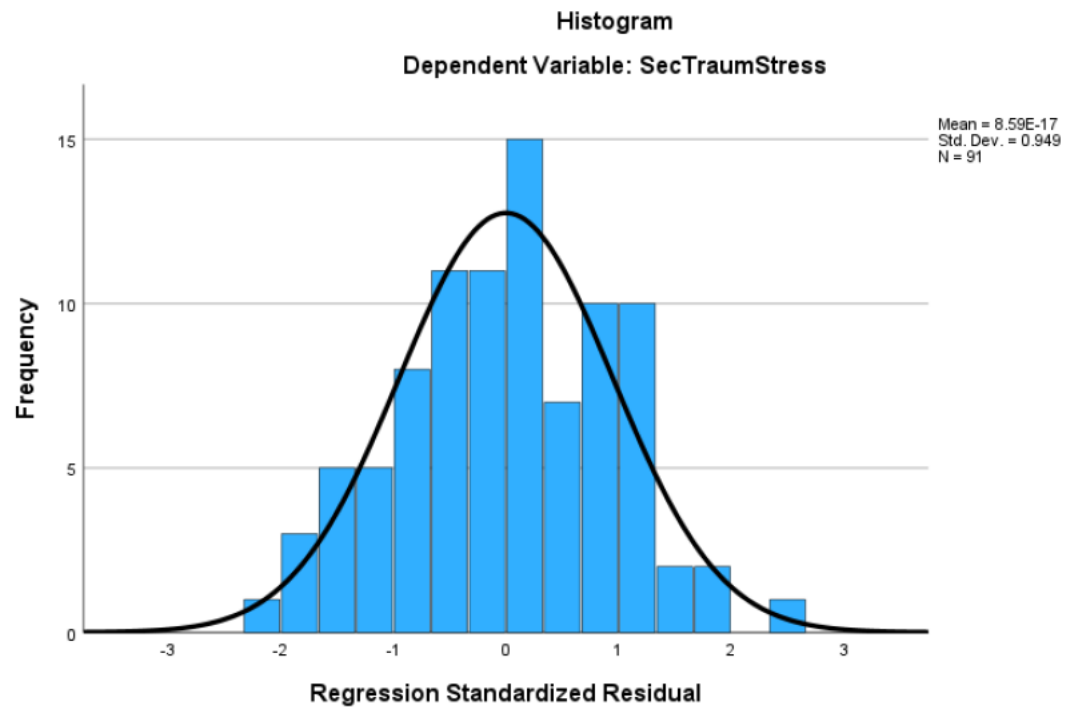
Model	Dimension	Eigenvalue	Condition	Variance Proportions									
			Index	(Constant)	Sentencing	StereoEnd	RiskPer	ATSTrust	ATSSocial Dis	ATSIntent	EnviSafety	QualSuperv	CoWorkSupp
1	1	9.400	1.000	.00	.00	.00	.00	.00	.00	.00	.00	.00	.00
	2	.381	4.967	.00	.02	.02	.00	.01	.00	.00	.00	.00	.00
	3	.077	11.056	.00	.00	.03	.07	.00	.00	.02	.02	.18	.00
	4	.046	14.319	.00	.02	.06	.10	.22	.01	.00	.04	.06	.01
	5	.038	15.634	.00	.10	.26	.00	.00	.00	.05	.19	.05	.00
	6	.025	19.411	.00	.05	.24	.02	.19	.11	.00	.07	.29	.01
	7	.015	25.232	.00	.00	.22	.00	.02	.26	.07	.57	.12	.05
	8	.011	29.018	.01	.28	.12	.40	.46	.00	.39	.00	.02	.01
	9	.005	41.392	.01	.01	.01	.21	.05	.37	.04	.10	.19	.91
	10	.002	70.751	.99	.52	.05	.20	.05	.23	.42	.00	.09	.01

