

PROFESSIONALS' EXPERIENCES OF WORKING  
THERAPEUTICALLY WITH SEX OFFENDERS

by

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## **Abstract**

In the last 10 years there has been a growth in working collaboratively with sex offenders by focusing on goals, tailoring treatment to the needs of the client, and an emphasis on therapist features like being empathetic and supportive (Andrews & Bonta, 2003; Lambert & Bergin, 1994; Ward, 2002). This thesis explored how sex offender treatment workers are responding to working with sex offenders in light of the changes.

The introduction describes the changes in sex offender treatment, and why therapist features are considered important. It covers the key concepts and theory relevant to the thesis, and highlights the aims. The second chapter is a systematic literature review looking at the impact of working therapeutically with sex offenders. The review highlighted the extent sex offender treatment workers are impacted by their work was inconclusive. The third chapter focused on critiquing the Trauma Symptom Inventory (TSI; Briere, 1995) as a potential tool that could be used to assess distress in sex offender treatment workers. The critique revealed that the TSI had good reliability and validity. The fourth chapter explored the experiences of sex offender treatment workers currently in the field using semi-structured interviews. All participants reported enjoying their work despite experiencing some negatives (i.e., intrusive images, suspiciousness, and concerns about clients re-offending). This chapter also highlighted that sex offender treatment workers reported using a range of coping strategies to manage the work. In addition, it was found that sex offender treatment workers believed a genuine interest in the work, hope, optimism, self-efficacy,

and circumstances outside of work were related to enhanced resilience. The last chapter of the thesis involved discussing the implications of the findings from each of the chapters.

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**CHAPTER 1**  
**INTRODUCTION**

## **Introduction**

Sex offender treatment in the 1960s adopted behavioural therapy approaches (i.e., conditioning, reinforcement and aversive strategies) to reduce sexual interests and behaviours (Marshall & Serran, 2000). During the last 30 years, sex offender treatment has shifted to cognitive behaviour therapy (CBT), as it has been found to be effective in reducing sexual reconviction (Ministry of Justice, 2010). In addition, sex offender treatment has been driven by the Risk, Need and Responsivity (RNR) principles (Andrews & Bonta, 2003), and the Good Lives Model (GLM) (Ward, 2002). Both of these additions to sex offender treatment will be discussed below;

In respect to RNR, the risk principle refers to the level of treatment offered to offenders. For example, those offenders at high risk of re-offending should be prioritised for treatment over low risk offenders. The need principle refers to treatment being tailored to the needs of the offender. This involves focusing on offence-related factors important to the individual like pro-criminal attitudes and substance misuse. The last principle known as responsivity relates to treatment being tailored to the learning style and abilities of the offender. In order for sex offender treatment to be effective, Andrews and Bonta (2003) suggested that all three principles need to be adhered to when offering treatment to sex offenders.

A more recent approach that has been used to structure treatment with sex offenders is the GLM. The model encourages professionals to help sex offenders to identify the needs that they were trying to meet through their offences. Once the needs have been identified, professionals are required to empower sex offenders by setting goals, and equipping them

with the skills needed to meet those needs in a pro-social manner (Marshall, Ward, Mann, Moulden, Fernandez, Serran & Mann, 2005; Ward, 2002).

Both of the above approaches require therapists to effectively deliver treatment to sex offenders by working collaboratively with them (Marshall et al., 2005). Previous research has suggested that process variables which include therapist features, and therapist-client alliance (i.e., cohesiveness of the relationship between the therapist and client) may positively impact on treatment outcomes (Lambert & Bergin, 1994; Marshall & Burton, 2010; Marshall, 2009). This is further supported by Drapeau (2005) who found that child molesters who had participated in a CBT programme stated that the therapist had been the most important aspect of the treatment, and the deciding factor for engaging. These findings highlight that the therapist plays a crucial role in the delivery of sex offender treatment and increasing offenders' motivation to participate in the intervention. However, despite the above findings, Marshall (2009) indicated that the important role the therapist plays in sex offender treatment remains ignored.

To raise awareness about how therapists contribute to the effectiveness of sex offender treatment, research has begun to explore specific therapist characteristics that lead to positive outcomes in sex offender treatment (i.e., reduction in denial and anger towards women). For instance, Marshall et al. (2002) found when judges were asked to identify therapist features from HM Prison Service video tapes of treatment, there were four features that positively correlated with treatment changes; empathy, warmth, being rewarding and directive. Other therapist characteristics identified in the literature (Marshall et al., 2002; Marshall & Serran, 2004) that have also been related to treatment effectiveness

include the following; genuineness, respect, confidence, promoting the importance of expressing emotions, encouraging participation, self-disclosure, flexibility, open-ended questioning style and humour. The findings above suggest that there are a number of therapist features that enhance the effectiveness of sex offender treatment.

A cohesive therapeutic alliance between the therapist and client has also been found to have a positive impact on treatment effectiveness (by increasing participation in treatment, enhancing trust, and improving sex offenders' self-esteem) (Serran & Marshall, 2010). The alliance is likely to be strengthened by the therapist adopting the features mentioned above and by engaging in the following behaviours; accepting the client, showing interest and offering supportive yet firm challenging (Serran & Marshall, 2010). It can also be reinforced through the therapist's ability to lead the intervention. This is particularly important in group programmes where it has been found that the therapist is responsible for creating a group climate that enhances cohesion amongst members of the group as well as with the therapist (Beech & Fordham, 1997).

Research has also found that certain therapist features (rejection of the client, low interest, manipulating the client for their own needs, confrontational style, and displaying anger/hostility towards the client) may reduce treatment effectiveness. For example, Hudson (2005) found that sex offenders disengaged from treatment, and instead engaged superficially when therapists were confrontational.

The above findings have emphasised the responsibility the therapist plays in enhancing the effectiveness of sex offender treatment. RNR principles and GLM have contributed to highlighting this pivotal role. Consequently, there is a need for research to explore how professionals working therapeutically with sex offenders cope with the demands of their changing roles. This is particularly important, as research has shown that when therapists adopt negative characteristics like anger/hostility, rejection of the client and/or a confrontational style, it may lead to sex offenders dropping out or not engaging (Beech & Fordham, 1997; Hudson, 2005). Furthermore, Sexton (1999) indicated that when professionals are impacted by their work it can have a detrimental impact on the individual as well as the organisation. Impact on the organisation includes poor service delivery, boundary violations, staff sickness, high staff turnover, and new staff being less experienced, and therefore, increasing their risk of experiencing secondary trauma. To prevent this from happening, professionals working with sex offenders need to adapt to their changing role to ensure sex offender treatment continues to be effective. This thesis aims to address this issue by exploring how sex offender treatment workers are responding to working collaboratively and positively with sex offenders. Below is a detailed description of the concepts and theory that describe the issues sex offender treatment workers may be confronted with as a result of their work.

Research investigating the impact of vicariously experiencing stressful events first emerged in the late 1970s when emergency workers were observed to have experienced symptoms similar to those of the victims they had helped (Sprang, Clark, & Whitt-Woosley, 2007). This phenomenon was explored further in other occupations that supported victims through

difficult situations (i.e., crisis workers, hotline workers). Stamm (1995) proposed that there were two types of trauma; 1) primary trauma, which occurred amongst people who were directly exposed to traumatic events, and 2) secondary trauma which was likely to be experienced by professionals who were indirectly exposed to trauma through listening to their clients' traumatic material.

There have been a variety of concepts that describe the range of responses that occur as a result of working therapeutically with traumatic material. Amongst the concepts that have been developed are burnout, compassion fatigue, countertransference and vicarious traumatisation. Whilst the concepts are similar, it is important to define all of them because they each have features that are different.

The term burnout describes the emotional exhaustion, depersonalisation and reduced personal accomplishment that can occur within the work environment when providing on-going support to clients, and exposure to emotionally demanding stressful situations (Figley & Kleber, 1995; Maslach, 1982; Pines & Aronson, 1988). On-going exposure to working with clients can lead to withdrawal and poor service delivery which can be exacerbated by workplace conditions such as high workload and lack of support. These factors combined can contribute to a decline in job satisfaction (Maslach, 1982). Although burnout is relevant to those who are indirectly exposed to trauma, it can also be applied to other occupations where there is little client contact (Stamm, 1997).

Compassion fatigue (CF) (also called secondary traumatic stress, STS) can develop when working empathically with clients. Symptoms of CF are similar to those of Post-Traumatic Stress Disorder (PTSD: re-experiencing the traumatic event, avoidance, and arousal, Figley, 1995; Moulden & Firestone, 2007). Another concept often cited in the literature is countertransference which describes the responses of professionals to clients, and relates to over-identifying with the client and using them to meet personal needs (Figley, 2002). Consequences of countertransference include anger towards the client, feeling numb, distant and hopeless (Tyagi, 2006).

Lastly, vicarious traumatization (VT) refers to changes in cognitions as a result of understanding client's traumatic material (McCann & Pearlman, 1990). The concept of VT stems from the Constructivist Self-Development Theory (CSDT) (Saakvitne & Pearlman, 1996) which suggests that schemas associated with psychological needs like safety, trust, power, control and intimacy are affected by trauma work. The trauma that therapists are exposed to through their work may contradict their already developed schemas. As a result, they may experience shifts in their affective, behavioural and interpersonal schemas. As such, their thinking around their worldview, identity and spirituality may change (Kadambi & Ennis, 2005; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Therefore, VT focuses on the cognitive schemas that are affected by working empathically with client material, whilst CF is concerned with the emotional-behavioural affects, and burnout heavily focuses on behavioural symptomology.

There have been a number of research designs used to assess psychological distress amongst professionals who work either with victims or offenders. These have ranged from qualitative approaches involving interviews, focus groups with participants and anecdotal accounts of therapist experiences, to quantitative methods such as questionnaires (Dean & Barnett, 2010; Kadambi & Truscott, 2003; Steed & Downing, 1998). A number of psychometrics tools have been developed to measure the various concepts discussed above, all of which have shown good reliability (alphas ranging from .71 to .90). For instance, the Maslach Burnout Inventory (MBI; Maslach, Jackson & Leiter, 1996) consists of three subscales (emotional exhaustion, depersonalisation and personal accomplishment) that measure burnout. Each subscale yields a score which can be categorised into low, moderate and high based on a normative sample. Another measure is the Traumatic Stress Institute Belief Scale (TSI; Pearlman, 1996) which assesses cognitive distortions in psychological needs of safety, trust, intimacy, control and power. The total score represents distortions to these needs with high scores supporting greater evidence of VT. The Professional Quality of Life Scale (ProQOL; Stamm, 2005) assesses burnout, STS and compassion satisfaction. Lastly, the Impact of Events Scale-Revised (IES-R; Weiss & Marmar, 1996) assesses VT through three subscales of avoidance, hyperarousal and vigilance.

There have been concerns raised by researchers that the above scales, particularly the TSI do not consistently yield similar patterns of VT across different studies, and therefore, suggesting that the scales may not be accurately measuring the construct (Kadamb & Ennis, 2005). This is supported further by Sabin-Farrell and Turpin (2003) who indicated that

there needs to be increased focus on developing the theoretical underpinnings of the constructs so that they can be accurately measured. The issues related to the measures used to assess secondary trauma in professionals will be discussed further in Chapter 3.

As mentioned above, this thesis is concerned with exploring how sex offender treatment workers are responding to working therapeutically with sex offenders. This is important when current treatment models like RNR and GLM emphasise the importance of therapist features. The overall aims of this thesis are as follows;

- To explore whether professionals working therapeutically with sex offenders are affected by their roles.
- To investigate how sex offender treatment workers cope with the demands of their roles.
- To determine how sex offender treatment workers adapt to their roles.

To fulfil these aims of the thesis, Chapter 2 reviews the current literature to establish whether sex offender treatment therapists are impacted by the work they do. Chapter 3 critically reviews a psychometric tool that could be used to measure psychological distress in sex offender treatment workers. Chapter 4 describes and presents a piece of research exploring the impact of working therapeutically with sex offenders via qualitative interviews with participants currently working in the field. Lastly, Chapter 5 discusses the

findings of each of the chapters, considering whether the aims of the thesis have been met, and discusses the implications of the thesis.

**CHAPTER 2**

**A SYSTEMATIC REVIEW INVESTIGATING THE IMPACT**

**OF WORKING THERAPEUTICALLY WITH SEX**

**OFFENDERS**

## **Abstract**

The aim of the systematic review was to explore the impact of working with sex offenders. Specifically to identify which factors lead sex offender treatment workers to experience distress, and to establish the factors which diminish negative impact. In addition, the coping strategies employed by sex offender treatment workers were investigated.

Studies were identified by searching electronic databases, examining reference lists and contacting key experts. Studies which met the inclusion criteria were quality assessed. Twelve studies were eligible for the review. Of these, six were qualitative studies, four were cross sectional and two adopted a mixed methods design. The quality scores ranged from 56% to 88%.

Findings from the review revealed that there were five studies that found professionals who worked with sex offenders experienced low levels of psychological distress. The remaining three studies suggested professionals were at risk of being negatively impacted by their work. Delivering treatment individually to sex offenders was the only factor found to increase the likelihood of negative impact. There were four studies that found peer support and supervision helped with reducing negative impact. The other two studies found supervision, and support to help professionals cope with the demands of work, also diminished negative impact.

Based on the results it is unclear to what extent sex offender treatment workers are impacted by their role and the factors which predict negative impact. Although, the themes that emerged from the qualitative research provided more clear and consistent findings. However, the results have confirmed the mitigating factors and coping strategies which are adopted by professionals to prevent or reduce distress. Future research in this area is highly recommended.

The review highlighted the importance of continuing to explore the impact therapeutic interventions may have on professionals who treat sex offenders. It is important for professionals and their managers to be aware of how their work can have an impact on them and to take appropriate steps to minimise distress.

## **Introduction**

This review is concerned with the psychological effects on those who are indirectly exposed to traumatic events. For a description of the concepts that describe the range of responses that occur as a result of working therapeutically with sex offenders, please refer to Chapter 1.

Traditionally, research assessing the impact of vicariously experiencing stressful events has focussed on therapists who work with victims of trauma (Kadambi & Ennis, 2005; Sabin-Farrell & Turpin, 2003). It is important to present the findings on professionals who work with victims of crime. This is because the experiences between professionals who work with victims and perpetrators have been similar (Way, VanDeusen, Martln, Applegate & Jandle, 2004). For example, a quantitative study by Craig and Sprang (2010) found that over half of their sample of social workers and psychologists from America who treated individuals suffering from trauma reported high levels of compassion satisfaction, and low levels of burnout and CF.

Another quantitative piece of research by Sprang, Clark and Whitt-Woosley (2007) found that practitioners from psychology, psychiatry and social work backgrounds based in the US experienced CF when working with victims, but that levels were lower than what had been reported in previous studies. One of the strengths of this study is that the sample included a range of professionals who worked with victims, and therefore the findings are generalisable to a wider population. Additionally, the findings suggest a range of professionals can experience symptoms of CF, highlighting that it is not restricted to one

type of occupation. However, a limitation of this research was that during data collection no attempts were made to increase participation via reminders, and hence there was a low response rate of 19%.

In another study conducted by Thorpe, Righthand and Kubik (2001) they found Department of Human Service case workers in the US reported significantly greater emotional distress than clinicians (psychiatrists, psychologists) and jurors. They reported this was due to case workers prolonged and extensive involvement with sex offenders as well as the victims.

In contrast, a qualitative study by Steed and Downing (1998) found that, after conducting semi-structured interviews with therapists who worked with sexual abuse/assault clients in Australia, all therapists experienced negative outcomes such as anger, emotional pain, suspiciousness of others and fatigue. Limitations of this study were that all participants were female, and it is not clearly stated if they worked solely with sex offenders or with victims. Similarly, Iliffe and Steed (2000) carried out semi-structured interviews with counsellors who worked with victims of domestic violence in Australia. The findings revealed that counsellors experienced a loss of confidence, visual images, difficulty trusting others and became aware of power/control dynamics between men and women (i.e., taking more notice of derogatory comments made by men to women). These findings indicate that when participants are questioned in-depth about the impact of their work through qualitative research, it appears those who worked with victims experience behavioural, emotional and psychological distress.

The above pieces of research on professionals who work with victims highlights a discrepancy in the levels of secondary trauma reported by workers, with quantitative studies showing little or no impact, and qualitative research showing high levels of secondary trauma (Iliffe & Steed, 2000; Sprang, Clark & Whitt-Woosley, 2007). It has been proposed that the differences in results may be due to methodological limitations in quantitative research such as sampling techniques, the measures utilised, or other variables that may impede the self-reports of professionals' level of burnout, STS and VT such as personal stress, circumstances outside of work, and problems within the organisation (i.e., lack of support, unclear policies and procedures) (Jenkins & Baird, 2002; Kadambi & Ennis, 2005; Sabin-Farrell & Turpin, 2003). Such differences, however caused, emphasise the need for further research to be conducted within this general field to determine the impact of this work.

In the 1990s, researchers became aware that professionals who work with perpetrators may also suffer from their work (Moulden & Firestone, 2007). More recently, attention has turned towards the occurrence of VT, CF and burnout amongst therapists who work with sex offenders. Sex offender treatment workers in the UK are likely to be involved in the assessment and treatment of sex offenders. They are employed by HM Prison Service, National Probation Service, the NHS, as well as private organisations and charities (Brampton, 2010). The exact statistics on the number of professionals working with sex offenders in the UK is unclear, but it has been reported over 1400 staff were trained on delivering sex offender treatment programmes in the late nineties (Perkins, Hammond,

Coles & Bishopp, 1998). Sex offender treatment is considered a growing field which requires professionals to have specialised skills and knowledge (Stop It Now, n.d). The interest in this area has developed due to awareness that sex offender treatment requires therapists to listen to traumatic details about the offence as well as sexual fantasies and motivations for offending whilst maintaining an empathetic relationship with the client. Also many professionals who work with sex offenders are faced with the task of assisting offenders in overcoming cognitive distortions like denial and minimisation (Ellerby, 1997; Kearns, 1995; Moulden & Firestone, 2007).

It is unclear from the research whether those who work therapeutically with sex offenders experience greater distress than other professionals or even the general public. The research is limited in this area due to the absence of comparison groups (Way, VanDeusen, Martin, Applegate & Jandle, 2004). Those studies that have included a comparison group have tended to use participants who work therapeutically with victims rather than professionals who work with other kinds of offenders (i.e. domestic violence offenders). The findings from such studies have found there to be no significant differences in levels of distress amongst sex offender treatment workers and victim workers (VanDeusen & Way, 2006). An implication in having a lack of control groups is it is uncertain if the levels of distress sex offender treatment workers experience is comparable, greater or less than other groups. Moreover, if the level of distress was less than or equal to other groups this may highlight that CF, VT and burnout may not be unique to those who work with sex offenders. It also highlights that the aspects of the job considered in the existing literature to be difficult (i.e. listening to traumatic stories, displaying empathy and working with denial)

may not make this professional group more likely to experience distress. An alternative explanation could be that they may have experienced distress but have developed coping strategies to manage the impact.

In Chapter 1, it was highlighted that therapist characteristics such as being warm and empathetic can have a positive impact on treatment effectiveness (Marshall et al., 2002). However, those same positive therapist characteristics may also impact both negatively and positively on the professional. For example, Tyagi (2006) proposed that empathy may place workers at risk of countertransference reactions due to the emotional reactions that occur when hearing details of the offence. Similarly, Moulden and Firestone, (2007) reported that empathy may be linked to the onset of VT. In contrast, a UK study by Brampton (2011) found that qualified facilitators believed one of the positives of delivering treatment to sex offenders was an improvement in their listening and empathetic skills. The same study also involved interviewing treatment managers. They also confirmed the positive impact of the work on the facilitators led to an increase of confidence in their skills and a sense of job satisfaction. The above findings show the empathetic nature of the job can lead to both negative and positive outcomes.

The evidence for the presence of concepts discussed in Chapter 1 for professionals who treat sex offenders has been varied. For example, there have been studies which have found professionals who treat sex offenders to have high levels of VT and other studies have found professionals to display high levels of personal accomplishment and satisfaction with their roles (Rich, 1997; Way, VanDeusen, Martin, Applegate & Jandle, 2004). For

example, Bains (2013) found that 18% of sex offender treatment workers recruited via Association for the Treatment of Sexual Abusers (ATSA), National Organisation for Treatment of Sexual Abusers (NOTA), and International Association for the Treatment of Sexual Offenders (IATSO) experienced high levels of burnout. It was also found that 5.5% of the sample experienced symptoms of VT. Despite, the sample experiencing distress, on the whole they were satisfied with their roles. Another study by Sheehy-Carmel and Friedlander (2009) found therapists in America working with male sex offenders experienced low levels of secondary trauma and moderate levels of CF and compassion satisfaction. This indicates that there appears to be a balance between negative and positive aspects of working with sex offenders resulting in only mild or moderate signs of psychological stress.

#### Factors mediating or moderating the impact of working with sex offenders

Research has begun to investigate the factors which increase the likelihood of experiencing negative outcomes of working with sex offenders, and protective factors. There have been a range of factors found to be associated with psychological distress including gender, age, previous exposure to trauma, empathy towards clients, length of time working with sex offenders, personal abuse history, supervision, training, self-care strategies and social support (Figley, 2002; Kassam-Adams, 1995; Way, Van Deusen, Martin, Applegate & Jandle, 2004). However, the evidence for the occurrence of the above factors across studies has been inconsistent. For example, Way et al. (2004) reported that there was no relationship between years of experience and VT amongst professionals who were members of national organisations such as ATSA. In respect to the influence of gender on

the impact experienced by American sex offender treatment workers, Jackson, Holzman, Bernard and Paradis (1997) found that there were no differences on burnout scores between genders. Contrastingly, Kassam-Adams (1995) found that female gender was a predictor of VT, along with the number of clients they worked with, and therapists' trauma histories.

In respect to therapists' personal experience of trauma as a factor to explain VT, Conrad (2011) reported childhood trauma and identifying with the person they are helping were risk factors for developing secondary trauma. He also stated lack of support, unbalanced professional and personal lives, and repeated exposure to clients contributed to developing secondary trauma. This is consistent with Bober and Regehr (2006) who found that the more time professionals worked with clients the higher their IES intrusion and avoidance scores. In contrast, a study by Bains (2013) found that the more time spent working with sex offenders and the more years of experience increased job satisfaction. It was also found that participants who delivered both individual and group treatment showed increased satisfaction with their roles in comparison to those who just delivered one type of treatment. In a study by Sheehy-Carmel and Friedlander (2009), high treatment alliance between American therapists and male sex offenders was associated with high compassion satisfaction scores and less symptoms of trauma. The relationship was mediated by therapists' sense of confidence and happiness with their work. This suggests forming a positive therapeutic relationship with sex offenders may increase satisfaction within their roles or satisfaction enables the alliance to form.

The Model of Dynamic Adaptation (MDA) (Clarke, 2004) was developed as a way of organising the different factors that may lead to positive and negative consequences of working with sex offenders. The model includes static factors (i.e., those characteristics of the individual that cannot be changed such as gender, age and trauma history), stable factors (i.e., those that change slowly like coping style and perspective taking), and dynamic factors which change rapidly and are out of the individual's control, such as accidents and a change in manager. Included in the model is a critical occupation element (i.e., all the factors related to the job itself, such as caseload and organisational policies). The model also covers positive psychological outcomes (i.e., finding the work rewarding), and negative psychological outcomes such as those described in Chapter 1. Strengths of the MDA are that it incorporates an array of factors involved in shaping the experiences of sex offender treatment workers and highlights how interventions to prevent or protect sex offender treatment workers can occur for each type of factor. However, the model does not take into account that in order for interventions to be offered there needs to consistency in the findings about the factors that lead to positive and negative outcomes of the work.

Connected to the above point, the findings above highlight the uncertainty regarding factors that contribute to the development of VT amongst sex offender treatment workers and factors that reduce negative consequences. This is further reinforced by Moulden and Firestone (2007) who concluded in their review of VT in sex offender treatment workers that therapists' years of experience, work setting and coping are the only variables that are consistently related to the onset of VT. Moreover, they confirmed professionals with the least and most amount of experience working with sex offenders, and those who worked in

secure settings (prisons and hospital units) were at greater risk of VT. They also highlighted in their review that positive coping (support, self-care) reduced negative outcomes, whilst negative coping (alcohol use) increased symptoms of VT. A limitation of this review is it did not adopt a systematic approach. Therefore, it is unclear the extent the studies in the review were rigorously assessed for quality.

A *systematic* review of the literature is therefore needed on professionals who work therapeutically with sex offenders. This is because the MDA, and past research (with those who work with victims and sex offenders) revealed that workers experienced both positive and negative outcomes. Also the only existing review to date into the impact of working with sex offenders did not adopt a systematic approach. It is therefore important to conduct a systematic review in order to understand the true extent of VT amongst sex offender treatment providers because previous research has been inconsistent, with quantitative studies showing little evidence of VT within a sample of therapists, and qualitative research indicating heightened levels of VT. This is an important topic to review in order to determine if interventions, like increased supervision and training covering the consequences sex offender treatment workers are likely to encounter, are necessary. It is also an important topic because if therapists are suffering from negative consequences like VT, CF and burnout, this may impact on the treatment provided to sex offenders and the therapeutic relationship.

As highlighted in Chapter 1 therapist' features and characteristics appear to be an important component contributing to the effectiveness of sex offender treatment (Marshall, 2009).

Furthermore, Moulden and Firestone (2010) have reported that care providers have an ethical duty to care for themselves before caring for others. In addition, as mentioned above, research has also highlighted that not all therapists are impacted by the traumatic material they are exposed to. It would, therefore, be helpful in this review to identify the factors which underpin this resiliency shown by some sex offender treatment workers. The specific objectives of the review are below:

- 1) To understand and explore the impact of working with sex offenders, both negative and positive.
- 2) To identify which factors lead sex offender treatment workers to experience distress.
- 3) To establish factors which protect against VT, CF and burnout among sex offender treatment providers.
- 4) To explore the coping strategies employed by sex offender treatment workers to cope with negative affect or to avoid suffering from the work they do.

## **Method**

### Sources of Literature

Prior to the systematic review a scoping search was conducted in order to examine the size of the relevant literature, and to identify existing reviews. A search of gateway Cochrane Database of Systematic Reviews (CDSR), Centre for Reviews and Dissemination (DARE) and Campbell Collaboration was employed during November 2011, March 2012, and

August 2014. On all occasions the search yielded one systematic review by Beck (2011), but this was not related to sex offender treatment work.

#### Databases and search terms

A search was conducted using four electronic databases; OVID PsycINFO; OVID EMBASE; OVID MEDLINE. The format of the search terms and/or how the search terms were entered into the search field was adapted depending on the requirements of each database (see Appendix 1 for full search terms). Below are the individual search terms of the review:

(therapist\* or "care professional\*" or "sex\* offender\* therapist\*" or psychologist\* or clinician\* or "treatment provider\*" or counse?or\* or facilitator\*

AND

("vicarious trauma\*" or "secondary trauma\*" or burnout or distress or impact\* or fatigue or countertransference or exhaustion or "occupation\* stress\*" or posttraumatic stress\*)

AND

("sex\* offend\*" or rapist\* or "sex\* devian\*" or "sex\* crimin\*" or pe?dophile or "child molest\*" or "sex\* predator\*" or "sex\* abuser\*" or (perp\* adj3 "sex\* aggression").

The following search strategies were employed;

a) A search was conducted using the above search terms on the four electronic databases; OVID PsycINFO (1987 to week four June 2014, completed on 27 June 2014), OVID EMBASE (1988 to week four, completed on 27 June 2014), OVID MEDLINE (1946 to

week four June 2014, completed on 27 June 2014) and ISA Web of Science (1990 to week four June 2014, completed on 27 June 2014). The total number of hits were 260 publications, 13 duplicates were removed leaving a total of 247 publications. From this amount a further 218 publications were removed on the basis that they were irrelevant and did not meet the inclusion criteria. This left 29 articles; 16 publications were categorised as 'yes' and 13 categorised as 'maybe.' From the 'yes' category three publications did not meet the criteria, and two publications could not be obtained, and were therefore removed due to timeframe constraints. Similarly, from the 'maybe' category seven publications did not meet the criteria, and five publications were excluded as they could not be obtained. The reasons for exclusion are shown in Appendix 2. Consequently, 12 studies were left for the quality assessment.

b) The reference lists of the 12 remaining studies were examined. Two publications were identified as appropriate for the review. However, one of these had to be excluded as it was presented at a conference and the author had no written information to send. The total publications for the review increased to 13.

c) A search was also conducted through the Cochrane gateway, but no publications were found.

d) Three key experts (Ineke Way, Lawrence Ellerby, and Jo Clarke) within the field were contacted; two experts responded back advising they currently were not in a position to e-

mail any unpublished work, and the other expert attached a presentation paper. However, the paper did not meet the inclusion criteria.

Inclusion and exclusion criteria

The following inclusion and exclusion criteria were developed. The search was limited to 1990 onwards as research investigating the impact of working vicariously with sex offenders began to emerge after this year (Moulden & Firestone, 2007). A population, intervention, comparator and outcome (PICO) framework was not constructed for the purpose of this review due to the studies related to the topic not having a clear intervention or comparison groups.

Table 1

*Inclusion and exclusion criteria*

<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
Publications should explore professionals who work therapeutically with sex offenders.	Publications which explore the impact of working with victims of crime.
The impact of working therapeutically with sex offenders should be covered.	Publications related to the impact of sex offender treatment on the offender or risk assessment.
Coping strategies, protective factors and predictive factors should be explored.	Studies related to professional groups who do not work therapeutically with sex offenders (i.e., nurses, police officers, and correctional staff).
English Language only	Editorials, book chapters, commentary, and any secondary studies.
1990 to present	

The inclusion/exclusion criteria (see Table 1) were applied to the remaining studies after all duplicates had been removed. The studies which met the inclusion criteria, based on the title and abstract were noted and the full text was obtained through the following methods; eLibrary at University of Birmingham, directly contacting the authors, and requesting inter-library loans. For some of the studies it was difficult to establish if they met the inclusion/exclusion criteria based on the title and abstract alone. Therefore, attempts were made to obtain the full text for these studies, categorized as 'maybe.' On inspection of those articles that met the criteria and those that were 'maybe', it was found that a number of articles were editorials or opinion papers. Therefore, they were excluded from the review.

### Quality Assessments

The research design of the 13 publications was determined by reading the abstract and methods section. There were seven qualitative papers, four cross sectional papers, and two mixed methods designs which adopted both cross sectional and qualitative aspects. For the qualitative papers, a qualitative assessment tool taken from Critical Appraisal Skills Programme (CASP, 2010) was used to quality assess these publications (see Appendix 3). There were 10 questions to consider and for each of these questions there were further key points to consider when scoring the articles. Some of these key points were changed to separate questions to allow each point to be carefully considered and scored. As a result, the total number of questions increased from 10 to 16. The questions covered areas such as sampling bias, measurement bias and other areas considered appropriate such as the role of the researcher during the research process, and the clarity of the findings. All seven

qualitative papers met the initial screening questions. For each question the following scoring guide was implemented; a score of two was given if the condition was met, one was given if the question was partially answered and zero was marked when the question was not answered. Unknown was only allocated when there was insufficient information available to establish whether the question had been covered. A high number of unknowns indicated less accurate reporting. The highest possible score was 32. The scores awarded for each article were converted into percentage quality scores. The higher the percentage was, the better the quality of the article.

The quantitative papers adopted a cross sectional design. The CASP website did not have a specific tool for cross sectional studies. Therefore, in order to quality assess these articles a new tool was developed. To assist with developing this tool a search was conducted online to see if any existing tools were available to use as a guide. Two cross sectional tools were found; one from the Scottish Government Website (2008) and the second from BioMed Central (n.d.). In addition, the cross sectional articles themselves were examined in order to explore the similarities and differences between them. This facilitated with question development and allowed comparisons to be made between the questions considered in the two tools found online, and the questions the research had proposed. Following the above process, a cross sectional tool including three screening questions and 16 detailed questions were developed (see Appendix 4). The questions focussed on sampling bias, measurement bias and overall study quality. The same scoring method used for the qualitative assessment tool was adopted. The highest possible score was 32. All four quantitative papers met the screening questions.

Two of the publications employed a mixed methods design. In order to quality assess the publications a search was carried out online to find existing mixed methods appraisal tools. Three evaluation tools were found; one by Pluye, Gagnon, Griffiths and Johnson-Lafleur (2009), another updated version called Mixed Methods Appraisal Tool (MMAT) by Pluye et al. (2011), and the third by Long, Gofrey, Randle, Brettle and Grant (2005). All three tools were used to develop a mixed methods tool that was tailored to the two articles, and would assist in evaluating the publications. The tool comprised of 16 questions that were split into the following categories; six questions related to the quantitative methodology; six questions to the qualitative aspect; three questions to the mixed methods design; one question to ethical considerations (see Appendix 5). The tool adopted the same scoring process as mentioned previously yielding a maximum score of 32.

Only one researcher was involved in quality assessing the articles. The Cochrane Collaboration (n.d) has highlighted one of the limitations of systematic reviews are there are no guidelines about cut-off scores for good quality. The reviewer looked through previous doctoral theses, and found cut-offs varied with some studies reporting 60% to others not stating any. Based on this, the reviewer decided if any of the articles received a percentage of 49% or below, these would be excluded from the analysis.

### Data Extraction

Data from the articles were extracted using a data extraction form detailed in Appendix 6. One researcher was involved in designing the form and extracting the data. The same form was used to extract important details from both the qualitative, cross sectional, and mixed

method studies. Headings in the form included method and results/analysis. There were sub sections specifically pertinent to qualitative and quantitative studies. The quality percentage and the number of questions that could not be answered due to lack of information in the article were transferred into the form.

## **Results**

### Description of the publications included in the review

In total, there were 13 publications which met the inclusion criteria. Twelve publications received a quality percentage score of 50% or above and therefore were included in the review. One publication by Farrenkopf (1992) was removed as it received a percentage score of 22% which was below the cut-off of 49%. The final 12 publications consisted of six qualitative papers, four cross sectional studies, and two mixed methods design (qualitative and cross sectional). Figure 1 illustrates the processes involved in arriving at the 12 publications included in the review. Table 2 displays the characteristics of each article which have been taken from the quality assessment forms and data extraction form.

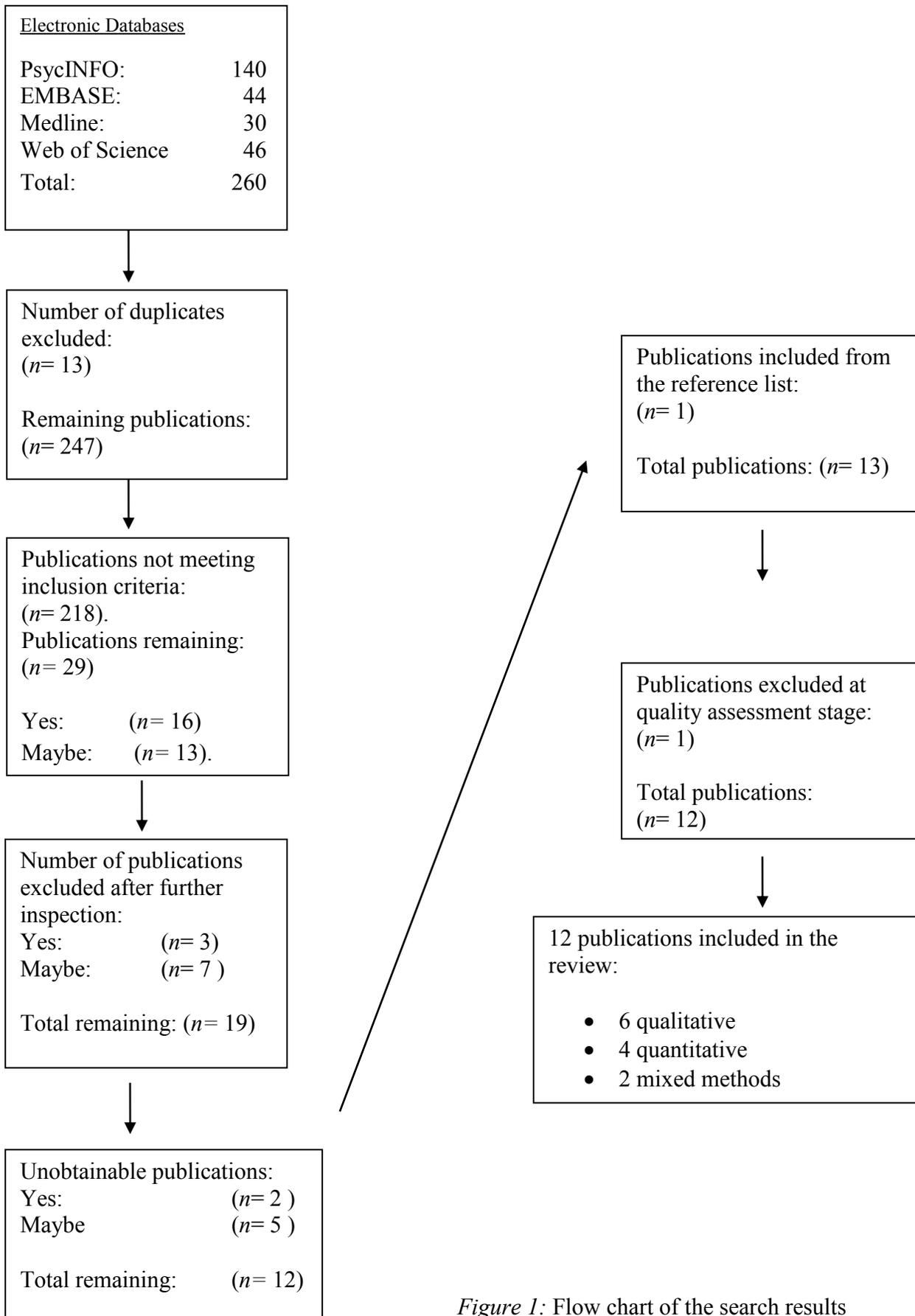


Figure 1: Flow chart of the search results

Table 2

*Characteristics of Included Publications*

<b>Author and date</b>	<b>Study type</b>	<b>Recruitment</b>	<b>Participant characteristics</b>	<b>Measures or data collection</b>	<b>Analysis</b>	<b>Findings</b>	<b>Strengths and weaknesses</b>	<b>Quality score</b>
Bond, K (2006)	Qualitative	<p>Purposive sampling.</p> <p>Participants contacted via Department of Corrections in US.</p>	<p>12 participants (8 men and four women).</p> <p>Age range between 31-61 years.</p> <p>Years of experience 3-30 years.</p>	Unstructured and structured interviews.	Inductive analysis and constant comparative analysis.	<p>Three categories; 1) world of the sex offender therapist (understanding sex offenders; theories of sexual offending; understanding sex offender treatment – accountability, therapeutic alliance; dealing with other people – negative reactions from other; reasons for being a sex offender therapist-internal reasons, external reasons), 2) how the sex offender therapists are affected by their work (VT, re-experiencing, avoidance, conversation,</p>	<p><u>Strengths</u> Good rationale for data collection and analysis methods.</p> <p>Considers the role of the researcher.</p> <p><u>Weaknesses</u> Evidence to challenge the themes is not mentioned.</p>	88%

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
						thoughts, compartmentalising, filtering, avoiding reminders, avoiding taking it home, avoiding feelings, turning emotions, alienation, contamination, cynicism, pessimism, increased arousal) and 3) how they manage the effects (selective focus, support, humour).		
Dean, C & Georgia, B (2011)	Qualitative	Individuals who deliver the Healthy Sexual Functioning programme (HSFP) to sex offenders in the UK.	11 participants in total (10 males, one female). Age range = mid-20s to mid-30s.  Participants had to have delivered at least two six month	Interviews, focus groups and one diary.  Diary involved participant reflecting on HSFP they had just delivered (thoughts, feelings and impact).	Content analysis	Eight themes identified - change in perception of self or others; intrusive cognitions; overly responsible; change in perception about therapeutic relationship; professional development; support available; context;	<u>Strengths</u> Rationale for research method.  Recruitment strategy was appropriate  <u>Weaknesses</u> No details of ethical issues.	59%

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
			programmes.  Forensic psychologists or trainee forensic psychologists.			one-to-one nature of the intervention.	The role of the researcher was not explored.  Not enough data to support themes	
Petry deCarvalho, S.S (2005).	Qualitative	Purposive sampling  Participants from New Jersey ATSA.	Nine males therapists (one African-American, four Latino, one Jewish and three Caucasian).  Age range, 27-43 years. 1 to 5 years of experience working with sex offenders.	Demographic data sheet, a three-generational, cultural and thematic genogram, and an audio-taped semi-structured interview. Two participants agreed to have interviews video-recorded for the researcher to use for training purposes.	Phenomenological reduction and content analysis.	Four themes on consequences; 1) impact (vigilance, cynicism, protection of family/physical, protection of family/emotional, and enhanced preparedness), 2) empathy (empathy and connection on ethnic/racial level), 3) view of masculinity (societal expectations of males, male guilt, and male discomfort), 4) Social justice (power and oppression as to gender, race, class, and sexual orientation; critical	<u>Strengths</u> Good rationale for methods used.  Clear description of the procedure.  <u>Weaknesses</u> Structure of data analysis is unclear.	86%

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
						<p>self-reflection; therapist as an agent of social change).</p> <p>Three themes on coping (support from colleagues, self-care, and sense that the work is gratifying).</p>		
Sandhu, D. K., Rose, J., Rostill-Brookes, H. J., & Thrift, S. (2012).	Qualitative	<p>Purposive sample.</p> <p>Participants from a forensic intellectual disability service in the UK. The first author had worked in the service for a number of years.</p>	<p>Eight participants (five males and three females).</p> <p>Currently delivering a sex offender treatment programme or had previously done so.</p>	Semi-structured interviews	Interpretative Phenomenological Analysis	<p>Main themes; 1) empathy challenge (sex offenders' lack of empathy for victims; participants trying not to think about the victims; separating offender from the offence), 2) the emotional impact of group work (emotional well-being of staff), 3) dealing with emotional challenges.</p>	<p><u>Strengths</u> Good rationale given for methods used.</p> <p>Findings are clear and relate to the aims.</p> <p><u>Weaknesses</u> Credibility of findings was not discussed in detail.</p> <p>Does not consider limitations of the sample or setting.</p>	69%

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
Scheela, R.A (2001)	Qualitative	Voluntarily participated  Participants from United States.	17 participants (nine males and eight females), age range (32-54 years, <i>M</i> = 47 years), years of experience working with sex offenders ranged from 6-14 years. Participants were from a range of professional backgrounds.	Unstructured face-to-face interviews were recorded.  Focus group and weekly staff meetings.	Constant comparative analysis.	Many positives to working with sex offenders.  Mitigating factors included; team support, supervision, group-decision making, not taking treatment personally and separating the person from the crime.	<u>Strengths</u> Rationale for qualitative methods.  Form of data was clear.  Enough data to support themes.  <u>Weaknesses</u> Role of researcher not discussed.  Data analysis process not clearly described.	56%
Slater, C., & Lambie, I. (2011).	Qualitative	Participants recruited via SAFE Network (largest community provider for	12 participants (seven males and five females).  Mean age = 41.08 years.	Semi-structured audio-taped interviews.	Inductive approach	Main themes included; 1) taking an optimistic perspective (ethos; holistic view of clients; witnessing change; persisting despite resistance;	<u>Strengths</u> Appropriate data collection and analysis used.  Enough quotes to support themes.	75%

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
		sex offenders) in New Zealand.	Years of experience ranged from 4-8.5 years.			strategies for staying optimistic), 2) working for community outcomes' (therapists as educators; building role models; coping with recidivism), 3) supportive agency culture (opportunities for innovation; multi-disciplinary teams; collegial spirit).	<u>Weaknesses</u> Researcher bias not considered.  Does not state if interviews were face-to-face or over the phone.	
Crabtree, D (2002)	Cross-sectional	500 surveys sent randomly to members of ATSA.  US study  42% response rate.	158 participants (age range, 26-68 years).  Mostly Caucasian participants that were psychologists.	Traumatic Stress Institute Belief Scale (TSI).  Impact of Events Scale (IES; Horowitz, Wilner & Alvarez, 1979).	2x2 ANOVA  Correlations	Participants that had a history of trauma reported more disruptions than participants who did not have a trauma history.  Males had greater disruptions than females on 'other-safety', 'other-trust', 'self-esteem', 'self-intimacy' and 'other-	<u>Strengths</u> Appropriate statistic tests used.  Discussed ethical issues.  <u>Weaknesses</u> Validity of measures not discussed.  No effect sizes or	81%

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
						<p>control.’ Correlations showed participants with personal history, more experience working with sex offenders, and worked with various age populations showed greater disruptions in self-intimacy schemas as well as intrusive symptoms.</p> <p>Work setting did not contribute to VT.</p>	<p>strength of relationships mentioned.</p>	
Ennis, L & Home, S. (2003)	Cross sectional	<p>200 participants from USA and Canada.</p> <p>Selected randomly from non-profit organisations</p>	<p>59 mental health professionals who worked with sex offenders (28 males and 31 females).</p> <p>Age range from 27-81 years (<math>M = 47</math> years).</p>	<p>The Los Angeles Symptom Checklist (LASC; King, King, Leskin &amp; Foy, 1995) – assesses Post-Traumatic Stress Disorder (PTSD)</p>	<p>Independent t-tests</p> <p>Linear regression analysis (IVs- contact hours, peer support, family support and supervision).</p>	<p>No significant differences for gender and contact hours per week with sex offenders on LASC.</p> <p>Perceived support was a protective factor for distress and PTSD symptoms.</p>	<p><u>Strengths</u> Appropriate measures were used.</p> <p>Results were clearly explained and statistical tests were appropriate.</p>	66%

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
		<p>Surveys sent to 114 participants across various settings.</p> <p>Received 112 surveys back (36% response rate).</p> <p>53% of 112 met the criteria (i.e., mental health professional and to have at least 3 hours per week with sex offenders).</p>	<p>Mostly Caucasian. Six participants were Native American, Latino/Hispanic, and Asian American.</p> <p>Professionals had different educational backgrounds.</p>				<p><u>Weaknesses</u> Reliability or validity of LASC not discussed.</p> <p>Details about scoring measures not reported.</p>	

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
Kadambi, M.A & Truscott, D. (2003)	Cross sectional	Surveys mailed to therapists working with sex offenders across Canada.  Response rate of 43%	91 participants (49 women, 42 men). Age range from 21-78 years.  Years of experience varied from 0-15 years.  9% were survivors of sexual abuse.	Treatment Provider Survey (Pearlman & McCann, 1995) - captures demographics.  Traumatic Stress Institute Belief Scale-Revision (TSI; Pearlman, 1996) – measures five psychological needs (safety, trust, intimacy, control and power) sensitive to trauma.  Impact of Events Scale (IES; Horowitz, Wilner, &	Independent t-tests - compare VT scores with comparison group of mental health professionals.  Step-wise multiple regression (IVs; years of experience, exposure to traumatic material, supervision, and venue to address concerns).	Team meetings and debriefing was associated with lower TSI scores.  Scores on the burnout scale were in the moderate range.	<u>Strengths</u> Measures were clearly explained and reliability coefficients were provided.  Appropriate statistical tests were used.  <u>Weaknesses</u> Ethical procedures were not explained.  Sampling bias of the criterion group (i.e. unclear if exposure to trauma in this group was controlled for).	72%