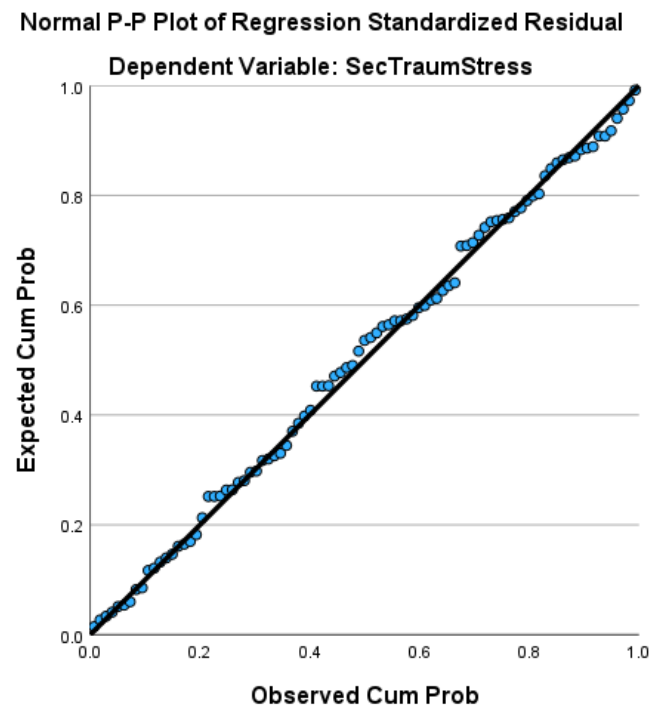
a. Dependent Variable: SecTraumStress

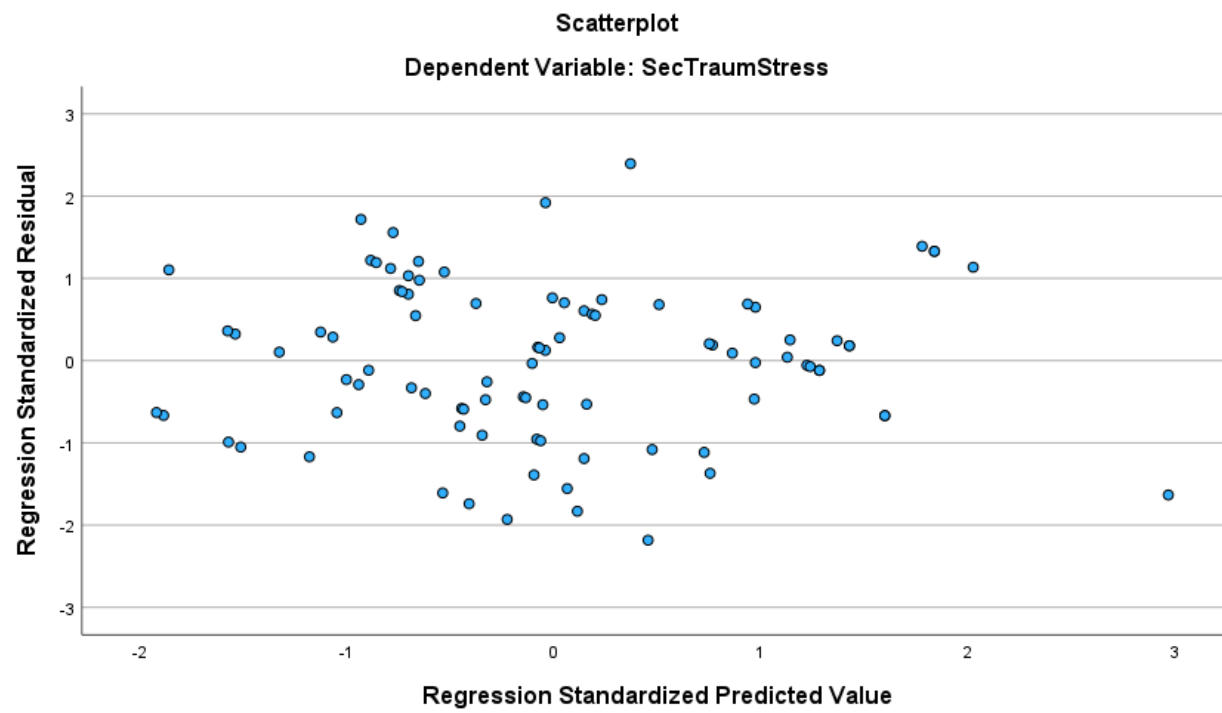
Residuals Statistics^a

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	16.81	39.28	25.63	4.595	91
Residual	-9.727	10.663	.000	4.225	91
Std. Predicted Value	-1.918	2.971	.000	1.000	91
Std. Residual	-2.184	2.394	.000	.949	91