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
				<p>Alvarez, 1980) – assesses reactions to stressful events.</p> <p>Maslach Burnout Inventory-Human Services Survey (MBI; Maslach, Jackson, &amp; Leiter, 1996).</p>				
Steed, L & Bicknell, J (2001).	Cross sectional	<p>Voluntarily participated</p> <p>Study conducted in Australia</p> <p>38% response rate</p>	<p>67 participants (46 women and 21 men). Mean age = 37.58, mean years of counselling experience = 9.61 and mean years of experience with sex offenders = 4.73. Mean percentage of</p>	<p>Compassion Satisfaction Fatigue Self-test for helpers (Stamm, 1995) -assesses burnout, compassion satisfaction and fatigue.</p> <p>Impact of Events Scale-</p>	Trend analysis	<p>46.2% of participants scored moderate or high risk for compassion fatigue.</p> <p>19.4% were moderate to high risk of burnout.</p> <p>97% experienced low levels for compassion satisfaction.</p> <p>No clinically</p>	<p><u>Strengths</u></p> <p>Reliability coefficients were included for the measures.</p> <p>Independent variables were relevant and confounding variables were discussed.</p>	59%

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
			weekly workload with sex offenders = 68.66%.	Revised (Weiss & Marmar, 1995).		significant scores on the IES-R.	<u>Weaknesses</u> Confidence intervals and effect sizes not reported.	
Hatcher, R & Noakes, S (2010).	Mixed method design	Seven correctional settings in Australia were sent questionnaire packs.  10 packs were sent to participants the researcher personally knew.	48 participants; 39 of them currently worked with sex offenders; nine participants previously worked with sex offenders in correctional settings; two participants no longer worked with sex offenders.  Time spent working with sex offenders, <i>M</i> = 56.64 months.	<u>Quantitative</u> Professional Quality of Life Scale (ProQOL; Stamm, 2005) - assesses compassion satisfaction, fatigue, and burnout.  Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1996)  Quality of Work Life Survey (Armstrong &	<u>Quantitative</u> Independent t-tests, ANOVA and correlations.  Regression analysis  <u>Qualitative</u> Content analysis	<u>Quantitative</u> Participants were at low risk of burnout and CF.  No significant differences for age, gender, ethnicity, job role, role location, supervision and delivery type on ProQOL scores.  <u>Qualitative</u> There were 16 themes for impact which were categorized as change of perceptions of humanity (safety; suspiciousness; behaviour and motives; worth;	<u>Strengths for quantitative</u> Measures and independent variables were appropriate.  Statistical tests were suitable.  Effect sizes were reported.  <u>Weaknesses for quantitative</u> Unclear about ethical procedures.  Validity and reliability of the measures was not	69%  1  unknow  n

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
				<p>Griffin, 2004) assesses environmental work factors.</p> <p><u>Qualitative</u> Open-ended questions included in the survey.</p>		<p>acceptance; injustice; human brutality) and changes directly affecting the self (professional vigilance; affect; professional confidence; imaginary; intimacy; coping strategy; professional support; attitude to sex).</p> <p>For coping strategies there were 17 themes separated into professional (supervision; colleagues; skill level; caseload) and personal coping strategies (laughter; time-out; rewards; health and exercise; hobbies; social network; balance; rest/relaxation; safety</p>	<p>reported.</p> <p><u>Strengths for qualitative</u> There is a rationale for the study design and methods.</p> <p>Coding of themes is explained.</p> <p>There is enough data to support themes.</p> <p><u>Weaknesses of qualitative</u> Role of the researcher is not considered.</p>	

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
						plan, and other (community action; home/work; cognitive; affective). For collegial support there were eight themes (debrief/discuss; share experiences; understanding; generate strategies; normalisation; down-time; negative experiences; not used).		
Jacobsen, L. N. (2014)	Mixed methods	Theoretical sampling  US study	10 therapists (six women and four men).  Age range 31-64 years.  Years of experiences from 2-32 years.	<u>Quantitative</u> Modified Secondary Trauma Questionnaire (STQ-R; Motta & Joseph, 1998) – assesses secondary traumatic stress.	<u>Quantitative</u> Measures scored. No statistical tests used.  <u>Qualitative</u> Grounded theory.	<u>Quantitative</u> STQ-R – Mean score of 29.6. Only 3 participants received clinically significant scores.  IES – Mean score of 4.7. No participants received clinically significant scores.	<u>Strengths</u> Good rationales for qualitative methods.  <u>Weaknesses</u> No statistical tests used.  No discussion of confounding variables that	78%

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
				<p>Impact of Events Scale (IES; Horowitz, Wilner &amp; Alvarez, 1979)</p> <p><u>Qualitative</u> Semi-structured interviews</p>		<p><u>Qualitative</u> Four categories with major and minor themes; 1) components of the therapeutic process that mitigate negative experiences (MAJOR = seeing the change and good in clients; finding the work rewarding/interesting. MINOR = developing genuine empathy/realistic; role in preventing future victims), 2) characteristics of treatment interactions that negatively contribute to therapists' experience (MAJOR = more security conscious; feeling threatened or uncomfortable. MINOR =</p>	<p>may have impacted on STQ-R and IES scores.</p> <p>Some of the participants were friends with the researcher. Therefore, may have been aware of aims of research.</p>	

Author and date	Study type	Recruitment	Participant characteristics	Measures or data collection	Analysis	Findings	Strengths and weaknesses	Quality score
						<p>frustration/patience being tested-resistance), 3) perceptions of issues that place therapists at risk of trauma (MAJOR = poor boundaries; previous trauma/unresolved issues. MINOR = poor coping skills/isolation), 4) coping strategies/mitigating factors (MAJOR = self-care; separation of personal and professional lives; supervision/consultation; good support-home and work).</p>		

## **Descriptive Data Synthesis**

As previously mentioned, 12 publications were included in this review; six publications adopted a qualitative approach, four publications were cross sectional and two publications used a mixed methods design incorporating qualitative and cross sectional aspects. The quality percentages ranged from 56% to 88% with a mean of 71.5%. One study was excluded due to scoring 22% on quality assessment (Farrenkopf, 1992). The total number of participants across the 12 publications was 502. This included 112 males and 217 females. However, the mixed methods research publication (Hatcher & Noakes, 2010) did not include any details about the proportion of males and females in their sample. Therefore, the figures are likely to be higher. The age range was between 20 and 78 years. The years of experience of working with sex offenders across all studies ranged from six months to 32 years. The studies ranged in location with two studies conducted in Australia (Hatcher & Noakes, 2010; Steed & Bicknell, 2001), three pieces of research took place in the United Kingdom (Dean & Barnett, 2010; Sandhu, Rose, Rostill-Brookes & Thrift, 2012; Slater & Lambie, 2011), five were carried out in America (Bond, 2006; Crabtree, 2002; Jacobsen, 2014; Petry deCarvalho, 2005; Scheela, 2001), another one in Canada (Kadambi & Truscott, 2003) and one study recruited participants from both America and Canada (Ennis & Home, 2003).

All publications were aimed at exploring the impact of working therapeutically with sex offenders, identifying the factors that predict and mitigate negative outcomes, and the coping strategies employed to overcome the impact. The qualitative studies used a combination of methods including unstructured interviews, focus groups (Bond, 2006; Dean & Barnett, 2010; Scheela, 2001), semi-structured interviews (Jacobsen, 2014; Petry deCarvalho, 2005; Slater & Lambie, 2011; Sandhu, Rose, Rostill-Brookes & Thrift, 2012), diary extracts (Dean & Barnett, 2010), taking notes in team meetings (Scheela, 2001) and open-ended questions in a

survey (Hatcher & Noakes, 2010). For the cross sectional studies a range of measures were used; Impact of Events Scale- Revised (IES-R (Hatcher & Noakes, 2010; Steed & Bicknell, 2001), non-revised version of the Impact of Events Scale (IES) (Crabtree, 2002; Kadambi & Truscott, 2003), Traumatic Stress Institute Belief Scale (TSI) (Crabtree, 2002; Kadambi & Truscott, 2003), Maslach Burnout Inventory (MBI) (Kadambi & Truscott, 2003), The Los Angeles Symptom Checklist (LASC) (Ennis & Home, 2003), Compassion Satisfaction/Fatigue Self-test for helpers (Steed & Bicknell, 2001), Quality of Work Life Survey (Hatcher & Noakes, 2010) and the Professional Quality of Life Scale (ProQOL) (Hatcher & Noakes, 2010).

#### Impact of working with sex offenders

##### Positive

In total there were five publications (Ennis & Home, 2003; Hatcher & Noakes, 2010; Kadambi & Truscott, 2003; Scheela, 2001; Slater & Lambie, 2011) that found that professionals who work therapeutically with sex offenders may suffer psychologically from their work. However, for the majority of participants the impact fell within the moderate range. For example, Kadambi and Truscott (2003) found that the mean scores for burnout fell within the moderate range for all subscales; emotional exhaustion ( $M= 19.42$ ,  $SD= 10.73$ ), depersonalization ( $M= 8.34$ ,  $SD= 5.63$ ) and personal accomplishment ( $M= 37.78$ ,  $SD= 6.28$ ). Consistent with these findings, Ennis and Home (2003) found that, on the whole, participants reported low levels of psychological distress ( $M= 17.24$ ,  $SD= 13.90$ ) and PTSD symptoms ( $M= 9.07$ ,  $SD= 7.56$ ).

Similarly, the quantitative findings from Hatcher and Noakes (2010) found the sample of sex offender treatment providers were at low risk of burnout and CF. Additionally, none of the

participants scored within the moderate or severe range for IES-R. Interestingly, findings from Scheela (2001) showed that despite therapists experiencing negative changes as a result of working with sex offenders, such as worrying about offenders' re-offending, safety concerns and suspiciousness of others, on the whole therapists were positive about their work with sex offenders, reporting that they enjoyed the challenges involved and witnessing offenders' growth and change. These findings suggest that individuals who work therapeutically with sex offenders may suffer little impact from their work.

### Negative

There were four publications which suggested participants suffer psychologically from providing treatment to sex offenders, experienced CF, and burnout (Crabtree, 2002; Dean & Barnett, 2010; Hatcher & Noakes, 2010; Steed & Bicknell, 2001). These changes related to disruptions to cognitions, concerns over safety and suspiciousness of others. However, there is evidence to contradict the above findings. For instance, Steed and Bicknell (2001) found that 46.2% of the sample was at moderate or high risk of CF and 19.4% of the sample was at moderate to high risk of burnout. The results also revealed 97% of participants indicated low levels of compassion satisfaction, therefore suggesting that participants may not attain pleasure from doing their work. Yet the study also found that none of the therapists obtained clinically significant scores on the intrusive, avoidant and hyperarousal scales which form the IES-R. This suggests that participants are not suffering from PTSD symptoms.

The qualitative aspect from Hatcher and Noakes's (2010) research supports the notion that professionals who treat sex offenders are impacted by their work. For example, two themes were found; perceptions of humanity and changes directly affecting the self. The former relates to changes in cognition about the world and the latter theme relates to changes to

professional and personal identity. The main ways in which sex offender treatment workers were affected by their work were concerns regarding safety (installing alarms and protecting their family) and an increased suspiciousness of interactions between men and children. Likewise, the qualitative findings from Dean and Barnett (2010) found participants to be negatively impacted by their work. For instance, they found participants to experience change in perception of self or others which involved questioning their view of themselves in relation to professional competence and being more critical of others. The second theme was intrusive cognitions where participants would think about offender treatment outside of the work setting or things outside of work would trigger thoughts about the client's sexual fantasies. The other themes that emerged related to feeling overly responsible for treatment, the change in perception of the therapeutic relationship and professional development. Themes related to mitigating factors and coping strategies will be discussed below.

#### Factors that mediate or mitigate the impact of working with sex offenders

In terms of the factors which contribute to negative consequences, there was one qualitative study found that participants had negative experiences if the delivery of treatment was on an individual basis than group treatment (Dean & Barnett, 2010). A quantitative study found that participants with a trauma history experienced greater distress than participants without a trauma history (Crabtree, 2002). All other studies failed to find significant relationships between the variables of interest (sex offender contact hours, years of experience, family support, supervision hours, gender, educational level, age, ethnicity, job role, role location, delivery type, trauma history) and the outcome measures (Ennis & Home, 2003, Hatcher & Noakes, 2010; Steed & Bicknell, 2001). This indicates that the above factors may not influence or predict negative impact of working with sex offenders.

There were a number of studies, both cross sectional and qualitative that found perceived social support and supervision to be important factors in alleviating the distress of working with sex offenders (Dean & Barnett, 2010; Ennis & Home, 2003; Kadambi & Truscott, 2003; Scheela, 2001). For instance, after entering four variables (number of sex offender contact hours, peer support, family support and supervision hours) into a regression equation, Ennis and Home (2003) found that the model significantly explained 26.70% of the variance for psychological distress,  $F(4, 53) = 4.8268, p = .0021$ . The variable that was most significantly negatively associated with psychological distress was perceived peer support ( $\beta = -6.67, p = .0047$ ). This suggests therapists who feel they are receiving support from their peers may be less likely to report psychological distress. The same regression model also significantly explained 27.70% of the PTSD symptom scale  $F(4, 53) = 3.95, p = .0070$ . Again, the predictor significantly associated with lower reporting of PTSD symptoms was perceived peer support ( $\beta = -3.33, p = .0107$ ).

Similar findings were obtained in Kadambi and Truscott's (2003) study. After entering four variables into the step-wise multiple regression model (amount of professional time spent working with sex offenders, perceived exposure to traumatic material, a venue to address personal impact of work and whether participants were supervised) the only variable to significantly predict the scores on the TSI scale was having a perceived outlet in which participants could address the personal impact of their work,  $R^2 = .30, F(1, 89) = 8.53, p = .004$ . These outlets included clinical team meetings, meetings with colleagues, supervision, and debriefing. Again these findings indicate that a support network is an important strategy that may prevent professionals suffering from their work.

## Coping

Four studies found that participants experienced both positives and negatives when working with sex offenders. Participants were able to cope with negatives using strategies like supervision and sharing experiences with colleagues (Bond, 2006; Hatcher & Noakes, 2010; Jacobsen, 2014; Petry deCarvalho, 2005; Sandhu, Rose, Rostill-Brook & Thrift, 2012). In addition, context was also perceived as a mitigating factor. Participants felt factors such as a comfortable environment and being a part of a large team of therapists assisted with reducing any negative impact of treating sex offenders (Dean & Barnett, 2010). Likewise, Scheela (2001) discovered that participants felt factors like team support, supervision, group decision making, separating the person from the crime and avoiding taking full responsibility for the treatment encouraged positive feelings when working with sex offenders. Furthermore, using holiday entitlement and adopting self-talk strategies were found to be useful coping mechanisms for participants (Dean & Barnett, 2010).

## Methodological Considerations

As previously mentioned, the studies included in this review either adopted qualitative, quantitative or mixed method designs. The designs of the studies require further discussion because the methods used each come with strengths and limitations that may impact on the quality of the findings.

One of the common strengths of qualitative studies in this review, was the provision of a strong rationale for choosing qualitative approaches, and the process of collecting data/analysis was explicitly explained (Bond, 2006; Dean & Barnett, 2010; Petry deCarvalho, 2005, Sandhu, Rose, Rostill-Brooks & Thrift, 2012; Scheela, 2001; Slater & Lambie, 2011). The implication of clearly explaining the rationale for methods, data collection, and analysis

is it helps the reader to understand how the methods answer the aims, and how the themes were selected.

A common limitation of the qualitative studies (excluding theses) was the authors did not explain their own role during the research process (Dean & Barnett, 2011; Scheela, 2011). A consequence of this is it is difficult to establish if the data collected or the themes selected have been shaped by the authors' views and experiences. Furthermore, if there is no information about the researcher's role during the data collection/analysis process, it is unclear if the findings accurately describe the experiences of the participants or have been shaped by what the researcher wanted to find out.

One of the strengths of the quantitative studies was that the independent variables measured were relevant to the research questions, and were consistent with what had been covered in the literature. Another positive was the use of appropriate measures to assess psychological distress (Crabtree, 2002; Ennis & Home, 2003; Kadambi & Truscott, 2003). However, the reliability and validity of the measures were not consistently discussed across studies, and the norms were not available (Ennis & Home, 2003; Hatcher & Noakes, 2010). This creates difficulties in determining how reliable the surveys were in measuring concepts such as VT, CF, PTSD and burnout. Moreover, it creates problems in understanding how participant scores compare with population norms (i.e., whether the scores fall within the moderate or clinical range). Another limitation of some quantitative studies was that the strength of significant findings was not supported through the reporting of effect sizes or confidence intervals (Crabtree, 2002; Steed & Bicknell, 2010).

Other limitations were sample sizes of both quantitative and qualitative studies were small, and recruitment in some studies was voluntary with little details known about the motivations for participants taking part. In particular, one study involved the researcher conducting interviews with colleagues in their own workplace (Scheela, 2001). This presents issues such as sampling bias and respondent bias. This could take the form of the author selecting participants that she knew would agree with her aims or participants saying what they think the author wanted to know. Therefore, the findings of this study may not represent what participants truly feel and have experienced.

## **Discussion**

The aim of this review was to understand the extent to which professionals working with sex offenders are impacted by their work, the factors that increase the likelihood of adverse consequences, to identify those factors which protect professionals from experiencing distress, and the coping strategies employed by professionals. Included in this review were 12 studies; six publications adopted a qualitative approach (Bond, 2006; Dean & Barnett, 2010; Petry deCarvalho, 2005; Sandhu, Rose & Rostill-Brooks, 2012; Scheela, 2001; Slater & Lambie, 2011), four publications were cross sectional (Crabtree, 2002; Ennis & Home, 2003; Kadambi & Truscott, 2003; Steed & Bicknell, 2001) and two publications used a mixed methods design incorporating qualitative and cross sectional aspects (Hatcher & Noakes, 2011; Jacobsen, 2014).

The review findings indicated that six publications (Ennis & Home, 2003; Hatcher & Noakes, 2010; Kadambi & Truscott, 2003; Jacobsen, 2014; Scheela, 2001; Slater & Lambie, 2011) found professionals who work therapeutically with sex offenders to be generally satisfied with their role and report low levels of psychological distress. The quality scores for these

studies ranged from 56% to 88%. There were five publications which suggested participants do suffer psychologically from providing treatment to sex offenders as well as from CF and burnout (Bond, 2006; Crabtree, 2002; Dean & Barnett, 2010; Hatcher & Noakes, 2010; Petry deCarvalho, 2005; Sandhu, Rose, Rostill-Brookes & Thrift, 2012; Steed & Bicknell, 2001). The studies used a range of measures to examine negative consequences, the samples varied in terms of participant characteristics (years of experience, age, professional background), and the studies were conducted in different countries. Therefore, the sample represented a range of sex offender treatment professionals.

The results on the impact of working with sex offenders varied considerably between different settings and professionals. An explanation for the differences in findings could be related to some professionals having greater access to resources that protect them from the negative consequences of working with sex offenders. For example, professionals may have regular supervision and more opportunities to share their experiences with colleagues. Another reason for the difference in findings could be due to some professionals working in settings that adopt a culture where they accept that negative consequences of work can happen, and ensure other protective strategies are in place like a large team of practitioners to support one another, to encourage group decision-making, to deliver more group treatment, to offer training, and promote self-care strategies (i.e., taking annual leave, and balancing work and home).

The difference in results could also be explained by the measures used. For instance, Jenkins and Baird (2002) suggested that the content validity of measures for CF and VT (i.e., Compassion Fatigue Self-Test; CFST and Traumatic Stress Institute Belief Scale; TSI) may need to be refined in order for the unique features of each construct to be measured. This is

because in their study it was found that there was some overlap between the CFST and TSI with general distress. An implication of this is it is difficult to establish if reported symptoms from professionals who work with sex offenders are attributed to personal stressors, or the therapeutic nature of the job (Sabin-Farrell & Turpin, 2003). Furthermore, researchers have suggested that concepts like burnout, STS and VT appear to have attracted the attention of professionals, resulting in them being accepted as likely consequences of working with traumatic material. This is despite research suggesting the constructs are poorly defined and not well measured (Devilley, Wright & Varker, 2009; Sabin-Farrell & Turpin, 2003). Similarly, Clarke (2011) suggested that the existing measures lack face validity, have limited research on construct validity, and are not driven by solid theory. Furthermore, she also highlights that the measures used to assess psychological distress (i.e., MBI or IES) may not accurately measure the specific consequences sex offender treatment workers are likely to encounter.

There were no significant findings for factors which predict negative impact for the cross sectional studies. Delivery of treatment was reported as an important variable by participants in a qualitative study by Dean and Barnett (2010). However, the study comprised of 11 participants who were responsible for delivering a specific sex offender treatment programme. Therefore, delivery type may only be specific to those people who deliver the HSFP programme. Consequently, it may be difficult to apply the findings to other populations who work in a different context with sex offenders.

Four studies found evidence of the mitigating factors (Dean & Barnett, 2010; Ennis & Home, 2003; Kadambi & Truscott, 2003; Scheela, 2001). For instance, Hatcher and Noakes (2010) found supervision and sharing experiences with others to be an important coping strategy

when working with sex offenders. In another study, participants reported making the most of holiday entitlement and using self-talk strategies to overcome distress (Dean & Barnett, 2010). These findings derive mainly from qualitative studies which used methods such as unstructured interviews, focus groups and open-ended questions. However, there was insufficient data to support and challenge the themes that emerged which impacts the quality of the themes. In particular, the qualitative studies had few quotes to support themes, and there was no discussion about participants' experiences that did not fit within the themes (Dean & Barnett, 2010; Scheela, 2001; Slater & Lambie, 2011).

In summary, the results show that there are inconsistencies on the extent to which professionals working with sex offenders are impacted by their work. This is also applicable to the factors which predict negative consequences. Although, the qualitative pieces of research appear to provide much more consistent themes about the kinds of consequences sex offender treatment workers experience. However, there is consistency between cross sectional studies and qualitative studies on the factors which mitigate distress and the coping strategies used. Future research will need to take into account the methodological limitations found in this review particularly in establishing the clinical norms for the measures. This will assist to fully understand the extent professionals are impacted by their work. In addition, research needs to focus on establishing the factors which predict or mitigate distress in order for professionals and managers to implement preventative and protective measures.

### Strengths and Limitations of the Review

Over 65% of the results presented in this review consist of published studies, and therefore, may be subject to publication bias (Higgins & Green, 2011). Contrary to the view that published studies tend to report significant findings (The Cochrane Collaboration, 2002), the

results in this review have been mixed with some studies reporting non-significant findings. This is possibly due to research within this area being in its infancy, and therefore, studies are aiming to clarify whether professionals working with sex offenders are impacted by their work and to what extent. The author attempted to contact experts within the field to obtain unpublished work but was unsuccessful. Likewise, those studies that fell into the categories of 'yes' and 'maybe' but could not be obtained due to time constraints, and the word count. The inclusion of additional studies may have provided alternative findings, or provided further insight into the factors that mediate or moderate psychological distress. Therefore, the absence of these studies raises uncertainty about whether the conclusions raised in this review are representative of all the studies conducted. However, the review did include unpublished doctorate theses which provided substance, and new insights into professionals who work with sex offenders.

Further strengths of the review were that the search terms covered a variety of terms which adequately represented the area of enquiry. The search itself was conducted across a range of databases ensuring all types of disciplines (psychological, social science, medical) were included, increasing the variability of the studies. The quality assessment tools used captured a number of issues including sampling bias, measurement bias, as well as overall clarity of the studies, including the results. It may have been helpful for another individual to quality assess the articles to ensure the scores awarded for each item were consistent with the author's scores. This would have increased the reliability of the quality assessments.

Despite the inconsistent findings in the review there are implications for clinical practice. Professionals working with sex offenders need to be aware of how their work may have an impact on them. Precautions such as attending supervision and speaking to colleagues appear

to be essential in preventing professionals suffering psychologically from their work. For those professionals who do not work as part of a team (i.e., those that are in independent work or private practices), may benefit from registering with organisations like NOTA. This would allow them to be a part of a network of sex offender treatment workers from whom they could seek support (i.e., attending training events). By being proactive, professionals are protecting themselves from experiencing distress as a result of working with sex offenders. The findings also highlight the importance of managers making arrangements for staff to attend regular supervision and to offer support for those who are impacted by their work such as allowing annual leave.

### Conclusion

From the findings of this review it is unclear the extent to which sex offender treatment providers are negatively impacted by their work. It is also uncertain which factors predict psychological distress in sex offender treatment providers. Future systematic reviews on the impact of working with sex offenders should aim to include articles that could not be obtained. They should also aim to use other sources of information that may add to the findings such as conference papers, and presentations. However, the systematic review has highlighted the factors which mitigate negative consequences and coping strategies used by professionals working with sex offenders. Professionals need to be mindful that the work they do with sex offenders may impact on them psychologically.

Based on this review, the qualitative studies have provided the most consistent findings about the impact of working with sex offenders. Therefore, future research should continue to investigate whether sex offender treatment providers suffer from their work and the factors that lead to distress through qualitative methods used in this review such as interviews, focus

groups, and diary extracts. In order for quantitative research in this area to progress, studies need to assess the reliability of the measures, and to establish if they accurately measure concepts like VT, CF, PTSD and burnout. It may also be useful to consider alternative psychometrics to measure distress like the Trauma Symptom Inventory (Briere, 1995) which will be as discussed in Chapter 3.

## **CHAPTER 3**

# **CRITIQUE OF THE TRAUMA SYMPTOM INVENTORY**

## **Introduction**

There has been a growing interest in how caring professionals are impacted by their work. In the 1990s this was extended to those working with sex offenders (Moulden & Firestone, 2007). The kinds of consequences sex offender treatment workers may face as a result of encountering client's traumatic experiences include burnout, countertransference, compassion fatigue, and vicarious traumatisation (Ellerby, 1997; Farrenkopf, 1992; Kadamabi & Truscott, 2003; Shelby, Stoddart, & Taylor, 2001). Although these were defined in Chapter 1; to recap: burnout refers to individuals experiencing little personal accomplishment, emotional exhaustion and depersonalisation as a result of their work (Maslach, 1982). Countertransference describes the affective, cognitive and behavioural responses of professionals towards clients (Figley, 2002; Tyagi, 2006). Compassion fatigue (CF) (also described in the literature as secondary traumatic stress; STS) occurs when listening to clients' traumatic stories leading to symptoms similar to those of Post-Traumatic Stress Disorder (PTSD). Lastly, vicarious traumatisation (VT) refers to the changes in cognitions as a result of empathically engaging with the client's traumatic material and experiencing PTSD symptoms (McCann & Pearlman, 1990).

For this critique the Trauma Symptom Inventory (TSI; Briere, 1995) will be reviewed, as it assesses a range of symptoms (emotional, physical and cognitive) that occur following a traumatic experience. Other reasons for selecting this tool to critique are there is a considerable body of research on its psychometric properties. Secondly, although it has been used less often to assess consequences of working with sex offenders in comparison to other measures (i.e. Impact of Events Scale-Revised, IES-R; Weiss & Marmar, 1996), research has reported it as one of the most popular assessments used to measure PTSD symptomology (Elhai, Gray, Kashdan & Franklin, 2005). Therefore, it has potential to be used as an

alternative or as an additional tool to measure the impact of working with sex offenders. Furthermore, in Chapter 2 the review found that the findings on the impact of working with sex offenders varied across settings, and professionals despite similar measures being used. This highlighted a need for future research which aims to improve existing measures so they accurately measured the construct, or to use alternative tools like the TSI.

The TSI is unique as it has three validity scales which other PTSD assessments do not have. Therefore, it can determine respondents' response style, and can be used to detect true/false cases of PTSD. Hence, the measure would be ideal for both clinical and research purposes. The TSI-2 (Briere, 2010) is a revised version of the TSI. The psychometric properties of this tool will not be discussed in this review due to limited research being conducted on how well the tool measures PTSD symptomology.

The TSI will be critiqued using characteristics that Kline (1986) has suggested make a good test. These include psychometrics being an interval scale, reliable, valid, and have appropriate norms. This is reinforced by Briere and Spinazzola (2005) who suggested that psychological tests should have good reliability and validity, and be standardised on a representative sample of the general population. In addition, they indicated that tests should also be able to accurately differentiate between true cases of PTSD (sensitivity) and those cases where PTSD is not present (specificity).

This chapter will begin by providing an overview of the TSI which will cover the aims of the tool, subscales, administration, scoring and norms. This will be followed by a detailed discussion on the reliability and validity of the TSI as well as sensitivity and specificity. Reliability will involve considering internal and test-retest reliability. In respect to validity

this will be assessed by discussing the following; face validity, concurrent validity, content validity, predictive validity and construct validity. Research evidence will be provided throughout to critique the TSI. The review will end with a key summary of the points highlighted as a result of the review and wider implications.

### **Overview of the Tool**

The TSI is a 100 item self-report interval scale that assesses the frequency of acute and chronic symptoms following traumatic experiences such as rape, abuse, assault, natural disasters and death of a family member. The manual does not specify the traumas it should be used for, suggesting that it can be utilised for a range of distressing situations. The measure takes 20 minutes to complete using pen and paper. It requires the participant to rate items on a 4 point scale ranging from zero (“never”) to three (“often”).

When constructing the TSI, Briere (1995) consulted with clinicians who specialised in trauma and reviewed the trauma literature. This included research on PTSD, symptoms following childhood sexual abuse, adult victimisation and natural disasters. He also referred to other measures like the Structured Clinical Interview Scale for the DSM-III PTSD scale (Spitzer & Williams, 1986), as well as another tool he had devised earlier called the Trauma Symptom Checklist (TSC; Briere & Runtz, 1989). The TSI comprises of ten clinical subscales, five of which are related to the DSM-IV (2000) criteria for diagnosing PTSD, and the remaining five scales measure general trauma-related symptoms (Briere, 1995). Examples of the items included in the scale can be found in Appendix 7. A description of each of the ten subscales is provided below;

- 1) Anxious arousal (AA) refers to symptoms of anxiety and hyper-arousal which can include shaking, worrying, and hyper-vigilance.

- 2) Depression (D) subscale focuses on low mood and cognitions. It covers symptoms such as feeling worthless, viewing the future as hopeless, and feeling sad.
- 3) Anger/irritability scale (AI) is concerned with angry feelings, the internal experience of anger, and angry behaviours including frustration and fantasies of hurting others.
- 4) Intrusive experiences (IE) relates to post-traumatic symptoms interfering with awareness such as nightmares, flashbacks and unwanted memories.
- 5) Defensive avoidance (DA) subscale measures attempts to intentionally avoid unwanted thoughts, feelings, and situations.
- 6) Dissociation (DIS) is a defence mechanism used to alter conscious awareness. It includes behaviours such as emotional numbing, distraction and depersonalisation.
- 7) Sexual concerns (SC) subscale assesses sexual dysfunction and distress through behaviours like negative feelings during sex and fear of sexual matters.
- 8) Dysfunctional sexual behaviour (DSB) subscale refers to sexual behaviours that are problematic and may lead to harm such as using sex to manage distress or being attracted to dangerous persons.
- 9) Internal self-reference (ISR) subscale measures problems related to identity and the internal-self.
- 10) Tension reduction behaviour (TRB) assesses the extent to which behaviours such as aggression and self-harm are adopted to alleviate negative feelings.

During the development phase of the TSI, confirmatory factor analysis was conducted on the ten clinical scales to determine the structure of the tool using a random standardised sample of 836 American males and females 18 years and over from the general population. The mean age of the sample was 47.3 years and over 75% of the sample was Caucasian. The manual indicates the sample was similar to the US 1990 Census. However, Caucasian participants

who were married and educated were over-represented. Briere (1995) found that the data supported a three factor model of trauma. The 10 subscales can be divided into three composite scales; 1) the trauma scale measures current levels of trauma and the impact it has on the individual. It includes IE, DA, DIS and ISR subscales; 2) the self-scale represents problems with identity and includes ISR, SC, DSB and AI; 3) the dysphoria scale measures negative mood and comprises of AI, D and AA subscales. In addition to the composite scales, the TSI also includes three validity scales that facilitate with identification of response style. Response level (RL) is designed to assess under reporting of symptoms or defensiveness. Inconsistent response (INC) detects participants whose responding may well reflect a lack of attention, and atypical response (ATR) relates to over responding (i.e., feigned PTSD symptoms).

The raw scores are obtained by adding the scores from each of the subscales and validity scales. The raw scores are then converted to T scores using a normative sample. Norms are available for two age categories; 18-54, and 55+, and are separated by gender. T scores of 65 or higher on the five PTSD related scales (AA; D; AI; IE; DA) reflects significant distress following a traumatic event. Whereas T scores of 65 or above for the other five scales (DIS; SC; DSB; ISR; TRB) suggest the individual has insufficient resources to cope with the distress. The RL validity scale includes items that were least likely to be scored as zero based on how the standardised sample had scored on these items. Therefore, scores of zero for these items indicate participants may be underreporting symptoms or responding defensively. The INC validity scale is assessed by inconsistent responses to 10 pairs of items that tap similar content areas. The ATR scale includes items that were less likely to be reported as present by the normative sample. Therefore, endorsement of these items may indicate over responding.

The manual also includes norms for Navy recruits (N = 3659), a university sample (N = 279), and psychiatric inpatients/outpatients from America (N = 370).

## **Reliability**

### Internal consistency

Internal consistency refers to the consistency of items measuring the same construct (Chen & Krauss, 2004). Initial studies of the TSI were conducted by Briere (1995) who found the scale to have good internal consistency using Cronbach's Alpha. The mean alpha co-efficients for the TSI were .86 amongst the standardized sample, .87 for the psychiatric sample, and .84 for both University and military samples. The alpha range for the standardised sample was between .74 and .91. Similarly, Briere, Elliott, Harris and Cotman (1995) found when the TSI was administered to 370 outpatients at a clinical centre the mean alpha reliability for all the scales was .87 with a range between .74 and .90. These findings support Briere's original study in that the TSI items appear to measure the same construct across different samples.

Since publication of the TSI there have been a number of studies which have investigated the internal reliability of the TSI across different samples. For instance, Runtz and Roche (1999) administered the TSI on a sample of 775 adult women in Canada enrolled on a Psychology course. They found the average reliability of the TSI was .82 across the ten clinical scales. The alpha co-efficients for each of the subscales were; AA ( $\alpha = .80$ ), D ( $\alpha = .90$ ), AI ( $\alpha = .88$ ), IE ( $\alpha = .87$ ), DA ( $\alpha = .89$ ), DIS ( $\alpha = .81$ ), SC ( $\alpha = .81$ ), DSB ( $\alpha = .81$ ), ISR ( $\alpha = .83$ ), and TRB ( $\alpha = .64$ ). The study also reported the alpha co-efficients for the two validity scales; ATR achieved .69 and RL was .60. The findings above indicate that the TSI has moderate to good reliability. However, the alphas highlight that the TRB scale had the lowest reliability along with the validity scales. The alphas received for these scales are below the

recommended cut off of .70 (Nunnally, 1978) therefore raising concerns regarding how much they add to the reliability of the tool.

Another study that assessed the reliability of the TSI was Synder, Elhai, North and Heaney (2009). The sample included 221 veterans suffering with PTSD from an outpatient treatment centre in the United States. They found the mean internal reliability was .83 across the ten scales, with a range from .73 for TRB to .91 for AI. Again this study highlights that the TSI has good internal reliability. It also suggests, like Runtz and Roche (1999) that the TRB subscale has the lowest alpha co-efficient out of the ten scales, although in this study it is slightly above the cut-off point of .70. Limitations of this study were that the sample comprised primarily of Caucasian males who had been diagnosed with PTSD. Therefore, the results on the reliability of the study may not be generalisable to those veterans who have yet to be diagnosed with PTSD, to women and other ethnic minorities.

Reliability of the TSI has also been assessed in adapted versions of the TSI. For example, Wang, Cosden and Bernal (2011) found when the Spanish TSI was administered to 225 Spanish speaking students in Puerto Rico the mean reliability co-efficient was .84, with a range from .69 to .91. These findings are similar to those from Briere (1995) and with the later studies discussed above. The low co-efficient of .69 was again for the TRB scale suggesting that out of all the scales this seems to be the least related to the construct. Despite this, on the whole, the findings indicate that even when the TSI is adapted to other languages it appears to be a reliable tool to assess PTSD symptomology. Furthermore, strengths of the scale are that it can be used with a range of populations and therefore has wide clinical and/or research utility which was one of the aims of the tool when it was initially developed (Briere, 1995).

Another study which examined the reliability of TSI in the Italian language was conducted by Gambetti, Bensi, Nori and Giusberti (2011). The TSI was distributed to 425 participants across three groups; the 'non clinical sample' was recruited via an advertisement or through the authors' personal contacts. The 'clinical sample' included participants who had been diagnosed with a mental illness either related to anxiety or mood. The 'PTSD sample' comprised of those who had been assessed to have PTSD at a treatment centre. The study found the reliability for the clinical scales ranged between .71 and .90, and for validity scales was .71 to .83 across all three groups. Following closer inspection, the TRB, SC and the ATR were found to have lower alpha co-efficients of .70, .70 and .71, respectively, for the 'non clinical sample'. However, the alpha co-efficient were higher in the clinical/PTSD samples. These findings indicate that reliability appears to be higher for these scales in samples where PTSD has already been diagnosed or for participants who are experiencing other difficulties. This is consistent with Runtz and Roche (1999) who found the reliability of the TRB scale tends to be lower in student populations. This highlights that perhaps the TSI is unable to consistently measure TRB symptomology in student samples. Despite this, the above findings are similar to the studies discussed earlier indicating that, on the whole, the TSI is a reliable tool to use to measure PTSD symptomology across a range of samples, populations and countries.

In respect to the inter-correlations between the clinical subscales, Runtz and Roche (1999) found the mean correlation co-efficient was  $r = .51$  with all correlations being significant at  $p < .001$  across 771 participants. This supports Briere (1998) who also found that the mean inter-correlations was,  $r = .54$  across the 10 subscales. As recommended by Dancey and Reidy (2011), these results represent a moderate correlation between the subscales. This indicates that the subscales all relate to one another and therefore measure the same concept.

### Test-retest reliability

Test-retest reliability relates to obtaining the same results from respondents across two occasions (Lavrakas, 2008). There is no information in the manual relating to the test-retest reliability of the TSI or in other studies. One of the reasons given for this is that archival data has often been used (Gambetti et al. 2011; Synder et al. 2009). Consequently, it is difficult to critique how well the TSI is able to yield the same score for an individual over different testing times. This requires further attention as obtaining similar results from a person at different points provides an indication of how consistent the TSI is in obtaining the same results. The wider implications are that clinicians may be relying on the results of one testing to determine symptomology and make decisions about whether an individual requires treatment. The problem with this is the TSI relies on self-report which may be influenced by confounding variables such as the respondent's mood, or worries/concerns they may have (Runtz & Roche, 1999). Furthermore, clinicians' cannot be confident that the individuals' results are an accurate reflection of the clients' symptomology without further testing. To counteract this, it has been suggested that PTSD is unlikely to change with time and symptoms can persist for months or even years (Royal College of Psychiatrists, n.d). This suggests that evidence of test-retest reliability may not be essential for TSI as PTSD symptoms are likely to remain consistent and therefore test-retest reliability should be high.

### **Validity**

#### Face validity

In respect to face validity (i.e., the perception that the scale appears to measure what it is supposed to) (Borstein, 2004), there is no information about this within the literature. Therefore, the author of this critique inspected each item of the scale to assess relevance to the aims of the tool and descriptions of the subscales. Overall, the items appeared to measure

acute and chronic symptoms. When reading through the items the author was able to identify which items fitted into each of the subscales apart from the following three items; item 11 ('lower back pain), item 21 ('fainting') and item 49 ('aches and pains). These did not appear to fit into any of the subscales although common sense understanding would assume that these are symptoms that could occur following a traumatic experience (Royal College of Psychiatrists, n.d). It would be expected that participants responding to the tool would also find most items appropriate and relevant to what the tool is supposed to measure. This suggests the TSI has good face validity and respondents would be able to recognise what they are being asked to consider.

## **Criterion Validity**

### Convergent validity

Convergent validity refers to how well a test correlates with other tools that measure the same construct (Cunningham, Preacher & Banaji, 2001). The convergent validity of the TSI has been assessed using a range of tools that measure PTSD and other trauma related symptoms. These have included the Beck Depression Inventory-II (BDI-II; Beck, Steer & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck & Steer, 1993), the Impact of Events Scale (IES; Horowitz, Wilner & Alvarez, 1979), the Life Experiences Survey (LES; Sarason, Johnson & Siegel, 1979), the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, Graham, Ben-Porath, Tellegen, Dahlstrom & Kaemmer, 2001), the Mississippi Combat PTSD Scale (M-PTSD; Keane, Caddell & Taylor, 1988), the Perceived Stress Scale (PSS; Cohen, Kamarck & Mermelstein, 1983), the Personality Assessment Inventory (PAI; Morey, 2007), the Post-traumatic Diagnostic Scale (PDS; Foa, 1995), the Survey of Recent Life Experiences (SRLE; Kohn & Macdonald, 1992), and the Symptom Checklist-36 (SCL-36; McNiel, Greenfield, Attkisson, & Binder, 1989).

There is no information in the manual regarding how well the TSI correlated with the MMPI-2 and PAI although they were administered on 100 University students (Briere, 1995). An example of a study that has measured convergent validity is Arbisi, Erbes, Polusny and Nelson (2010). They found that the TSI subscales correlated well with subscales of the PDS (re-experiencing; avoidance; arousal) when using a sample of 96 female veterans from a healthcare clinic in the US. However, the findings showed that the subscales expected to correlate highly with the PDS subscales which did not. For example, the TSI D scale correlated higher with PDS arousal ( $r = .73$ ) than the TSI AA scale ( $r = .64$ ). This suggests that the items in the D scale may not accurately measure depression, and instead are related to the anxious symptoms of PTSD.

Another study by Synder et al. (2009) found that the TSI subscales, particularly D and AI, correlated well with similar subscales of the PAI, BDI, BAI and M-PTSD. This indicates that the TSI measures the construct of PTSD and is similar to other tools within this area. In respect to how well the TSI relates to the IES, another popular tool used to assess PTSD (Elhai, Gray, Kashdan & Franklin, 2005), it has been found that the IES total score correlated well with the DA ( $r = .70$ ) and IE subscales ( $r = .68$ ). They also found the IES intrusion and avoidance subscales had a weak positive relationship to the TSI counterparts of intrusive experiences ( $r = .67$ ) and defensive avoidance ( $r = .69$ ) (Briere & Elliott, 1998). Similarly, Runtz and Roche (1999) found that all of the clinical TSI subscales correlated with the following measures; General Health Symptoms ( $r = .37$ ), LES ( $r = .23$ ), SRLE ( $r = .47$ ) and the PSS ( $r = .34$ ). Therefore, the more Canadian women reported experiencing stress the higher their scores were on the TSI. The findings from Runtz and Roche need to be viewed with caution as the strength of the positive correlations are considered to fall in the weak to moderate range as suggested by Dancey and Reidy (2011). However, on the whole these

relationships found between the TSI and other measures highlight that subscales in the TSI relate to other measures, particularly more to the IES, therefore, indicating the TSI is measuring what it is supposed to be measuring.

Adapted versions of the TSI have also been found to correlate with other PTSD measures. For instance, Wang et al. (2011) found that the Spanish version of the TSI significantly correlated with the BDI ( $r = .77$ ) and with the depression subscales of the SCL-36 ( $r = .80$ ). Likewise, Gambetti et al. (2011) found that all of the Italian TSI scales were moderately related to MMPI-2 PK (PTSD) scale particularly for the D ( $r = .67$ ) and ISR ( $r = .61$ ) subscales. In regards to the IES-R, the avoidance subscale correlated moderately with DA ( $r = .63$ ), and the intrusion scale correlated moderately with IE ( $r = .58$ ) of the TSI. For the hyper-arousal scale this was moderately associated with the AA ( $r = .52$ ) TSI subscale. Again these findings indicate that when the TSI is adapted into different languages it still correlates moderately with other similar measures, therefore, suggesting that the TSI is successfully able to measure the construct of PTSD.

### Predictive validity

In respect to the predictive validity of the TSI this has two aspects; first how well the TSI predicts PTSD, and second how well the test is able to differentiate respondents who have experienced traumatic events from those who have not. Research on the predictive validity of the TSI has been positive (Stamm, 1996). For instance, Briere (1995) found the TSI was able to predict child and adult trauma (i.e., sexual and physical victimisation). This suggests that high scores on the TSI predicted whether participants had experienced sexual or physical abuse either as a child or as an adult. He also found that all of the TSI subscales could predict PTSD in 91% of a sub group of the standardised sample. Similarly, in a review paper by

Courtois (2004) it was stated that the TSI was able to predict complex PTSD, and provide an insight into the client's symptoms.

In another study, Briere and Elliott (1998) found, in comparison to IES, the TSI was able to accurately discriminate traumatic events history, particularly the DA and IE subscales in a random sample of 498 adult males and females from across US. This suggests that the TSI may be better at predicting traumatic histories in comparison to the IES. This is supported by Briere et al. (1995) who found that childhood sexual abuse was related to all 10 scales of the TSI. They also found that childhood physical abuse was associated with all of the subscales apart from SC and DSB. Adult trauma (i.e., sexual assault) was linked to eight of the subscales, particularly D and IE. These findings indicate that the TSI can predict childhood and adult sexual and physical abuse. The TSI seems to better predict childhood sexual abuse as evidenced by all subscales being related to it. However, there is little research on how well the TSI predicts PTSD with other traumatic experiences such as natural disasters or secondary trauma. This is particularly important as the TSI is meant to be non-trauma specific, and therefore, be used with respondents who have experienced a range of traumatic experiences.

### Content Validity

Content validity refers to whether the test includes all possible items related to what is being measured (Haynes, Richard & Kubany, 1995). It has been reported that content validity was achieved by selecting items based on the existing literature, clinical experience and consultation with trauma experts (Briere, 1995). Details regarding which trauma experts were approached are not made clear. If this information was provided it could assist with determining how accurate the knowledge obtained was in selecting items to include in the

TSI. It would also have been worthwhile consulting with patients who had been diagnosed with PTSD, their family and other professionals that may have worked with them in deciding items to include in the TSI. This would have provided a holistic and comprehensive overview of items to include in the TSI.

During the development of the TSI, Briere (1995) conducted a confirmatory factor analysis on all 10 scales to establish the content structure using a random standard sample of 836 American adults from the general population. The analysis revealed that the TSI supported a three factor model of trauma which included the following factors; trauma (IE, DA, DIS, ISR), self (TRB, DSB, SC, AI), and dysphoria (AA, D, and AI). Research that has investigated the content validity of the TSI has tested whether the three factor model proposed by Briere exists within other data sets using confirmatory factor analysis. For instance, Synder et al. (2009) found their data supported the three-factor model. Similarly, Gambetti et al. (2011) found that their data supported both a three factor model (trauma, self-dysfunction, dysphoria) and a two factor model (trauma/dysphoria; self-dysfunction). These findings suggest the content structure of the scale appears to be similar across studies indicating that the items included in the scale accurately reflect what the TSI is supposed to be measuring.

### Construct validity

This relates to the degree to which a test measures the construct the test was designed for (Peng & Mueller, 2004). There have been a number of studies (Briere, 1995; Runtz & Roche, 1999) that have investigated whether the TSI can measure the construct of PTSD and the association it has with self-reported traumatic experiences, particularly victimisation. This has been tested using multivariate statistics such as MANOVA. Results of these studies have

been promising, showing that the TSI accurately measures the construct. For example, in an Italian study by Gambetti et al. (2011) they found participants in the PTSD condition scored higher on the TSI than in the clinical and non-clinical samples. This suggests that the TSI can measure PTSD symptomology, and therefore shows support for the construct validity of the tool.