a. Dependent Variable: SecTraumStress







Appendix P: SPSS Output for Multiple Regression Analysis on Burnout

Descriptive Statistics			
	Mean	Std. Deviation	N
Burnout	25.36	5.413	91
SentManag	29.32	12.069	91
StereoEnd	15.30	5.054	91
RiskPerc	20.90	4.575	91
ATSTrust	18.56	5.683	91
ATSSocDis	23.45	5.214	91
ATSIIntent	23.85	6.851	91
EnviSafety	13.92	3.600	91
QualSuperv	17.01	4.520	91
CoWorkSup	20.93	3.003	91
p			

Correlations

		Burnout	SentManager	StereoEnd	RiskPerc	ATSTrust	ATSSocDis	ATSIIntent	EnviSafety	QualSuperv	CoWorkSupp
Pearson Correlation	Burnout	1.000	.421	.366	.327	-.400	-.437	-.550	-.625	-.359	-.346
	SentManager	.421	1.000	.710	.464	-.710	-.722	-.892	-.482	-.195	-.326
	StereoEnd	.366	.710	1.000	.263	-.605	-.537	-.713	-.394	.093	-.186
	RiskPerc	.327	.464	.263	1.000	-.624	-.573	-.348	-.395	-.311	-.097
	ATSTrust	-.400	-.710	-.605	-.624	1.000	.692	.674	.479	.177	.217
	ATSSocDis	-.437	-.722	-.537	-.573	.692	1.000	.620	.577	.172	.501
	ATSIIntent	-.550	-.892	-.713	-.348	.674	.620	1.000	.400	.067	.247
	EnviSafety	-.625	-.482	-.394	-.395	.479	.577	.400	1.000	.469	.638
	QualSuperv	-.359	-.195	.093	-.311	.177	.172	.067	.469	1.000	.488
	CoWorkSupp	-.346	-.326	-.186	-.097	.217	.501	.247	.638	.488	1.000
Sig. (1-tailed)	Burnout	.	<.001	<.001	<.001	<.001	<.001	<.001	<.001	<.001	<.001
	SentManager	.000	.	.000	.000	.000	.000	.000	.000	.032	.001
	StereoEnd	.000	.000	.	.006	.000	.000	.000	.000	.190	.039
	RiskPerc	.001	.000	.006	.	.000	.000	.000	.000	.001	.181
	ATSTrust	.000	.000	.000	.000	.	.000	.000	.000	.047	.019
	ATSSocDis	.000	.000	.000	.000	.000	.	.000	.000	.051	.000
	ATSIIntent	.000	.000	.000	.000	.000	.000	.	.000	.264	.009
	EnviSafety	.000	.000	.000	.000	.000	.000	.000	.	.000	.000
	QualSuperv	.000	.032	.190	.001	.047	.051	.264	.000	.	.000
	CoWorkSupp	.000	.001	.039	.181	.019	.000	.009	.000	.000	.
N	Burnout	91	91	91	91	91	91	91	91	91	91

SentManag	91	91	91	91	91	91	91	91	91	91	91
StereoEnd	91	91	91	91	91	91	91	91	91	91	91
RiskPerc	91	91	91	91	91	91	91	91	91	91	91
ATSTrust	91	91	91	91	91	91	91	91	91	91	91
ATSSocDis	91	91	91	91	91	91	91	91	91	91	91
ATSIIntent	91	91	91	91	91	91	91	91	91	91	91
EnviSafety	91	91	91	91	91	91	91	91	91	91	91
QualSuperv	91	91	91	91	91	91	91	91	91	91	91
CoWorkSu pp	91	91	91	91	91	91	91	91	91	91	91

Variables Entered/Removed^a

Model	Variables Entered	Variables Removed	Method
1	CoWorkSupp, RiskPerc, StereoEnd, QualSuperv, ATSIIntent, EnviSafety, ATSTrust, ATSSocDis, SentManag ^b	.	Enter

a. Dependent Variable: Burnout

b. All requested variables entered.