In another study by Briere et al. (1995) construct validity was measured by assessing the relationship between the TSI and history of victimisation. It was found those who had experienced child or adult victimisation had higher scores across all of the TSI scales than those who had not experienced victimisation. This provides evidence that the TSI is able to measure symptomology that is likely to occur following traumatic events, particularly in those who have experienced victimisation. However, as mentioned earlier in this review whether the construct of PTSD can be measured accurately and reliably for other traumatic experiences is unclear.

In Wang et al's. (2011) study construct validity was also assessed by examining the difference between the TSI scales for those with or without a history of abusive experiences. It was found that those who had experienced abuse differed significantly on nine of the TSI subscales than the non-abused participants. Analysis of the means indicated that abused participants received significantly higher scores on each of the subscales apart from DSB. It was suggested by the researchers that items that made up the DSB subscale may not fit in with cultural values of religion and gender roles in Puerto Rico. This highlights that on the whole the TSI is able to measure the construct of PTSD across different populations. However, it is important to be aware that subscales of the TSI such as DSB may not accurately measure the construct of PTSD with certain samples due to cultural factors.

### Sensitivity and Specificity

In relation to the TSI, sensitivity refers to the number of individuals with PTSD that are correctly identified as having the diagnosis. In contrast, specificity is defined as those individuals who do not have PTSD and are correctly identified as not having the diagnosis (Rosen et al., 2006). Since the development of the TSI, concerns have been raised in respect to the ATR validity scale, specifically that the ATR scale is ineffective at detecting feigned or credible cases of PTSD (Arbisi, Erbes, Polusny & Nelson, 2010; Edens, Otto, & Dwyer, 1998). Consequently, this can lead to high rates of false positive diagnoses of PTSD and credible cases being missed. For instance, Nye, Qualls and Katzman (2006) found in 47 male combat veterans the ATR scale indicated that 19% of the sample responded in a non-credible manner. However, this 19% of the sample had received a diagnosis of PTSD and were receiving disability benefits. Similarly, Elhai et al. (2005) found that the ATR scale was unable to identify college students who faked PTSD symptoms as well as those seeking treatment for PTSD. Another study by Rosen et al. (2006) found a voluntary sample of 161 American college students who were asked to fake PTSD symptoms had higher scores than the honest condition. It was also found using receiver operating characteristic analysis that the sensitivity rate was 68.3% and the specificity rate was 80%. The above findings highlight the ATR subscale may not accurately detect true and false cases of PTSD. This undermines the reliability and validity of the TSI because it suggests the tool is unable to identify who has PTSD. The wider implications are that those respondents who require treatment and support may not actually receive it.

### Conclusion

In relations to Kline's (1986) criteria for a good test the TSI does meet these. The findings from the review highlight that the TSI is an interval scale, has appropriate norms and

adequate reliability and validity. It appears to measure what it was intended to be used for across a range of samples and populations in a reliable and consistent manner. However, there are limitations to using the TSI; first, there is little information on face validity and content validity of the tool. This means it is difficult to determine if respondents' scores are a true reflection of their symptoms, and if the items used to assess PTSD cover the entire area of the disorder. Second, in Briere's (1995) original study it does not include any information about test-retest reliability. Subsequent studies also have not investigated test-retest reliability due to archival data and limited longitudinal research. This raises concerns about whether the TSI can reliably obtain similar results from individuals across different testing times. Without this information the reliability of the TSI may be undermined. Third, the ATR validity scale has been found to be ineffective in differentiating between true and false cases of PTSD. Consequently, the tool may not accurately discriminate between those who require support highlighting that the validity of the scale may be undermined. Fourth, although positive relationships between the TSI subscales and victimisation history have been reported, there is little research on the predictive validity of the TSI for those who have experienced other traumatic events.

Whether the TSI can be used to measure the impact of working with sex offenders is questionable. There have been no studies conducted on the psychometric properties of the TSI with helping professionals let alone those that treat sex offenders. However, as mentioned above, the review has shown that the TSI can be applied to different samples and is effective in measuring PTSD symptomology. Therefore, there may be potential for the TSI to be used with sex offender treatment workers. However, Moulden and Firestone (2007) have suggested that only measures that assess secondary trauma should be used with

professionals who work with sex offenders. This is because the norms available for other psychometrics have been based on those that have suffered from primary trauma.

Linked to the point made by Moulden and Firestone (2007), it is unclear whether the TSI would be suitable to assess symptoms that are unique to professionals who experience secondary trauma. Furthermore, it is possible that professionals who treat sex offenders may not score at all on the TSI, or only on some of the subscales. In Chapter 2, three of the studies included in the systematic review (Hatcher & Noakes, 2010; Jacobsen, 2014; Steed & Bicknell, 2001) found that participants did not score in the moderate or clinically significant range for the IES-R, which has also been used to measure PTSD symptoms. Therefore, it is possible that similar findings may also be obtained if sex offender treatment workers were to complete the TSI. It is worthwhile for future research to explore this further by testing whether the TSI is an appropriate measure to use with sex offender treatment workers.

If the TSI was found to be an appropriate tool to use with sex offender treatment workers, it has been recommended that the TSI should perhaps be used as part of a battery of tests to measure trauma (Bride, Radey & Figley, 2007). It may also be worthwhile incorporating a clinical interview into the assessment process to obtain further detailed information regarding symptoms of PTSD, the nature of traumatic events experienced, and to corroborate psychometric findings from other psychometrics. In addition, it is important to consider all sources of information such as observations, informal discussions and speaking to significant others when assessing if sex offender treatment workers have been vicariously impacted by their work. This could be trialled on sex offender treatment workers particularly in circumstances when employers are concerned about employees being negatively affected by the work. The TSI could also be given to sex offender treatment workers as part of a battery

of assessments on a yearly basis during an appraisal to assess staff members' that are impacted by work, and start the process of supporting them. By adopting a range of assessment approaches clinicians and researchers may be able to obtain accurate psychometric findings supported by clinical interviews to diagnose PTSD or secondary trauma.

## **CHAPTER 4**

# **A QUALITATIVE STUDY EXPLORING THE EXPERIENCES OF SEX OFFENDER TREATMENT WORKERS**

## **Abstract**

The systematic review in Chapter 2 highlighted how the findings from qualitative studies produced more consistent results than studies that had adopted a quantitative methodology. Therefore, the aim of this chapter was to explore the experiences of sex offender treatment workers using a qualitative methodology. In addition, the aim was to learn about the ways they cope with the work, and the factors that enhanced their resiliency.

Participants were recruited through the National Organisation for the Treatment of Abusers (NOTA), the Association for the Treatment of Sexual Abusers (ATSA) and the International Association for the Treatment of Sex Offenders (IATSO). At the end of a survey which was given out as part of the Masters research, 199 participants were asked if they would like to take part in a follow-up interview. Those participants who registered their interest were sent an email asking if they were still interested in taking part. In total, nine participants were recruited for interview.

Semi-structured interviews were conducted with participants via telephone. Each interview was transcribed verbatim and then analysed using both Template Analysis (TA) and Interpretive Phenomenological Analysis (IPA). The themes revealed that participants experienced a range of emotions (both positive and negative) when working with sex offenders. Despite the negatives, all participants described enjoying the work, and finding it rewarding. The findings also revealed participants used a range of coping strategies including supervision, collegial support, humour, and self-care, and self-reflection. They also highlighted factors that enhanced resiliency (i.e., a genuine interest in working with sex offenders, hope and optimism).

Implications for those working with sex offenders are that they need to monitor their feelings, and be vigilant for changes in how they feel about their work. They should be proactive in seeking support, and making the most of collegial support. Implications for organisations included ensuring managers are given time to offer supervision, and to provide refresher training on how to cope with the work.

## **Introduction**

In the 1970s, it was observed that emergency rescue workers experienced similar symptoms to the victims they helped. This was explored further in other helping professionals such as hotline workers and crisis workers. Later this moved to professionals who worked with victims of crime, and, more recently those who work with perpetrators (Moulden & Firestone, 2007). Stamm (1995) termed the experience of supporting victims and perpetrators as secondary trauma. She proposed that professionals who are indirectly exposed to trauma through supporting or listening to clients' traumatic material may be negatively affected by the work.

Secondary trauma has been explored in professionals who support a broad spectrum of offenders from domestic violence perpetrators to offenders with personality disorders (Morran, 2008; Moulden & Firestone, 2007). For this chapter, the focus will be on the psychological effects on those that are indirectly exposed to traumatic events through their work with sex offenders. Sex offenders present with a unique set of characteristics and behaviours that differ to other kinds of perpetrators (Edmunds, 1997). They tend to describe disturbing stories of sexual violence, voice pro-offending attitudes condoning sexual violence, and present with inappropriate sexual interests or behaviours (Ellerby, 1997). Professionals working with sex offenders are required to listen to their stories, work with denial/minimisation, show empathy, and be supportive as well as challenge beliefs (Marshall et al., 2002). Listening to sex offenders' stories and empathetically engaging with them may evoke strong emotions, and lead to cognitive changes within professionals (Slater & Lambie, 2011). For further information about the kinds of secondary traumatic experiences sex offender treatment workers may encounter as a result of working directly with sex offenders, please refer to Chapter 1.

This introduction will attempt to provide an overview of research on the consequences of working therapeutically with sex offenders. It will also present theories on resiliency, and coping. After the above areas have been reviewed, aims and research questions specific to this chapter will be presented.

### Impact of working therapeutically with sex offenders

The systematic review revealed that qualitative research provided a consistent account of the experiences of sex offender treatment workers than quantitative studies. To recap, the results from the quantitative studies in the systematic review produced mixed results on the impact of working with sex offenders. For example, some studies found that sex offender treatment workers experienced negative consequences such as, emotional exhaustion, depersonalisation, withdrawal, hyper-vigilance and increased suspicions of others (Kadambi & Truscott, 2003). The other studies highlighted that although sex offender treatment workers experienced negative consequences of the work, they also experienced high levels of compassion satisfaction (Ennis & Home, 2003; Shelby, Stoddart & Taylor, 2001; Steed & Bicknell, 2001).

Therefore, the studies discussed in this research introduction will focus on qualitative research exploring the impact of working with sex offenders. For instance, Dean and Barnett (2011) conducted semi-structured interviews and focus groups with facilitators of the Healthy Sexual Functioning Programme (HSFP) across HM Prison Service in England and Wales. Their analysis found four themes present; facilitators questioning core beliefs (i.e., doubting professional competence, gender roles, and identity), experiencing intrusive imagery and becoming overly suspicious of others. They also found participants gained satisfaction from empowering clients and treatment success. Although, the sample size of 11 was small, and

the study only focused on one sex offender treatment programme, this research provided a useful insight into facilitators' experiences of delivering the HSFP programme. It also highlighted the negative and positive experiences of those who work with sex offenders.

A New Zealand study by Slater and Lambie (2011) aimed to explore further both the positive and negative aspects of working with sex offenders. To achieve this they carried out a qualitative study with clinicians from the Safe Network, which works with a range of clients that present with sexually harmful behaviours. Data analysis revealed that participants were passionate about their roles, believed the clients they worked with could change, they were able to separate the offence from the person, and were motivated to make a difference. They also described wanting to be involved in educating the community about sexual abuse, and allowing clients to become role models. The negatives of working with sex offenders included managing resistant clients, and when clients re-offended. The clinicians took this as a sign of failure to themselves, the client and society. This piece of research highlights there are a number of positives to working with sex offenders which appear to outweigh the negatives.

A common limitation of the two qualitative studies discussed above is the research was conducted with participants from one context (i.e., the HSFP programme, and the Safe Network). Consequently, these studies have both reported that the findings may be unique to those participants in the study, and therefore, not generalisable to professionals who work in other contexts. It may be useful for studies to include professionals from a range of settings to see if they share similar experiences, and to enhance the generalisability of the results.

The qualitative aspect of Hatcher and Noakes's (2010) study revealed Australian sex offender treatment workers who worked in correctional settings experienced changes to schemas in relation to safety, suspiciousness, acceptance and tolerance as a result of their work in this area. However, these changes did not result in symptoms of VT or CF. Hatcher and Noakes suggested participants in the study may have utilised strategies like sharing experiences with others to cope with the work. They also proposed that participants may have become resilient to the impact of the work, and highlighted the need for future research to explore the factors that underpin resiliency in sex offender treatment providers.

There have been qualitative studies that have explored the impact of working with sex offenders with other professionals like nurses. The studies discussed below focus on the experiences of nurses who have specialised in psychiatric mental health, and have been involved in delivering treatment to sex offenders. A practitioner who has published a number of papers on nurses' experiences of working with sex offenders is Scheela (2008). When discussing her own experiences she reported experiencing both negative and positive reactions to the work. The negative impact was similar to the definition of VT; it included feeling nauseated by the stories she heard, increasingly being aware of how unsafe the world can be, and increased suspicion of peoples' motives. The impact described by Scheela is consistent with the Constructivist Self-Development Theory (CSDT) (Saakvitne & Pearlman, 1996) which states changes to cognitive schemas like trust and safety can occur as a result of working with sex offenders. Scheela also reported her work with sex offenders allowed her to see their positive characteristics, she learnt about strength and courage via sex offenders' stories, and she developed faith that people can change. A drawback of this paper is it only relies on the experience of one nurse, and therefore, it is difficult to generalise to others in the same profession whose experiences may differ.

In another explorative study by Scheela (2001), she conducted interviews with therapists working in an outpatient sexual abuse treatment programme in America. The findings revealed that on the whole the therapists liked working with sex offenders especially if they witnessed change, and could separate the offences from the person. However, they struggled with societal attitudes (reactions from the public when they found out about their jobs), concerns about clients' re-offending, and personal changes. Personal changes included becoming hardened to abuse and taking safety precautions. For example, one of the participants reported carrying pepper spray, and another participant discussed concerns over the safety of their own children. Although this piece of research provided a good balance of the positives and negatives of working with sex offenders it does have limitations. The main limitation was the researcher worked in the outpatient centre. The implications of this are the possibility of socially desirable responses from the participants, and researcher bias. Participants may have been aware of the research questions/aims, and therefore, tried to provide responses the researcher wanted to hear. This may have increased depending on the working relationship between the researcher and participants. For instance, if the researcher was the participant's manager this may have affected their responses to questions; participants may have been less inclined to provide open and honest responses to their manager in order to maintain the relationship in their job. In respect to researcher bias, the researcher may have selected the participants due to convenience, and because they may have provided the responses that answered the research questions.

The findings discussed above relating to the extent sex offender treatment workers are impacted by their work remains largely inconsistent. Furthermore, the above research has also highlighted that not all therapists are affected by the traumatic material they are exposed to. In fact, some workers do not suffer from negative consequences and enjoy the work they

do. It would, therefore, be helpful to explore the literature on resiliency, and identify the factors which could underpin resiliency shown by some sex offender treatment workers.

### Resiliency

Resiliency is a concept which is not clearly defined (Luthar, Cicchetti & Becker 2000). There are inconsistencies in respect to defining positive adaptation and the kinds of adversities that can trigger resilience (Luther et al., 2000). For example, resiliency has been investigated in those who have experienced traumatic experiences like war, poverty or other life experiences such as the loss of a loved one to divorce (Luther et al., 2000; Windle, 2010). Life event checklists have also been used to assess resiliency, which often include an array of difficult experiences. For instance, The Life Events Checklist for DSM-5 (LEC-5; Weathers et al., 2013) includes adversities like war, abuse, loss of a family member and illness. It also includes an item described as ‘any other very stressful event or experience’. This indicates that hardships can be anything the individual perceives as stressful or difficult. There is also uncertainty regarding if resiliency is a personality trait, a dynamic process, if it can be learnt or whether it can be measured (Rutter, 2007). The general view is that resiliency is the ability to positively adapt when exposed to experiences of significant adversity or stress (Luthar et al., 2000; Luthar & Cicchetti, 2000; Rutter, 2006; Wolin & Wolin, 1993). It involves using psychological and physical resources to overcome challenges in a positive, manageable and meaningful way (Antonovsky, 1990). It has been suggested by Hernández, Gansei, and Engstrom (2007) that resiliency is a dynamic process which is affected by the interactions between the individual and the environment. Rutter (2006) proposes that individuals respond differently to similar situations and recommends work in this area to focus on the reasons why individual differences occur.

Factors linked to resiliency can occur on three levels: individual, family and wider social environments (Luthar et al., 2000). Some of the factors which have been linked to resiliency within the workplace are as follows: internal locus of control, strong social support, positive attitudes about work, access to resources such as supervision, making sense of the situation, hope, spirituality and religion (Callahan & Dittlott, 2007; Greene, Galambos & Lee, 2004; Kuyken, Peters, Power & Lavender, 2003; Luthar & Cicchetti, 2000). Research in this area has tended to focus on defining the concept, identifying factors linked to resiliency, and studies of resiliency in people who have experienced adversity first hand. There appears to be little research on resiliency in those people who may be at risk of experiencing secondary trauma like sex offender treatment workers. This highlights a gap in knowledge and an area that will be explored further in this chapter.

A useful piece of work in this area is that of Farrenkopf (1992) who proposed four phases of impact that describe the progressive adjustment of sex offender therapists to their work: shock, mission, anger and either erosion or adaptation. Shock involves feelings such as fear and vulnerability when first encountering the sex offender. Therapists then go on to experience a period of mission within which they engage in client empathy and adopt a non-judgmental approach towards their clients. Anger involves feelings of intolerance towards offending behaviour. Once sex offender treatment workers have consecutively passed through each of the above phases they will then either experience erosion or adaptation.

The erosion phase is similar to the experience of burnout as it includes responses like resentment towards clients, exhaustion and negative feelings towards treatment. In contrast, however, the adaptation phase involves a motivation to fulfil the role by having a realistic expectation of the treatment outcomes, and being able to effectively disengage from clientele

material. A drawback of Farrenkopf's theory is it fails to identify the factors that lead some therapists to experience erosion, whilst others experience adaptation. Another limitation is this model has not been empirically tested to establish if sex offender treatment workers go through the phases indicating a need for future, longitudinal research to explore whether professionals go through the phases.

Another model that has been proposed by Scheela (2001) to explain the process of working with sex offenders is the remodelling process. The process highlights that professionals may experience six steps when working with sex offenders. These include the following; falling apart, taking on new roles, tearing out old assumptions/attitudes, rebuilding, doing upkeep to maintain change, and moving on. When Scheela introduced this model in interviews with therapists working in an outpatient sexual abuse treatment programme in America, the participants agreed that their experiences reflected the remodelling process. They also reported that the process is not linear. Instead participants highlighted that each process can be experienced simultaneously, sometimes within the same day, and with the same client. This challenges Farrenkopf (1992) who suggested the phases of impact occur sequentially. As mentioned earlier, one of the limitations of Scheela's study is she worked with the participants. Therefore, the participants may have known about the aims of the research, and therefore, reported what they thought the researcher wanted to hear.

In a study by Leicht (2003) it was found clinical psychologists experienced negative emotions following working with sex offenders. They described the process of working with sex offenders as beginning with feelings of disgust, followed by curiosity and then understanding. The ways these participants coped with the initial feelings of disgust were to separate the client from the offence, and to hold onto their beliefs that they could help the

client change. The findings by Leicht have highlighted another process sex offender treatment workers may undergo whilst working with sex offenders. The findings also emphasise factors like separating the client from the offence, and having a belief that clients can change may enhance resiliency of sex offender treatment workers, and help them overcome feelings of disgust.

A new concept known as vicarious resilience may help to explain why some professionals adapt to their roles and others erode. Vicarious resilience refers to gaining inspiration through listening to clients' stories, and learning from clients about how to overcome difficult situations (Hernández, Gansei & Engstrom, 2007). Hernández et al. carried out a qualitative study in Columbia with clinicians who worked with clients that have experienced traumatic events (i.e., torture; kidnap). The aim of the research was to explore how clinicians were positively impacted by their work. The findings revealed clinicians learnt from their clients about coping with adversity; they became more resourceful, less fearful, developed hope, increased tolerance for frustration, and realised the capacity humans have to heal. The clinicians also reported to feel negative emotions like anger, hopelessness, and feeling overwhelmed. The findings indicate clinicians experienced negative feelings as a result of listening to traumatic experiences. However, their work also led to positive changes in clinicians' thinking about coping. This may have had an impact on the ability for clinicians to adapt to their role rather than erode.

In another paper by Hernández, Engstrom and Gansei (2010) they discuss the limitations of vicarious resilience; 1) it assumes in order for clinicians to learn about coping, the clients themselves must have overcome their difficulties and be resilient. This highlights that vicarious resilience may not develop amongst clinicians who are working with clients that are

still experiencing traumatic events and are not resilient; 2) the concept does not take into account whether vicarious resilience occurs when listening to stories of clients overcoming difficulties, that may not necessarily be described as traumatic (i.e., coping with anxiety, overcoming substance misuse); 3) the researchers have not explored whether vicarious resilience occurs amongst professionals who work with perpetrators. Therefore, it is not clear whether, for example, sex offender treatment workers are likely to experience vicarious resilience. However, Scheela (2001) reported that she learnt about strength and courage through her work with sex offenders. This suggests that perhaps vicarious resilience can occur amongst professionals who work with sex offenders.

In a review paper by Gillespie, Chaboyer, Wallis, and Grimbeek (2007) other factors that may enhance resiliency are proposed such as self-efficacy, hope and coping. Self-efficacy relates to an individual's confidence about their ability to achieve a task (Bandura, 1977). The reason this relates to resiliency is because confidence about ability is likely to increase persistence and effort in order to overcome adversity (Rutter, 1990). Individuals who are hopeful are likely to believe goals can be reached and as a result this can encourage problem-focused coping (Snyder, 2000). Coping can also lead to increased resiliency because it involves evaluating how to resolve a problem and taking action to alleviate distress (Rutter, 1990). The attributes of resiliency identified by Gillespie et al. appear to be internal factors. A limitation of the review paper is that it does not clearly explain how these factors interact with the environment. This is important to know as Hernández et al. (2007) suggested resiliency develops due to a combination of individual and external factors.

## Coping

Coping comprises of the cognitive and behavioural responses used to manage situations perceived by the individual to be stressful and taxing on resources (Folkman & Lazarus, 1988). The factors that lead individuals to appraise situations as threatening include personal characteristics (i.e., past experiences of coping, beliefs about one's ability, commitment to goals) and environmental factors (i.e., resources to cope). There are two types of coping styles to reduce negative states; emotion-focused coping which refers to the changes one makes to their emotional thinking. It has been suggested that factors like optimism and hope influence emotion-focused coping because it may lead to positive feelings and persistence (Snyder, 1999). The second is problem-focused coping which involves taking steps to reduce negative states (Lazarus, 1993; Snyder, 1999). Examples of problem-focused coping strategies are goal-directed problem solving, positive reappraisal (seeing a situation in a positive light) and cognitive appraisal (i.e., assessing the situation to see if it is harmful to well-being and considering if they have enough resources to cope) (Folkman, 1997; Lazarus & Folkman, 1984). It has been suggested by Lazarus (2000) that both processes are often used in combination by individuals to solve situations.

There has been research that has explored the coping strategies of those who are required to listen to traumatic stories. For instance, Conrad (2011) suggested the most common coping strategies employed by professionals exposed to secondary trauma included; self-reflection, self-monitoring of cognitive/emotional states, and the use of supervision. Similarly, Bober and Regehr (2006) found the most useful strategy for therapists working with victims in America was the use of supervision and leisure activities outside of work. They also highlighted that positive coping strategies such as peer consultation, training, and self-care (i.e., balance between work and home and managing caseload) can protect sex offender

treatment workers from psychological distress. This is supported by McCann and Pearlman (1990) who suggested that strategies to reduce VT included acknowledging feelings, having a variety of cases, and receiving regular supervision. It has also been found by Harrison and Westwood (2009) that an optimistic attitude, being aware of personal feelings and seeking support via supervision prevents and reduces any negative consequences of working with sex offenders.

Sexton (1999) collapsed coping strategies into two categories; organisational and individual. Organisational strategies include an organisational culture that accepts that negative impact can occur, and has procedures in place to protect workers, such as engaging in supervision, case discussions and management of caseload. The individual strategies comprised of the ability to reflect on the work, a clear balance between work and personal lives, and taking responsibility for seeking support. An alternative way in which coping strategies have been collapsed is proposed by Inbar and Ganor (2003). These categories include; individual, professional, cognitive-behavioural, and social organisation. Similar to Sexton, individual strategies included monitoring feelings, and professional coping comprised of supervision and training. The cognitive-behavioural strategies included identifying sources of stress and problem-solving. Social-organisational coping highlighted a culture that has procedures in place to prevent burnout and promote coping.

Research that has explored the coping strategies adopted by professionals working with sex offenders has been similar to the findings discussed above (Dean & Barnett, 2010; Moulden & Firestone, 2007). For instance, Scheela (2001) found that sex offender therapists reported using professional coping strategies such as supervision, varied caseload (i.e. not just sex offenders), making decisions as a team, humour and becoming detached from the work.

Examples of personal coping strategies used by the participants were enjoyable hobbies, exercise and separating work from home. Similarly, Leicht (2003) suggested emotion-focused coping strategies employed by sex offender treatment workers included separating the offender from the offence, perceiving the offender as the victim of abuse, and trying to understand the function of the sexual offence. In respect to problem-focused coping this involved seeking support via supervision, attending training, humour and hobbies.

In their review paper, Moulden and Firestone (2010) proposed that professionals working with sex offenders have an ethical duty to care for themselves before caring for others. This means that therapists in the field need to find ways of processing their reactions to sex offender treatment work in order to remain objective and committed to providing treatment. Moulden and Firestone do not state the ways in which sex offender treatment workers can adapt to their role. However, as with the studies above, they do highlight that self-reflection is crucial to identifying negative feelings and identifying steps to overcome the problem. They also emphasised the importance of supervision and attending training to alleviate any negative impact of the work. The findings highlighted by Moulden and Firestone are consistent with Kottler and Markos (1997) who explored the literature on personal reactions of those who work with perpetrators of sexual abuse. They emphasised that it was important to be aware of personal reactions to sex offenders because if negative feelings are not dealt with it can have an impact on treatment delivery. They explained that evaluating one's work with sex offenders can assist with building a therapeutic relationship, which can increase job satisfaction.

The aforementioned studies and the systematic review in Chapter 2 have indicated that one of the main strategies for coping with the negative aspects of working with sex offenders is

supervision. Supervision is concerned with reflecting on practice with the aim of developing as a practitioner and learning from experience (Carroll, 2007). It involves monitoring performance, evaluating work, and developing skills (Falender & Shafranske, 2007). Lane and Corrie (2006) indicated that there are a number of benefits of supervision such as; it provides a space for practitioners to reflect, helps practitioners to identify strengths/weaknesses of work, getting to learn from the supervisor, and offering protection to clients because supervision is used to discuss cases. These findings highlight supervision not only benefits the practitioner but also the client.

Limitations of supervision have been raised. For instance, Goodyear and Bernard (1998) suggest in order for supervision to be perceived positively by the practitioner the supervisor needs to be considered helpful. Goodyear and Bernard have also highlighted that practitioners' experiences of previous supervision may impact on how supervision is used. They suggest the style of the supervisor can also impact on the usefulness of supervision. Therefore, while supervision has been found to help sex offender treatment workers manage their feelings, it is important to be aware that supervision may not always be effective, particularly if the practitioner does not feel they are learning from it.

This piece of research will build on findings such as those by Dean and Barnett (2011), Hatcher and Noakes (2010), Scheela (2001), and Slater and Lambie (2011). These studies have found that professionals working with sex offenders experience negative consequences such as; increased suspicions, concerns regarding safety, changes to core beliefs (gender roles, professional competence) and taking it personally if clients re-offend. The same studies have also found that there were positives about working with sex offenders including witnessing change, empowering clients, and protecting the public. The studies have not

provided a consensus about the factors that increase secondary trauma as outlined in the systematic review. However, the above research has consistently shown that supervision, self-reflection, balance between work and home may serve as protective factors against the negative effects of working with sex offenders.

To determine the factors that influence whether a sex offender therapist experiences adaptation or erosion, as described by Farrenkopf (1992), it is essential for this thesis to explore the experiences of sex offender treatment workers, but this time with an emphasis on what makes professionals resilient. This is because previous research has yet to focus in detail on the factors that enhance resiliency in sex offender treatment workers despite previous research, for example from Hatcher and Noakes (2010), highlighting that workers seem to have become resilient to the challenges the job can bring. The research will also build on existing qualitative research by including participants that work in different settings. This will provide an insight into whether the experiences of professionals who work in different settings vary, and make the findings relevant to a range of professionals involved in working therapeutically with sex offenders.

In addition, the research will use Template Analysis (TA) with aspects of Interpretative Phenomenological Analysis (IPA) to explore the experiences of sex offender treatment workers. Combining both approaches was considered most appropriate because the TA approach allows the data to be organised in a meaningful way (King, 1998), and IPA involves making sense of participants' experiences and giving them a voice (Smith, Flowers & Larkin, 2009). The systematic review identified that only one published study to date used IPA (Sandhu, Rose, Rostill-Brookes & Thrift, 2012). Again, this study focused on a unique

group of professionals who provided group treatment to sex offenders with intellectual disabilities.

The overall aim of this research was to explore the experiences of those who work therapeutically with sex offenders through the use of qualitative methodology. The purpose of this research was to narrow the gaps in knowledge about the occurrence of VT, CF and burnout amongst therapists working with sex offenders. This is because clarification is needed about the extent to which professionals working in different settings experience psychological distress. The research also aimed to learn about risk factors, coping, and the factors that allow therapists to remain resilient to the effects of secondary traumatisation. The specific research aims and/or questions were as followed:

- 1) To learn about the experiences of sex offender treatment workers.
- 2) To find out about the consequences of working with sex offenders, both positive and negative.
- 3) To determine how sex offender treatment workers cope with their work.
- 4) To investigate the factors that underpin resiliency in sex offender treatment workers.

## **Methodology**

### Research design

A qualitative research approach was adopted for this study as it is considered useful for gaining an in-depth understanding of participants' perspectives on a particular topic (Flick, 2009; Black, 1994). Silverman (2013) recommended that the method chosen for research depends heavily on what you are trying to discover. As one of the aims of the research was to explore the experiences of sex offender treatment workers, qualitative methodology was

considered the most appropriate method to achieve this. The study adopted a combination of deductive and inductive approaches. The deductive aspect of the design allowed a template based on the aims of the research to organise the interview schedule and coding of the data. The inductive aspect of the study enabled new themes to emerge from the data that were not underpinned by the researcher's interests (Braun & Clarke, 2006; Willig, 2013). An advantage of integrating the two approaches is that it provides a comprehensive analysis of the data (Willig, 2013).

Another reason for using qualitative methodology is because previous research has suggested some of the psychometric assessments used to measure VT like the Trauma Attachment Belief Scale (TABS; Pearlman, 2003) lack validity because they may not adequately measure the construct (Deville, Wright & Varker, 2009; Sabin-Farrell & Turpin, 2003). Consequently, this may be one of the reasons the results across studies have varied considerably as revealed in Chapter 2. Also, the findings discussed in the systematic review revealed that more detailed information about the experiences of sex offender treatment workers were obtained from qualitative studies, rather than from quantitative studies. Based on the above reasons, it was decided that a qualitative methodology would be the most appropriate to explore the experiences of sex offender treatment workers.

### Ethics

The author previously completed a quantitative study assessing the impact of working therapeutically with sex offenders as part of a Master's degree. Prior to the commencement of the Master's research, a proposal was submitted and approved by the Science, Technology, Engineering and Mathematics Ethics Review Committee based at University of Birmingham.

The Ethical Review number was ERN\_12-0682. The proposal also outlined the current research which was approved at the same time.

For the Master's research ethical approval was also sought from each of the organisations where participants were recruited from. These included the following; National Organisation for the Treatment of Abusers (NOTA), the Association for the Treatment of Sexual Abusers (ATSA), and the International Association for the Treatment of Sexual Offenders (IATSO). The process of obtaining ethical approval from each organisation varied slightly, but involved providing a brief proposal incorporating a literature review, aims of the research, methodology and confirmation of receiving ethical approval from the University. Two of the organisations (NOTA and IATSO) immediately granted permission for the survey to be distributed to their mailing list. Approval from ATSA involved the proposal being passed onto their research committee and was later approved. All organisations stipulated that a disclaimer was to be included on the invitation e-mail that was sent to participants stating the research had been approved.

### Sample

Participants who took part in the Master's research were required to complete an online survey that assessed the impact of working with sex offenders. At the end of the survey, participants were asked if they would be interested in taking part in a follow up study involving telephone interviews (see Appendix 8). If they wished to take part they were asked to e-mail the researcher confirming this. In total 22 e-mails were received between January 2013 and March 2013 from participants confirming they were happy to take part in the follow up research. All participants were sent an e-mail thanking them for contacting the researcher, and that they would be contacted within 12 months. In early 2014, an e-mail was sent to the

22 participants asking if they still wanted to take part in the follow up research (see Appendix 9). An information sheet (see Appendix 10) and a consent form (see Appendix 11) were attached to the e-mail for participants to electronically complete, and to be e-mailed back to the researcher. In total, 11 consent forms were received, but only nine participants were interviewed. This was due to their availability; two were not available during the times the researcher could contact them. The nine participants who agreed to take part all worked therapeutically with sex offenders and were associated with the professional organisations mentioned above. None of the participants withdrew from the research following the interviews.

In total there were seven females (77.7%) and two males (22.2%) with an age range between 24 and 64 years ( $M= 46.8$ ). Seven participants from the sample (71.7%) were affiliated with NOTA, one participant (11.1%) was a member of ATSA and another was (11.1) a member of IATSO. In total, six participants were from England (66.6%), one (11.1%) was from Ireland, another participant was from America (11.1%), and another participant from Denmark (11.1%). In terms of job profession, three (33.3%) were from a psychological background (qualified psychologists, assistant psychologist), two (22.2%) had consultancy positions, and four (44.4%) were probation staff who facilitated sexual offending treatment programmes. Most of the participants worked within the community which included probation or outpatient clinics. There was one participant who worked in a prison, and another participant that worked across low and medium secure wards for an independent healthcare provider. The majority of participants delivered a combination of individual and group interventions to sex offenders. The number of years participants had worked with sex offenders varied from 20 months to 29 years ( $M=12.83$  years), and the number of hours a week spent working directly with sex offenders ranged from two hours to 30 hours ( $M= 12.44$  hours).

## Procedure

Data were collected using semi-structured telephone interviews. This method was considered the most appropriate for this piece of research because participants were from various locations which included United Kingdom, Europe and America. Therefore, the easiest, most convenient and cost-effective way of reaching participants was by telephone (Mann & Stewart, 2000). Other advantages of telephone interviews include interviewees feel more relaxed (Novick, 2008). However, collecting data via telephone interviews does not come without limitations. For example, Opdenakker (2006) suggested it can be difficult to build a rapport in the absence of social cues like facial expressions and gestures. Therefore, both the interviewer and interviewee are unable to tell whether what is being said is consistent with what they show. This may lead to a loss of data and distortions which could impact on the quality of the data obtained from the interview. However, Opdenakker indicates that there is enough information such as voice and tone for a telephone interview to be conducted. He also adds that the spontaneous nature of the interview means the interviewer and interviewee directly react to what is being said which can be used as another source of information. In addition, he adds that the responses obtained via telephone interviews are considered more realistic than collecting data via e-mail where participants have time to ponder over their responses.

Another limitation Opdenakker raises is that the interviewer has no control over the setting the interviewee is in. Again the setting participants are in (i.e., loud, distracting) at the time of the interview may impact on the quality of the data. Despite the limitations there is little research evidence that has explored whether absence of social cues or setting has an impact on the quality of the data obtained (Novick, 2008). Those that have compared telephone and

face-to-face interviews have found that there are no differences in the quality of interview transcripts between the two methods (Sturges & Hanrahan, 2004).

A semi-structured approach using open-ended questions was adopted because it enables the interviewer to cover key questions/topics related to the research aims. However, it also allows for further exploration of participants' experiences' through probing and prompting (Barriball & While, 1994). The method usually provides rich, detailed and reflective data that can be useful in understanding how participants interpret the phenomenon being explored and make sense of it (Larkin & Thompson, 2012). One of the key strengths of semi-structured interviews is the flexibility to tailor the interview to the participants' personal understanding of the phenomenon (Lewis-Beck, Bryman & Liao, 2004).

After receiving consent forms from participants, a mutually convenient time was arranged via e-mail for a telephone interview. Participants were then contacted at pre-arranged times for their interviews. The interview schedule was used to guide the structure of the interview (see Appendix 12). After checking if participants could hear the researcher and if the digital recorder was working, the interview commenced with some introductory topics. This included re-capping the aims of the research, discussing the format for the interview, and how long it would approximately take. The interview then moved onto background questions (i.e., job role, hours spent working with sex offenders, work setting), followed by the main interview questions which focused on experiences of working with sex offenders, coping, and resiliency. The interview closed by asking participants if there was anything they wanted to add or reflect on. It was also used as an opportunity for the researcher to explain about withdrawing and the next steps of the research. The length of interviews ranged from 35 minutes to 70 minutes ( $M = 68$  minutes).

## Analysis

Once all interviews had been completed each interview was uploaded onto a secure USB device, and transcribed verbatim by the researcher. The transcripts were then analysed using Template Analysis (TA; King, 1998) and aspects of Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009). TA involves producing a template that includes themes that represent the dataset. TA was considered appropriate for the study because it allowed salient themes that were relevant to the research questions to be coded in a meaningful and organised way (King, 1998). Templates can be based on theory, research evidence, research questions or questions asked in interview schedules (Reynolds, 2003). The strengths of TA are it can be helpful for those new to qualitative research and can make the data manageable to analyse. TA does not have specific procedural steps and is not underpinned by a particular methodological position which means it is flexible, can be used for different kinds of qualitative research and can be combined with other approaches (Brooks & King, (2014). A limitation of TA is that it can produce broad descriptive themes that lack interpretation resulting in the participants' voices being lost (Reynolds, 2003). King (1998) recommends that it is essential for the researcher to develop an interpretative strategy that fits in with the study aims. Therefore, IPA was also chosen due to its emphasis on how participants make sense of their experience. The main aim of IPA is to give participants a voice; it takes into account claims and concerns they have described, and provides an interpretation of the data (Thompson, Larkin & Smith, 2011). It is influenced by idiography (focussing on the meaning of experience for a participant) and hermeneutic phenomenology (meaning can always be interpreted) (Larkin & Thompson, 2012). Combining multiple methods of analysis has been recognised by researchers as a way of enhancing the richness and quality of the analysis (Bailey & Jackson, 2003). Furthermore, King (2004) highlighted

that TA compliments IPA because they both involve identifying themes and clustering them into groups.

When carrying out the analysis, the researcher referred to guidance from King (1998) on conducting TA and used some of the steps identified by Smith, Flowers and Larkin (2009) for IPA. The process began by reading through each transcript to become familiar with the content and the participants. This was followed by highlighting anything that the researcher found interesting or relevant to the study. The IPA element of the analysis involved highlighting important claims or concerns the participant discussed. In particular, the researcher identified 'objects of concern' which is anything that matters to the participant, and then considered the 'experiential claims'. This focuses on the meaning of what matters to participants by looking at narrative and linguistics. After line-by-line coding had been completed, the TA aspect of the analysis involved incorporating the 'objects of concern', with quotations from the participant, followed by what the 'experiential claims' were into a preliminary template. The template was based on the research aims because this was considered by the researcher to be the most appropriate way to make sense of data and to organise it in a meaningful way. In IPA Smith et al. suggest that it is important to capture initial coding in a flexible manner to make it easier when it comes to identifying common themes across transcripts.

The next step was to identify themes for each transcript using initial codes/templates, and to consider what these themes might mean. Once the themes for each transcript were identified and included in the template, the researcher then applied the template across all nine transcripts. This was followed by considering what the themes might mean for the participants as a whole. During this stage, the researcher also made a note of themes that

differed between participants. The process from coding to analysis was then visually represented in a template table which can be found in the results section. Quotations from the participants were used to evidence each theme.

Once the themes had been selected, the researcher shared them with her supervisor, and presented them during peer supervision with colleagues who had knowledge of IPA. During peer supervision, colleagues questioned the researcher about the theme names, and their meanings. In addition, throughout this process the researcher kept a note of reflective experiences and how this impacted on coding, identifying themes and interpreting the data. A reflective account of the researchers' experience is presented in the Discussion.

## **Results**

This chapter is concerned with telling the story of sex offender treatment workers who participated in this study. This is an important area to explore because the aim of this thesis is to gain an insight into how professionals are responding to working with treatment models like RNR and GLM. These models require therapists to display features like an empathetic and supportive approach. This chapter addresses the gap in knowledge by sharing the experiences of sex offender treatment workers, how they cope, and what makes them resilient. An account of the themes and sub themes considered salient to sex offender treatment workers who participated in this study is provided. An interpretation of why the themes are important for them will also be discussed.

As previously mentioned TA was used to organise and structure the data. The template was based on the research aims. The first question to be explored is how sex offender treatment workers are affected by their role. This includes discussing the themes/sub themes related to

the positive and negative aspects of the role. The analysis will also tell the story of how sex offender treatment workers cope with their work by presenting the main themes/sub themes. The last section of the analysis will cover the themes/sub themes that provide an insight into what participants think enhances their resiliency. A full structure of themes can be found in Appendix 13. A summary table of the research questions, themes, and subthemes is presented here.



		roles, sexualisation of women, vulnerability, human suffering and suspiciousness
<b>Coping</b>	<p>Theme 10 – Support networks</p> <p>Theme 11 – Humour</p> <p>Theme 12 – Engaging in self-reflection</p> <p>Theme 13 – Understanding function of behaviour</p> <p>Theme 14 – Remind oneself of the importance of the work</p> <p>Theme 15 – Faith in God</p> <p>Theme 16 – Self-care</p>	<p>Theme 10 sub themes – Collegial support and formal supervision</p> <p>Theme 16 sub themes – Being aware of personal limitations, taking slow steps, interests outside of work, boundaries between home and work, and realistic expectations.</p>
<b>Resiliency</b>	<p>Theme 17 – Genuine interest in working with sex offenders</p> <p>Theme 18 – Optimism and hope</p> <p>Theme 19 – Believing that obstacles can be overcome</p>	<p>Theme 18 subthemes – Viewing the client as a human and having a belief that sex offenders</p>

	Theme 20 – Ability to detach from the work	can change
	Theme 21 – Circumstances outside of work	

## How are sex offender treatment workers affected by their role?

### Positive impact

#### *Theme 1- Rewarding and satisfying*

*Sub themes - Privileged to be working with sex offenders, involved in the process of change, preventing further abuse*

All participants were positive about their role as sex offender treatment workers. There was a great sense that participants enjoyed the work that they did and found it incredibly rewarding and satisfying. One of the aspects of the job that contributed to this was some of the participants felt honoured and privileged to be in a position to help sex offenders. Two participants share below how they feel about working with sex offenders and the aspect of the job that gives them the most joy;

I feel very honoured and privileged to be in this position that people let me into their lives, they trust me (Participant one).

I'm really pleased. I feel quite privileged actually erm to be in this position and I and and I I actually feel quite privileged that men will actually open up, and engage, and to be in a treatment room with men who are talking about erm things that they've never spoken to anybody else before (Participant four).

The participants give the impression that they feel privileged when sex offenders allow them to enter their lives, and when they share their experiences. This may be important to the participants because it represents a positive therapeutic relationship, and an opportunity to help the client. This is likely to bring participants joy, satisfaction and feelings of achievement.

Another aspect of the role participants found rewarding was being involved in the process of change. For some participants this was about creating the appropriate group environment where offenders could learn, for others it was seeing clients becoming less resistant, and, most importantly, it was about witnessing clients change in terms of cognitions and behaviour. The examples below highlight witnessing change to be an important aspect of the role, and something participants thrive being a part of.

actually the rewards for me are in being connected to other peoples' personal change  
(Participant three).

it's very satisfying to see progress in the guys. I have an incredibly deep belief that  
these guys can make changes (Participant eight).

Seeing clients change appears to be important to participants as it may act as evidence that the work that they have been doing with clients is working. This is likely to evoke feelings of accomplishment and fulfilment. It may also give them hope that sex offenders can change.

For some participants, job satisfaction is derived from the opportunity to prevent further abuse through their work with sex offenders. For example, two participants spoke about their work not only helping sex offenders improve their lives, but also protecting the public.

I think doing the work that I've been doing I'd like to think that I have helped to  
protect some families from abuse (Participant seven).

I have this sense, the strong sense that I the work that I'm doing is important and that it, it saves another child from being abused (Participant eight).

The participants appear to experience job satisfaction and fulfilment from preventing further abuse. This is likely to make participants value their work, think that it is meaningful, and take great pleasure in what they do. Another interpretation is that preventing further abuse may motivate participants to continue with their work.

### *Theme 2- Building therapeutic and collaborative relationships*

Three participants felt building collaborative therapeutic relationships with clients was extremely important. This is because it made it easier to work with clients.

So if you've got good rapport with somebody that you're working with, you're going to be able to work therapeutically a lot better with them (Participant four).

Another reason for building a collaborative relationship was it helped with sex offenders opening up about their experiences. One participant felt sex offenders may have struggled to feel comfortable talking to anyone about their feelings, so when they did open up, it was a significant step in treatment.

you know helping men who erm maybe never ever opened up or talked about things that so deeply shameful and difficult for them, to see and just how you know one therapy session can improve. That is really exciting you know it's really kind of life giving (Participant one).

Building therapeutic relationships with clients seems to help participants to work with sex offenders. It also seems to be important for participants as it may provide them with feelings of satisfaction and accomplishment, particularly when it is the first time clients open up to professionals. It may also increase the participants' confidence in their ability to work with clients, and the skills they have as treatment providers.

### *Theme 3- Opportunity to tailor treatment to client needs*

Two participants contributed to this theme. These two participants felt one of the positives of their job was the opportunity to tailor treatment to the needs of the client. This was important to them because it ensured clients were getting the treatment that they required. It also made the work varied, interesting, enjoyable and satisfying.

So it's just something you know something new that I can put my teeth in and I get to help to design the programme. So it's about my ideas and skills as opposed to doing somebody else's from a long time ago (Participant six).

the role I'm in allows me to work sometimes in groups, sometimes individually, and sometimes a mixture that allows us to work with areas of deficit rather than trying to find everybody the same stuff (Participant nine).

A reason why only these two participants consider tailoring treatment to the needs of the client as important is because they both had previous experiences of working with a rigid manual which they disliked. The other participants may not have thought that this theme was important because they were already in positions where the treatment was tailored to the needs of the client. Therefore, it may have never been an issue for other participants. In

addition, some participants may even like working from a manual because it makes treatment delivery clear and structured.

### Negative impact

#### *Theme 4- Intrusive thoughts*

##### *Sub theme- Offence/victim thoughts*

One of the negative aspects of working with sex offenders for two of the participants was the intrusive thoughts they had about the offence or the victim. These thoughts seemed to interfere with their home life and possibly caused them distress.

kind of sometimes remembering aspects of the offence at times you know intrusive thoughts at times (Participant one).

when I go home that certain phrases or images keep appearing in my head, and that that's things usually take me a few days to get rid of (Participant five).

Interestingly, both of these participants worked as psychologists solely with sex offenders. It is possible that the nature of their work (i.e., a combination of assessment and treatment) which specifically involved going over the offence, and reading details of the offence contributed to both of them experiencing intrusive thoughts.

#### *Theme 5- Working with difficult, resistant and challenging clients*

Over half of the participants found resistant or challenging clients one of the most difficult aspects of working with sex offenders.