Model Summary^b

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.807 ^a	.650	.612	3.373	2.016

a. Predictors: (Constant), CoWorkSupp, RiskPerc, StereoEnd, QualSuperv, ATSIIntent, EnviSafety, ATSTrust, ATSSocDis, SentManag

b. Dependent Variable: Burnout

ANOVA ^a						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1715.353	9	190.595	16.750	<.001 ^b
	Residual	921.680	81	11.379		
	Total	2637.033	90			

a. Dependent Variable: Burnout

b. Predictors: (Constant), CoWorkSupp, RiskPerc, StereoEnd, QualSuperv, ATSIIntent, EnviSafety, ATSTrust, ATSSocDis, SentManag

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	66.856	7.440		8.986	<.001	52.052	81.659					
	SentManag	-.400	.080	-.892	-5.003	<.001	-.559	-.241	.421	-.486	-.329	.136	7.372
	StereoEnd	.062	.115	.058	.535	.594	-.167	.291	.366	.059	.035	.373	2.678
	RiskPerc	.072	.120	.061	.600	.550	-.166	.310	.327	.067	.039	.421	2.375
	ATSTrust	.170	.111	.179	1.535	.129	-.050	.391	-.400	.168	.101	.317	3.150
	ATSSocDis	-.211	.136	-.203	-1.557	.123	-.481	.059	-.437	-.170	-.102	.253	3.950
	ATSIIntent	-.867	.124	-1.097	-7.012	<.001	-1.112	-.621	-.550	-.615	-.461	.176	5.668
	EnviSafety	-.783	.155	-.521	-5.057	<.001	-1.091	-.475	-.625	-.490	-.332	.407	2.459
	QualSuperv	-.347	.112	-.289	-3.085	.003	-.570	-.123	-.359	-.324	-.203	.490	2.040
	CoWorkSupp	.337	.194	.187	1.739	.086	-.049	.722	-.346	.190	.114	.374	2.671

a. Dependent Variable: Burnout

Collinearity Diagnostics^a

Model	Dimension	Eigenvalue	Condition Index	Variance Proportions									
				(Constant)	Sentencing	Stereotyping	Risk Perception	AT/Trust	AT/Social Dis	AT/Intent	Environment	Quality of Service	Co-Work Support
1	1	9.400	1.000	.00	.00	.00	.00	.00	.00	.00	.00	.00	.00
	2	.381	4.967	.00	.02	.02	.00	.01	.00	.00	.00	.00	.00
	3	.077	11.056	.00	.00	.03	.07	.00	.00	.02	.02	.18	.00
	4	.046	14.319	.00	.02	.06	.10	.22	.01	.00	.04	.06	.01
	5	.038	15.634	.00	.10	.26	.00	.00	.00	.05	.19	.05	.00
	6	.025	19.411	.00	.05	.24	.02	.19	.11	.00	.07	.29	.01
	7	.015	25.232	.00	.00	.22	.00	.02	.26	.07	.57	.12	.05
	8	.011	29.018	.01	.28	.12	.40	.46	.00	.39	.00	.02	.01
	9	.005	41.392	.01	.01	.01	.21	.05	.37	.04	.10	.19	.91
	10	.002	70.751	.99	.52	.05	.20	.05	.23	.42	.00	.09	.01

a. Dependent Variable: Burnout

Residuals Statistics^a

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	15.43	33.63	25.36	4.366	91
Residual	-8.263	8.082	.000	3.200	91
Std. Predicted Value	-2.275	1.895	.000	1.000	91
Std. Residual	-2.449	2.396	.000	.949	91

a. Dependent Variable: Burnout