I kind of think one of the most difficult things is when I have to work with someone who are erm very er convinced that their way of acting and seeing things is the right way of doing things (Participant five).

Participants that had worked with difficult clients appeared to feel frustrated about clients' unwillingness to engage in treatment. This concern mattered to them because they were worried about how much the client was taking on board, and their risk of re-offending if the work was not completed. Participants may have also felt drained and suspicious of clients; particularly those that presented superficially. On a positive note, one participant spoke about working harder when confronted with a resistant client.

Erm resistance often er encourages me to be more tenacious and be more to stay with it more. Erm resistance although negative in the short run and rarely runs that course for a long time (Participant eight).

The above extract highlights how the way a situation is interpreted can determine the extent participants' find resistant clients difficult to work with. For participant eight, resistance in clients appears to make her more determined to work with them. This participant had worked with sex offenders for a number of years. Her experiences may have helped her to have realistic expectations about resistance in clients, and also made her aware that resistance is an obstacle that can be overcome.

#### *Theme 6- Clients' re-offending*

Three participants were worried and fearful about clients' re-offending, particularly those clients that were in the community. One participant found it frustrating working with sex

offenders who had a learning disability. This is because they did not understand what was being covered in treatment. This frustration was further reinforced by wider systemic issues resulting in the participant feeling alone.

I suppose you might feel like you have a lot of pressure in the group to make sure make sure know these guys don't re-offend. But then you think oh you know but it's not all on me cuz they've got their probation officers, well the probation is in the pull, it's all over the place. Then all of a sudden that safety net of it's okay probation officers are in there as well goes away so it does put that a bit of extra pressure on you (Participant two).

The above extract suggests that the participant may have felt a sense of personal responsibility to ensure clients did not go on to commit further offences. As described by the participant, this may have placed additional pressure on her. Another interpretation of her experience was that the systemic issues surrounding the Probation Service may have contributed to her feeling isolated and responsible for making sure the clients she worked with understood the material.

For those participants that had clients who did re-offend they found it an extremely upsetting and disappointing time. This is supported by two participants who both appear to feel saddened by the experience of clients re-offending;

it has a couple of times and you know that can be very devastating in terms of how you feel (Participant one).

when someone reoffends absolutely that that grieves me'. (Participant eight)

The words used by the participants to describe the experience of clients re-offending (i.e., “devastating”, and “grieve”) emphasise how difficult such an experience can be for them. In particular, they may feel disappointed, let down by the client, and may even question their own practice with the client.

### *Theme 7 - Fatigue from the work*

Another negative aspect of the job identified by two of the participants was feeling fatigued and drained from the work. There was an emphasis that the work is demanding and requires a considerable amount of energy and drive.

I'm finding it at times a little bit relentless (Participant one).

I think it was just kind of got tired of the cynicism and you know it's quite heavy going emotionally, I think doing this job (Participant six).

The reasons given by the participants for feeling fatigued from work were due to the way clients presented in their attitudes and behaviours. For example, participant one stated;

I guess the biggest thing is that a lot of the people I trained with and friends and colleagues you know when you're working in the community you see change, in sexual offending work the changes are tiny.

As sex offender treatment workers, participants may feel disappointment in the slow progress clients make. They may feel drained and hopeless about how much they can realistically achieve with clients. For this participant, making comparisons with friends who work with other client groups may have highlighted the differences in working with sex offenders.

*Theme 8 – Growing frustrations of unjust support for victims in comparison to sex offenders*

This object of concern was voiced by one participant. The participant expressed her feelings about wanting to work with victims following facilitation of a sex offender treatment group.

what also started to frustrate me was that erm I was putting so much energy and effort and time into working with offenders, and I was thinking you know that that the victims here their victims have probably had nowhere near as much contact with psychologists, therapists and all sorts (Participant two).

This concern mattered to the participant possibly because she may have felt a sense of guilt working so closely with sex offenders. The participant may have also felt that victims are more deserving of treatment than sex offenders. The other participants did not raise this during interviews. One of the reasons which may have contributed to this participant wanting to work with victims was because she was obtaining an array of experiences to develop her career prospects. The work she had done with sex offenders may have highlighted a gap where more psychological support is required and a career development opportunity. It may have also made the participant realise that working with victims is an area of interest and a field she may want to work in. An alternative explanation is her work with sex offenders may have made her feel that the amount of support victims get in comparison to sex offenders is unfair, and possibly unjust.

*Theme 9 –Change in world view*

*Sub themes – Desensitisation, gender roles, sexualisation of women, vulnerability, human suffering and suspiciousness*

Seven of the participants reported changes in world view. The two participants who did not experience a change in world view (participant eight and nine) generally reported experiencing very positive experiences working with sex offenders, and little negative impact.

One of the concerns expressed by three of the participants was becoming desensitised to the material they were exposed to (i.e., offence details). They appeared to have become less distressed by the offences clients had committed, and less shocked by what they were exposed to as workers.

nothing really shocks me in term kind of sexual deviance sexual violence (Participant one).

I suppose I sometimes worry I that I'm just getting a bit blasé about it (Participant three).

This is likely to concern participants because they may feel if they lose sight of the nature of the offence, and do not feel strong emotions, it could impact on their work. For example, participant five reported viewing certain sexual offences (i.e., downloading child pornography) as less serious because the offender had not physically harmed someone. The consequence of this is it may impact on how much cases are prioritised, and reduce how

much workers empathise with the victim. Therefore, their passion/drive to motivate sex offenders may change.

Working with sex offenders also impacted on the male participants' views about gender roles. Their role of working with sex offenders seemed to make them more aware of the harm inflicted by men against women.

it's heightened my kind of social awareness and erm understanding of the role that gender plays in dominance and control of family and in a institutions (Participant seven).

The two participants contributing to this subtheme may feel anger and frustration that men in most cases, appear to be the instigators of violence against females or vulnerable children. This may have led to these participants feeling let down by their own gender, and to question their own masculinity, thinking, and behaviours. Positively, the increased awareness of the role of gender in sexual offending may have allowed them to work positively with sex offenders by role modelling positive behaviours.

Linked to gender roles, is the sexualisation of women in the media. This was a concern expressed by one of the female participants. Below participant one describes changes in society's attitudes about sex and women;

how sexualised women can be in celebrity land and you now in in the media. As a society it's almost like we have now developed this attitude that we're entitled to sex,

we deserve it that that it's ours to be taken, and I just feel like screaming no it's absolutely no.

When sharing her concerns about the sexualisation of women, her tone suggested she feels very strongly about the change in society's attitudes towards sex. For this participant it seems like she may feel frustrated and angry by the messages presented in the media. The wider concern for this participant may be the impact the messages are having on the younger generation, and how it may impact on men who already have cognitive distortions about sexual offending. The participant seemed to be aware that this issue was out of her control which may have led her to feel hopeless.

Another change in thinking experienced by one of the participants was the realisation that she would not be able to protect herself if attacked in the community by a male sex offender.

so that idea of me being able to protect myself is something oh no no you actually couldn't (Participant two).

As a result of working with sex offenders this participant also realised that sex offenders do not follow the stereotypical image presented in the media. Therefore, she felt it would be difficult to spot a sex offender in the community. This reinforced the vulnerability the participant may have felt about her ability to protect herself from being attacked. This change in world view may also have increased her empathy and concern for the victim as being someone who was helpless, and who could not do anything to overpower the attacker. This could have been another reason why this participant was keen to work with victims.

The change in world view theme also included a subtheme of increased awareness of human suffering. This is reflected by the comments made by participant five;

Negatively erm I think that it has it has changed erm my view on what people are capable of doing to other human beings.

The above quotation highlights as a result of working with sex offenders, participant five has gained an insight into the levels of pain and suffering humans can experience. Although this experience may have initially been a difficult process, it can also be viewed as a positive. Consequently, the client may have a realistic view of what the world can be like, and is prepared to see or hear shocking stories from sex offenders.

The final subtheme that contributed to changes in world view was increased suspiciousness. Participants seemed to have noticed as a result of their work that they were more wary of their surroundings, and people around them. For example, participants referred to noticing people that were too close to children, or were overly fascinated in the work that they did with sex offenders. For two of the participants the increase in suspicions appeared more apparent within the context of raising their children.

sort of being overprotective of of your children or suspicious of anybody else  
(Participant four).

if I go to a playground with my children I I look at the bystanders in a different way than other people do (Participant five).

It seems, as a result of working with sex offenders, that parents can become more suspicious of how people interact with children. Although negative, suspiciousness may serve as a protective strategy for these participants. Being vigilant and wary may make these participants feel they are being proactive and protecting their children. However, suspiciousness could also negatively impact on participants' lives if they are constantly worried about others' intentions. This interpretation was disregarded because other participants in the study reported that their work helped them to educate their children about what to look out for and how to protect themselves.

### Coping

#### *Theme 10 –Support networks*

##### *Sub themes – Collegial support and formal supervision*

One coping strategy that all participants used often was seeking support either informally with colleagues or via supervision. Seven of the participants found collegial support was an extremely useful coping strategy. Informal conversations with colleagues were a venue through which participants could express their concerns, obtain support and guidance. Examples of how useful participants found collegial support are illustrated below;

I think the best and the absolute best strategy of all is collegial support (Participant one).

What really helped me doing that group was the relationship I had with my colleagues (Participant two).

Collegial support is likely to be used often by these participants because it is much more accessible than formal supervision, which usually takes place at a set time each week or month (BPS, 2010). Informal collegial support also allows participants to express their feelings as and when they arise. This is likely to be important for participants because they are able to address their concerns promptly. Another reason why participants found this coping strategy helpful was because they felt listened to by their colleagues. This may have led participants to feel reassured and validated. Also some of the participants felt they were able to be more open and honest about their feelings with their colleagues who they had formed trusting relationships with rather than in supervision.

Although participants seemed to value collegial support, they also found formal supervision to be an effective coping strategy when working with sex offenders.

in order to stay in the work and to keep exposing yourself as a worker to the kind of most awful things that people do to each other you need a way ventilating it you know having it erm dealt with in supervision (Participant seven).

By engaging in regular supervision, participants were able to discuss their concerns and use it cathartically. It can also be used to learn from the supervisor, and develop as a practitioner. One participant describes the benefits of formal supervision and how it differs to collegial support;

I think the formal supervision is is important in order to to be able to discuss something as a group and also to get some concrete erm suggestions on what to do (Participant five).

Participant experiences suggest that a combination of collegial support and formal supervision are used as coping strategies when working with sex offenders. They both provide an outlet for participants to address their concerns but in different ways. Collegial support is important for expressing concerns and receiving validation, whereas, supervision provides a space for participants to express their concerns, reflect and learn from their experiences.

### *Theme 11 –Humour*

Humour was another coping strategy participants found useful when working with sex offenders. This is illustrated further by two participants;

one of the most amazing thing about this work is our use of black humour (Participant one)

Then in debrief we would laugh about it that that helped with the frustrations (Participant two).

The use of humour within the work setting helped to create a positive atmosphere. It seemed to be used by participants to put a positive spin on something that actually may have been quite disturbing or difficult to listen to. In addition, it might have increased team cohesion and allowed participants to express their feelings in a socially acceptable manner.

### *Theme 12 –Engaging in self-reflection*

This theme is concerned with participants being aware of their feelings and behaviours when working therapeutically with sex offenders. Six participants felt self-reflection was an important skill to have as a practitioner as it helped to cope with the work.

It's absolutely vital and I think that you know it should be one of the biggest things everybody self-awareness (Participant one).

I think the biggest thing for me is the reflective practice bit (Participant nine)

This coping strategy was important for participants as it allowed them to be aware of their limitations (what they felt they could and could not do), monitor their feelings and behaviours. Self-reflection also encouraged participants to think about what actions they need to take in order to overcome negative feelings and difficulties they may have faced when working with clients. Therefore, self-reflection is an important coping strategy for participants as it helps them to learn, develop, prepare, and flourish.

### *Theme 13 –Understanding the function of behaviour*

When three of the participants had faced difficult clients (i.e., resistant to treatment, denied offences or lacked motivation), their way of dealing with these difficulties was to think about the reasons for the client's behaviour.

I tend to think about well where's that coming from, why he's like that, what erm what has he said that helps help with it (Participant three).

way that I work with people like that I try to sort of get underneath the presentation of what really going on for this person (Participant four).

Focusing on the function of the behaviour appeared to be an important coping strategy for these participants. This is because it may have helped them to make sense of the situation by considering the different reasons to explain the client's behaviour. By hypothesising what might be driving the clients' behaviour, it could help with generating strategies to overcome difficulties.

*Theme 14 –Remind oneself of the importance of the work*

The analysis revealed that participants felt strongly that the work they were doing with sex offenders was important. This was because it had wider implications, such as reducing re-offending and preventing further victims. Reminding themselves about the importance of the work seemed to help participants cope with the demands of the job and to remain committed despite challenges.

It's more because you know sexual abuse is horrible and I'm working for the victims in a very roundabout way (Participant six).

I only have to ask myself that question to realise that what I'm doing is important that I can't not do it (Participant eight).

I value what I do. I know its worth (Participant nine).

The above comments indicate by remembering how important the work is for the offender and the public helps participants to remain focused and motivated to working with sex offenders. When participants think about this it appears to be a strong motivator for persevering through challenges.

### *Theme 15 – Faith in God*

This theme was extremely important to one participant. Her faith in Christianity and God seemed to sustain this participant and help her to cope with the work.

I have a strong Christian faith and that and that's erm and a part of that and and I play music (Participant eight).

Her faith in God helped her to accept upsetting situations such as if a client re-offended. Instead of ruminating about the situation she turned to God and focused on what she could learn from the experience. Her faith also influenced the activities the participant chose to engage in during her spare time. For example, being a worship leader or singing helped the client to separate from work and immerse herself in her faith.

### *Theme 16 – Self-care*

*Sub themes – Being aware of personal limitations, taking slow steps, interests outside of work, boundaries between work and home, and realistic expectations*

Most participants engaged in some form of self-care to help them to cope with their work. Self-care was about taking personal responsibility for looking after oneself, rather than relying solely on organisational strategies like colleagues and supervision.

One of the ways participants took care of themselves was by being aware of personal limitations. This involved being aware of what they could and could not handle. Participant one demonstrates this more clearly below;

the longer I am in this field the more I realise my limitation and what's achievable and what's not and needing to manage that so you don't get burnout (Participant one).

The participant highlights in order to cope with the work she needs to be aware of what she can achieve as a practitioner. Later in the interview, she provides an example of saying no to working with a client if she does not feel she can work with them. For this participant it is important for her to know what she is capable of doing so she does not take on cases that become unmanageable, which could lead to negative consequences like burnout.

A self-care strategy adopted by one of the participants was taking slow steps. This involved pacing oneself to avoid feeling overwhelmed.

I think it was just about pacing yourself and things erm to manage the frustrations (Participant two).

This participant worked on an adapted treatment group for sex offenders with learning disabilities. Taking slow steps seem to relate directly to the client group she was working with. The participant had reported it was frustrating working with this client group because it took time for them to grasp concepts like consent. Taking small steps helped the participant to cope with frustrations, and was also good for the clients as she went at their pace.

Four participants felt it was important to have interests outside of work. One participant in particular felt it was essential to engage in activities that were different to what she did at work. For example she made the following comment;

I always have something to do, some hobbies whether it's an acting class or something to do with music, or just something totally different (Participant six).

Engaging in hobbies outside of work assisted with taking participants' mind off work, and facilitated with creating a work and home life balance. It also provided them with something to look forward to, and served as a reward.

As mentioned above having hobbies helped with creating a balance between home and work. Home and work life balance was considered important to achieve particularly by two participants. The concern of one participant was that sometimes personal situations could interfere with work.

I think it is making sure that erm outside of work is okay and you're not blurring the boundaries between work and home (Participant four).

For participant four, self-care involved coping with difficulties at work, but also taking responsibility for resolving problems outside of work. This was to prevent them interfering with job performance. For both participants who supported this theme they had either experienced personal difficulties affecting their focus at work, or they had observed other members of staff struggling when they had difficulties in their personal life.

Five of the participants felt it was important to have realistic expectations when working with sex offenders.

I need to lower my expectations erm so not feel completely frustrated by by him  
(Participant three).

It's recognising that this might happen I think in first instance and foremost you need to be aware that this might happen (Participant four).

By having realistic expectations participants were able to accept what they could achieve and also how much a client is likely to progress. It prevented participants from becoming frustrated or disappointed by clients' progress. This is an important self-care strategy for participants particularly as other participants in the study highlighted how changes in sex offenders can be slow.

### Resiliency

#### *Theme 17 –Genuine interest in working with sex offenders*

One factor that four participants felt underpinned resiliency was whether workers were genuinely interested in helping sex offenders. Participants felt this was important because those professionals who enjoy the work are likely to remain in the role despite challenges they may face.

I think if you've got any interest in the area it's great, if you don't I wouldn't go into it (Participant one).

usually the ones who erm who continue being good at what they do, who have genuine er care for the patients and and actually want want to help them and and become better at their job (Participant five).

I enjoyed doing that kind of work. It was a kind of discovery I was interested in it (Participant eight).

The above comments highlight that it is essential for sex offender treatment workers to have a genuine passion and drive to work with sex offenders. This ensures that they remain focused, committed, and continue to find helping sex offenders enjoyable and interesting.

### *Theme 18 – Optimism and hope*

#### *Sub theme – Viewing client as a human and having belief that sex offenders can change*

Four participants felt that being optimistic and hopeful about the client and their potential to change were important factors which increased resiliency. In particular, participants felt that if sex offender treatment workers were able to view the client as a human or to find things about the client they liked that would help them to work with sex offenders.

I read him as a person, as an individual not as a sex offender (Participant eight).

I see them as people in a horrible place you know done horrible thing but actually there's a lot more to them than just that (Participant six).

in order to help them we have to find something we can like about him (Participant five).

Participant five felt workers' who disliked sex offenders or could not find anything they liked about them, often left the field prematurely. Viewing the client as a human is important for the participants in this study because it helps them to work with them. It is also likely to help the worker to show compassion and empathy towards the client which is one of the key therapist features that have been found in the literature to help sex offenders engaging in treatment (Marshall et al. 2009).

Participants also endorsed the view that resiliency was enhanced if you believed sex offenders could change:

I'm conscious that actually there's quite a good chance that this man's going to develop into a more positive way either in the next hour or the next ten months  
(Participant three).

Hope and faith that the client will change helps participants to remain motivated and committed to working with sex offenders. It is possible that workers who do not believe sex offenders can change may become cynical, frustrated and disappointed with the slow progress.

#### *Theme 19 – Believing that obstacles can be overcome*

Two participants were confident in their ability to overcome difficult challenges when working with sex offenders.

I almost feel like I could be faced with anything and have a sense of roughly how to deal with it (Participant one).

This belief that they can overcome challenges appears to relate to how they have dealt with previous experiences. One of the participants went into detail about difficulties she had previously and how coping with it gave her confidence that she could face any future obstacles. The experience the participant describes is similar to that of self-efficacy (Bandura, 1977). Self-efficacy seems to be another important factor that underpins resiliency for these participants. It ensures they remain motivated and committed despite any obstacles they may face.

#### *Theme 20 – Ability to detach from the work*

There were two participants that contributed to this theme. Both participants felt a detached coping style made them resilient. Detached coping for these participants involved having boundaries between work and home, and not overly thinking about the work.

I think you need to be detached erm for I need to be detached from from from that really (Participant four).

I think detached copers do much better. Ruminators don't do very well at all (Participant nine)

Adopting this detached coping style made both these participants resilient to the work. In fact, they were both very positive about their experiences, and emphasised the importance of not letting work interfere with home life. Their description of detached coping is consistent with existing literature which refers to it as being detached from the events, feeling independent from the circumstances, and not taking things personally (Roger, Jarvis & Najarian, 1993).

### *Theme 21 –Circumstances outside of work*

Linked to theme 18, this theme relates to personal circumstances interfering with working with sex offenders. Again both participant four and nine felt resiliency was influenced by personal circumstances.

I think it's very much what's going on your personal life that will that will affect  
(Participant four).

I think at different times people, when other things are going on in their lives people's  
levels of resilience vary (Participant nine).

Both of these participants held managerial positions within the organisations they worked. Therefore, they had either witnessed personal problems of other workers affecting their resiliency at work, or they had experienced their own problems. As a result of personal experiences, an individual's resiliency may vary depending on what is happening outside of work. This highlights how resiliency is dynamic (Hernández, Gansei & Engstam, 2007).

### Summary

This section has described the ways in which sex offender treatment workers are impacted both positively and negatively by their roles, the coping strategies they use, and what keeps them resilient. The experiences have contributed to meeting the thesis aim of gaining an insight into how sex offender treatment workers are responding to their role of working therapeutically and collaboratively with clients. The next step is to consider how the data from the analysis fits in with previous research, the implications on practice, future research, and the role of the researcher in shaping the findings.

## **Discussion**

The aim of this study was to gain an insight into the experiences of sex offender treatment workers. In particular, to understand the consequences (both positive and negative) of working with sex offenders, to learn how professionals cope with their work, and to identify factors that underpin resiliency. To meet these aims the study adopted a qualitative design which involved carrying out semi-structured interviews with professionals who worked therapeutically with sex offenders. The interviews were then transcribed and analysed using TA and aspects of IPA. In total, 21 themes emerged from the data which are discussed further below;

The themes were separated by research questions in order to enhance the structure and transparency of the analysis. The themes highlighted that sex offender treatment workers experienced a number of positive and negative consequences as a result of the work. The positives included finding aspects of the job rewarding (privileged to be working with sex offenders; involved in the process of change; preventing further abuse), enjoying building therapeutic relationships with clients, and being able to tailor treatment to client needs. The positive aspects of the job ensured participants felt satisfied within their roles, accomplished, and proud to be in a position to provide treatment to sex offenders, and prevent further abuse. The negatives of working with sex offenders included the following; intrusive thoughts (offence/victim thoughts); working with resistant clients; clients re-offending; fatigue from the work; growing frustration of unjust support for victims in comparison to sex offenders and change in world view (desensitisation; gender roles; sexualisation of women; vulnerability; human suffering; suspiciousness). These themes indicate whilst working with sex offenders participants experienced some negative emotions that caused them to feel distressed, worried and frustrated. Some of the negatives identified, such as fatigue,

experiencing intrusive images and change in world view, are consistent with the definitions of burnout and VT (Pearlman & McCann, 1995; Pines & Aronson, 1998). This highlights that some of the participants may have experienced psychological distress.

The themes also highlighted an array of coping strategies adopted by professionals who work with sex offenders. These included the following; support networks (collegial support; formal supervision), humour, engaging in self-reflection, understanding the function of the offenders' behaviour, reminding oneself of the importance of the work, faith in God, and self-care strategies (being aware of personal limitations; taking slow steps; interests outside of work; boundaries between work and home; realistic expectations). All of these strategies helped participants to reflect on their feelings, share their concerns with others, and make sense of difficult situations. Setting boundaries and forming interests outside of work facilitated with taking their mind off their jobs.

There were four themes that helped to explain what enhanced resiliency in sex offender treatment workers. These included the following; having a genuine interest in working with sex offenders, optimism and hope (viewing client as a human; belief that sex offenders can change), believing that they can overcome obstacles; ability to detach from work, and circumstances outside of work. The findings highlight that participants felt these were the most important factors that enhanced resiliency.

The themes on the positive impact of working with sex offenders support quantitative studies that have also found that sex offender treatment workers to experience high levels of accomplishment, and satisfaction from their roles (Hatcher & Noakes, 2010; Shelby, Stoddart & Taylor, 2001). This indicates that despite different methodologies both quantitative and

qualitative designs have yielded similar findings. The current study also discovered that some participants experienced negative consequences like fatigue, intrusive images and changes in worldview. However, the way the negative consequences were described by participants suggested that they did not appear to be causing them significant distress. This contradicts previous studies that have shown sex offender treatment workers to experience high levels of emotional exhaustion, and compassion fatigue (Kadambi & Truscott, 2003; Steed & Bicknell, 2001). As highlighted in Chapter 2, the differences in findings may have occurred because the psychometric tools used in quantitative studies do not accurately measure the constructs. The results may also be explained by there being different professionals included in the study who have worked in different settings. The professionals may vary in the amount of support they have received, their caseload and organisational policies. The discussion below considers the extent the findings from the current study relate to, or challenge, previous qualitative research.

The current research highlighted that although sex offender treatment workers may find aspects of their role negative, on the whole they were passionate about their work. This finding is similar to other qualitative studies like Dean and Barnett (2011) who found that facilitators of a sex offender treatment programme in the UK gained satisfaction from empowering clients and witnessing change. The negatives they experienced included questioning core beliefs (i.e., gender roles, identity), experiencing intrusive imagery, and becoming overly suspicious of others. This is similar to the negatives that were identified in the current study. This suggests that the experiences of sex offender treatment workers are similar across both studies; they are generally satisfied with their roles despite experiencing some negative consequences.

Another qualitative study that supports the current findings is by Scheela (2001). It was found that therapists who worked with sex offenders enjoyed the work especially if clients changed, and if professionals could separate the offence from the client. This is consistent with the current findings because many of participants reported gaining satisfaction when clients progressed in treatment. Participants in the current study also reported it was easier to work with clients if they viewed them as humans. The negatives raised by therapists in Scheela's study were also similar to the current findings. Both studies found that participants struggled when clients re-offended, were more suspicious, and experienced changes to cognitive schemas like safety and gender roles.

Findings from the current study are also similar to a qualitative study conducted in New Zealand by Slater and Lambie (2011). They found that participants who worked with sex offenders were passionate about their roles, and believed that the clients they worked with could change. They were also able to separate the offence from the person, and were motivated to make a difference. The downside of working with sex offenders included managing resistant clients and when clients re-offended. Again, these findings are similar to the current study because they reveal that sex offender treatment workers experience both positive and negative consequences of the work. The findings also indicate that sex offender treatment workers are generally satisfied with their roles. Therefore, perhaps the positives of the job outweigh the negatives. The consistency in findings between the current study and studies previously conducted highlight that, although the contexts in which sex offender treatment workers work may be different (i.e., different countries, work settings) the overall experience appears to be similar.

## Coping

The themes on coping support previous studies that have shown that supervision, self-reflection, and self-care help to reduce the negative consequences of working vicariously with sex offenders (Bober & Regehr, 2006; McCann & Pearlman, 1990; Moulden & Firestone, 2007). For example, Scheela (2001) found sex offender treatment workers coped by using supervision, humour, activities outside of work, and detaching themselves from the work. Findings from Leicht (2003) also support the current findings as they found sex offender treatment workers used the following strategies; supervision, hobbies and understanding the function of the behaviour. The themes on coping in this study, particularly supervision, self-reflection, self-care and humour are consistent with other qualitative and quantitative studies. This strengthens the quality of the findings because both methodologies elicited similar findings. This emphasises that the coping strategies employed by the participants in this study may be a reflection of what other workers are using.

There are coping strategies found in the current study that are less consistently mentioned or not mentioned at all in the previous literature, such as understanding the function of behaviour, reminding oneself of the importance of the work, and faith in God. These strategies may be specific to the participants that engaged in the current study, and may not be strategies widely used. For example, faith in God can only be used as a coping strategy by those who have a faith.

Participants reported that perceiving the offender as a human and adopting an optimistic and hopeful outlook increased resiliency. This differs to previous research, which has suggested that viewing the offender as a human and an optimistic attitude helped sex offender treatment workers *cope* with the work (Harrison & Westwood, 2009; Leicht, 2003). There appears to be

some overlap between the literature and current findings about how professionals cope with working with sex offenders and what makes them resilient. This is supported by Harrison and Westwood (2009) who suggested that an optimistic outlook, being aware of personal feelings and seeking support via supervision helped professionals to cope with the work, but also protected them from negative consequences. An explanation for the overlap between coping and resiliency has been proposed by Rutter (1990). He suggested coping is related to resiliency because it involves evaluating how to resolve a problem and taking action to alleviate distress.

### Resiliency

There is limited research on the factors that enhance resiliency in sex offender treatment workers. As mentioned above, the current research discovered themes for resiliency which appear to mirror what other researchers have labelled as coping strategies. For example, Leicht (2003) found clinical psychologists coped with the work by separating the client from the offence and by holding onto a belief that they could help the client change. This is consistent with one of the themes for resiliency; optimism and hope which had sub themes of 'viewing the client as a human' and 'believing that sex offenders can change'. It is possible that the way professionals cope with the work also contributes to resiliency. This helps to explain why there may be an overlap between themes for resiliency and the literature on coping. The implications of this is further research is required to explore resiliency in sex offender treatment workers. In particular, to identify factors that are different to the way professionals cope. This will be discussed in detail later in this discussion.

### Strengths and Limitations of the research

One of the strengths of this research was the method used to recruit participants. By recruiting participants through organisations like NOTA, ATSA and IATSO the research was advertised to a range of professionals who worked with sex offenders. An advantage of this method was it widened the search for participants, therefore, increasing the likelihood that a number and range of participants would be recruited for the study. The final number of participants was nine. Previous research by Thompson, Smith and Larkin (2011) indicates that this figure is appropriate for doctorate research. A further advantage is the participants recruited ranged in the countries they were from, the settings they worked in, and their occupations.

A further strength of the study was conducting interviews via telephone. This made it easier to reach participants outside of the UK. Although telephone interviews are an effective way of reaching out to participants, it does have limitations as outlined in the Method. One of the participants reported that it was difficult to hear what the researcher had said and felt this was made more difficult by the absence of non-verbal facial expressions. However, this was the only participant to report this, and most of the others were extremely forthcoming about their experiences, and provided detailed accounts.

It has been recommended by Smith, Flowers and Larkin (2009) that the sample should be homogenous. Although all participants worked therapeutically with sex offenders, three of them were from outside of the UK. It could be argued that the sample is not homogeneous because the experiences of participants working with sex offenders outside of the UK may differ to UK participants. However, the participants from outside of the UK reported similar themes to those in the UK. Also, one of the participants had worked in the US and the UK,

and reported there were no differences in experiences between the two countries. This highlights that the experiences of sex offender treatment workers appear to be consistent across different contexts. This seems to be a common finding when comparing the results from the current study to previous research that has used different designs, different contexts, and countries. This shows the experiences of sex offender treatment workers, and coping strategies used are similar particularly in qualitative research.

The mean age of participants was 48 years, and some of the participants had over 20 years of experience working with sex offenders. A limitation of this is it may have contributed to participants reporting positive experiences of working with sex offenders. This is because it is expected that those who had stayed in the field for many years are likely to have enjoyed the work. It is possible if the study included younger, more inexperienced participants the experiences reported may have been different.

A further limitation of the qualitative study was only one researcher was involved in analysing the data. This was due to time constraints and resources. An implication of this is inter-coder reliability could not be assessed. Therefore, it is unclear if the themes identified in the research would also be identified by others. To counteract this, the process of identifying themes has been clearly explained which, was one of the recommendations made by Silverman (2013), to enhance quality and transparency of the themes. Additionally, the researcher has considered biases that may have impacted on the analysis, and discussed the themes during peer supervision, and with the academic supervisor.

### Role of the researcher

TA requires the researcher to use a template through which themes are developed, and IPA requires the researcher to engage with data from participants. The purpose is to make sense of meaning, and provide a detailed focus on the phenomenon being explored (Larkin & Thompson, 2012). Therefore, for both methods of analysis it is important that the researcher reflects on how their experiences and assumptions impact on the interpretation process. This is because it could impact on the reliability and validity of the interpretations (Silverman, 2013).

The questions included in the interview schedule were based on the findings of previous research, and my research questions. Therefore, the schedule adopted a deductive stance because the information obtained from participants fitted in with what I wanted to learn. However, the semi-structured nature of the interview, allowed me to explore areas participants had brought up that I had not considered. For example, a participant that had worked in two countries, and another participant spoke about the impact of Government policies on the treatment for sex offenders, and how this affects workers.

For data analysis, I initially found it difficult to interpret participants' accounts. At times, I felt I was clutching at particular words participants had said, or their tone of voice to ascertain what it might mean for the participants. To help with interpretation, especially during the first couple of transcripts, I thought about my own experiences of working with sex offenders. In particular, I considered if I had experienced any of the positives or negatives the participants had, and if I did what they had meant to me. I also did this for themes on coping. For example, I thought about what it means for me to have supervision, and to understand the function of the clients' behaviour. I found this helped me to practice IPA

skills, and begin to put myself into the participants' shoes. I became more confident by practising meaning-making using my own experiences I then applied the technique to the participants. It is possible some of the interpretations may have been influenced by my own experiences. To minimise this, I tried to compare and contrast transcripts to see whether other participants had similar concerns, and if they could shed light on what it meant for them. I also included themes in the analysis that differed to other participants. In addition, I shared the themes and interpretations with my supervisor. I also discussed them during a peer supervision session with colleagues who had knowledge about IPA.

### Implications of the research

An implication of the research is it highlights that although professionals working with sex offenders experienced negative consequences (i.e., resistant clients, intrusive images; change in world view) as a result of the work, the positives (i.e., being involved in the process of change; preventing further abuse; building therapeutic relationships) seem to outweigh the negatives. The findings also highlight that all participants found the work rewarding and satisfying. This indicates that sex offender treatment workers may be less affected by the work than has been originally suggested (Farrenkopf, 1992; Kadambi & Truscott, 2003). This highlights how more attention should be devoted to finding out what factors lead to sex offender treatment workers remaining well, and how these can be used to prevent any negative outcomes of the work.

One of the reasons that might explain why participants are happy with their roles is the coping strategies used. The participants reported engaging in a number of coping strategies such as making use of support networks, humour, and understanding the function of the clients' behaviour to assist with managing difficulties they faced when working with sex

offenders. An implication of this is employers should be offering refresher training to sex offender treatment workers about the consequences that may occur when working with sex offenders, and the best ways to cope with the difficulties. Increasing awareness of the negatives of their work, and providing workers with information on how to deal with the impact may equip them to better manage the work.

One of the most important coping strategies identified by participants was making use of support networks which included colleagues and supervision. It is recommended that supervision is consistently made available to staff members working therapeutically with sex offenders regardless of the setting (i.e., community, private practices, prisons, probation, hospitals). This is important because the participants in the current study highlighted that it provided an outlet to discuss concerns, learn and develop as a worker. Managers should be ensuring employees receive regular clinical supervision on a weekly, fortnightly or monthly basis depending on the service needs. If the organisation is unable to offer regular supervision, it is recommended that they consider buying this service in so that their employees have the opportunity to obtain support.

The participants' experiences about the factors that increase resiliency highlighted that professionals need to be genuinely interested in working with sex offenders, and adopt an optimistic outlook about treatment. An implication of this finding is that employers should ensure when recruiting for jobs, interest and optimism is assessed during interviews. This could be achieved through questions about why they are applying for the job, and why they are interested in working with sex offenders. It may also be important to include this as an essential requirement for the role. This may prevent individuals applying for positions in which they are not genuinely interested. Managers could also ask these kinds of questions

during supervision or yearly appraisals to ensure those already employed still enjoy the work. In addition, employees should also take responsibility to monitor their feelings.

#### Avenues for future research

As the research has highlighted participants were happy with their roles it is essential for research to continue to explore the factors that underpin resiliency. It is also important to explore this further because the ways in which participants cope, and what makes them resilient, seem to be blurred. This could be achieved through qualitative methodology using semi-structured interviews, initially with participants from one organisation such as HM Prison Service, and then moving onto other organisations like the NHS. This would allow rich and detailed data to be obtained from participants who work in two of the main organisations in the UK delivering treatment to sex offenders (British Psychological Society, n.d). Identifying these factors could assist with employers being aware of what they need to look out for in potential candidates during interviews. This would ensure that the individuals they recruit can cope with the demands of the job, enjoy the work, and stay within the role for longer. It would also be helpful for existing employees to be aware of the factors that underpin resiliency because they can use the knowledge to evaluate their own practice, and develop as a practitioner. Furthermore, by understanding what helps sex offender treatment workers to be healthy and psychologically well will ensure preventative measures are in place if consequences like burnout, CF or VT occur when delivering therapeutic treatments to sex offenders.

As previously mentioned there appears to be an overlap between resiliency themes and coping literature. Consequently, further research is required to clarify the definitions of both concepts so that the distinctive features of each are explicit. Future research should also aim

to explore other factors that underpin resiliency that are not related to coping. This is because the body of evidence on how sex offender treatment workers cope with the work is fairly strong, but there is little on other characteristics that enhance resiliency. As previously mentioned, Luthar et al. (2000) suggested that resiliency is shaped by individual, family or environmental (i.e., workplace settings) factors. In an article by Clarke (2011) she suggested factors that may mediate resiliency, such as, managing energy (renewing energy expended), how much workers value their work, emotional sensitivity, and work climate (i.e., poor communication).

Once sufficient qualitative data has been obtained on the factors that increase resiliency in sex offender treatment workers, research can move onto testing how these factors relate to scales like the Professional Quality of Life Scale (ProQOL) (Stamm, 2005) which includes a subscale to measure compassion satisfaction, as well as for burnout and CF. The Maslach Burnout Inventory (MBI; Maslach, Jackson & Leiter, 1996) could also be used as it comprises of three subscales (emotional exhaustion, depersonalisation and personal accomplishment) that measure burnout. It is important to carefully consider which scales to use as previous findings have highlighted that some of the scales used within this field do not produce similar patterns of secondary trauma across different studies (Kadambi & Ennis, 2005). However, it is not clear if this is due to the reliability or validity of the tools, or the constructs themselves.

During interviews, participants did not discuss anything related to the new concept of vicarious resilience which relates to gaining inspiration through listening to clients' stories, and learning from clients about how to overcome difficult situations (Hernández, Gansei & Engstrom, 2007). However, participants were not specifically asked about this new concept,

and were instead asked to discuss the positives and negatives of the job. It would be worthwhile exploring this further to see; 1) if this phenomenon actually occurs amongst sex offender treatment workers, and 2) if it could be another factor to explain resiliency amongst sex offender treatment workers.

### Conclusion

The study aimed to explore the consequences of working with sex offenders, how sex offender treatment workers coped in their role, and the factors that lead to resiliency. The participants reported experiencing negative consequences of the work. However, despite the negatives, all the participants spoke about how much they enjoyed their jobs, and how rewarding they found it. A number of strategies were adopted by the participants to cope with their work, such as supervision, self-care and self-reflection. These themes were consistent with previous findings on those who work with sex offenders. The themes on resiliency provided an insight into what enhances resiliency. Although some of the themes were similar to the coping literature, there were other themes (i.e., circumstances outside of work) reported by participants that explained how resiliency may be enhanced or decreased. The implications of the research are that employees should take steps to recognise symptoms and seek assistance. For employers, they should ensure all workers receive regular training on the consequences of the working with sex offenders and how to cope. They should also provide opportunities for staff to have regular supervision whether that is with a line manager, peers or an external agency.

**CHAPTER 5**  
**THESIS DISCUSSION**

## **Thesis Discussion**

The first chapter introduced the aims of this thesis which were 1) to explore how sex offender treatment workers were affected by working therapeutically with sex offenders, 2) to learn how sex offender treatment workers are coping with their roles, and 3) to find out how they remain resilient. The purpose of carrying out this research was because previous research had highlighted that therapist features like empathy, warmth, rewarding, and directive approach may contribute to treatment effectiveness (Serran & Marshall, 2010). In addition, RNR principles and GLM requires the therapist to tailor the treatment to the client needs, and adopt a positive approach to encourage offenders to meet their needs in pro-social ways (Andrews & Bonta, 2003; Ward, 2002). Therefore, it is important that sex offender treatment workers are psychologically well and are coping with working with the above treatment models for sex offenders.

To meet the aims of the thesis, Chapter 2 involved conducting a systematic literature review, to establish the extent sex offender treatment workers are impacted by their work, the factors that mediate/moderate psychological distress, and how they coped. In Chapter 3, the TSI was critiqued to assess its suitability in measuring psychological distress in sex offender treatment workers. Chapter 4 was concerned with qualitatively exploring the impact of working therapeutically with sex offenders with participants currently working in the field. The findings and implications from each chapter will be discussed below.

## Summary of findings

### Chapter 2 - Systematic literature review

The systematic review contributed to the thesis aims by providing a snapshot of previous findings on the experiences of sex offender treatment workers. It also facilitated with identifying gaps in knowledge, future research, and implications on practice. The 12 studies included in the review revealed that the extent to which sex offender treatment workers are negatively impacted by their work and the factors that predict psychological distress in sex offender treatment providers is unclear. However, the qualitative studies were much more consistent in their findings in comparison to quantitative research, suggesting that the measures used in quantitative studies may not accurately assess secondary trauma. The most consistent findings from the review was that strategies like supervision and speaking to colleagues protected sex offender treatment workers from experiencing negative consequences of the job (i.e., intrusive thoughts, suspiciousness), and also helped them to cope in times of distress. Another finding of the review was that in some studies (Dean & Barnett, 2011; Scheela, 2001; Slater & Lambie, 2011) participants experienced both positives and negatives of the job. The positives (satisfaction, rewarding) seemed to override the negatives particularly when participants adopted the strategies mentioned above.

### Chapter 3 - Critique of the TSI

This chapter involved critically evaluating the reliability and validity of the TSI because Chapter 2 highlighted that previous psychometrics used to assess secondary trauma may not be measuring the constructs adequately. It contributed to the thesis aims by considering whether the TSI could be used by organisations to measure distress in sex offender treatment workers.

The findings from the critique were that the TSI had adequate reliability and validity. The strengths of the TSI were that it measured what it was intended to be used for across different samples and populations in a reliable and consistent manner. The limitations of the TSI included a lack of information on content validity and test-retest method. Additionally, there was limited information about the predictive validity of the TSI for those who have experienced traumatic events other than victimisation. This is particularly important especially if it were to be used to assess psychological distress in sex offender treatment workers. This is discussed further below when considering implications.

#### Chapter 4 - Research findings

The purpose of the fourth chapter was to explore the experiences of sex offender treatment workers using qualitative methodology. A qualitative design was considered most appropriate because the review in Chapter 2 revealed that the findings were more consistent across qualitative studies. Similar to the systematic review, the aims were to find out how sex offender treatment workers were impacted both positively and negatively by their work, the coping strategies utilised, and the factors that enhanced resiliency.

The themes identified highlighted that sex offender treatment workers experienced both positive and negative outcomes. The positives included finding aspects of the job rewarding, enjoying building therapeutic relationships with clients, and being able to tailor treatment to client needs. The negatives of working with sex offenders included the following; intrusive thoughts, working with difficult clients, clients re-offending; fatigue from the work; growing frustrations of unjust support for victims in comparison to sex offenders and change in world view.

The themes also highlighted an array of coping strategies adopted by professionals who work with sex offenders. These included the following; support networks, humour, engaging in self-reflection, understanding the function of the offending behaviour, reminding oneself of the importance of the work, faith in God, and self-care strategies. The factors that led to resiliency in sex offender treatment workers included; having a genuine interest in working with sex offenders, optimism and hope, believing that they can overcome obstacles, having the ability to detach from work, and circumstances outside of work.

#### *Implications for therapists and clinical practice*

The chapters of this thesis have highlighted that it is difficult to draw solid conclusions about the extent to which sex offender treatment workers are impacted by the work, particularly for quantitative studies where the findings have been mixed (Ennis & Horne, 2003; Kadambi & Truscott 2003; Steed & Bicknell, 2001). In contrast, the qualitative research, including the study described in Chapter 4, has provided more consistent findings. These are that sex offender treatment workers experience negative aspects of their work (i.e., intrusive thoughts, fatigue, and change in world view), however they enjoy their jobs, and find them rewarding. This indicates that the positives of the work may override the negative consequences. Additionally, it highlights participants may have developed strategies to help them cope with the negative consequences of delivering treatment to sex offenders that adopts RNR principles, and the Good Lives approach.

The implications of this are that sex offender treatment workers need to be aware that the work could have an impact on them, and what to do to prevent/minimise distress. Findings from the chapters have highlighted that the most commonly reported coping strategies used by sex offender treatment workers were supervision, speaking to colleagues, and to regularly

engage in the process of self-reflection either individually, during supervision, or with colleagues. An implication of this is that sex offender treatment workers need to be proactive in ensuring they regularly engage in supervision, seek collegial support, and reflect on practice in order to remain mentally and physically well when working therapeutically with sex offenders. Self-reflection can provide an opportunity for sex offender treatment workers to think about their practice with clients, monitor feelings, and notice changes in thoughts/behaviour (Lane & Corrie, 2006). By engaging in self-reflection, sex offender treatment workers may notice signs of distress and take responsibility to overcome these. Certainly, for professionals who have undergone training (i.e., psychologists, social workers and therapists) reflecting on practice is sometimes a mandatory requirement of their training and on-going professional development (O' Donovan, Halford & Walters, 2011). Therefore, it would be expected that these professionals would be accustomed to engaging in self-reflection and be familiar with the process.

Self-reflection may not be a skill that all professionals are familiar with or find easy to do. For example, in a systematic review on reflective practice (Mann, Gordon & MacLeod, 2009) the ability of practising professionals (i.e., nurses, teachers, and medical practitioners) to engage in reflection varied across individuals. The review also highlighted that the skills of reflection can be learnt through diaries, portfolios, and group discussions. These findings suggest professionals who struggle to self-reflect may develop this skill with further support or training. Although, training may not always be possible for organisations where resources are limited, professionals could practice self-reflection strategies independently by writing a diary.

Other coping strategies that have emerged from the previous chapters are the importance of self-care strategies like having boundaries between work and home, hobbies, and realistic expectations about how much sex offender clients can change. Those who work with sex offenders should consider what they can realistically achieve with the clients, and set personal boundaries (i.e., how much work they can take on, if they are struggling with clients, or if they need a break).

The research also highlighted that resiliency was enhanced when workers have a genuine interest in helping sex offenders, and are hopeful that clients can change. An implication of this is if workers lose interest or hope it may impact on the therapeutic relationship with clients. Workers may be less committed to working with sex offenders, show frustrations, become cynical, and withdraw from the work (Farrenkopf, 1992; Sexton, 1999). It is important for sex offender treatment workers to recognise how they feel and take action to prevent this from happening. This could involve engaging in supervision, speaking to colleagues or using the other coping strategies identified in the research.

#### *Implications for managers and organisations*

An implication for organisations is to offer refresher training to sex offender treatment workers about the consequences that may occur when working with sex offenders, and how to cope. This will increase awareness and equip sex offender treatment workers with the skills required to manage the work.

As previously mentioned, the chapters of this thesis have highlighted the importance of supervision as a preventative/coping measure. An implication of this finding for organisations is that they need to value the important role supervision plays in helping staff to address

issues, and make it an essential part of the job requirement. They also need to be aware that supervision provides an outlet for staff to reflect on their work, develop as a practitioner, and improve clinical practice (Lane & Corrie, 2006). To ensure sex offender treatment workers have an outlet to discuss concerns, organisations should give managers time to consistently provide supervision to staff. If managers are unable to consistently offer this service to staff, organisations should consider hiring an independent provider to offer supervision. Another option is to encourage senior members of staff who are not necessarily managers to offer supervision to colleagues. This would free up managers' time to focus on offering supervision to those workers who may be struggling with the work.

Previous chapters have also indicated that speaking to colleagues is a useful coping strategy to manage distressing aspects of the job. An implication for organisations is to offer sufficient opportunities for colleagues to interact with one another. This could include peer supervision, reflective practice sessions, case formulation discussions, and training. These outlets would allow sex offender treatment workers to discuss concerns, reflect on practice, and gain advice and support from colleagues.

It was also found that participants believed having a genuine interest in working with sex offenders and believing that clients can change enhanced resiliency. An implication for managers is that during supervision they should ask questions to find out about how much sex offender treatment workers are enjoying the work. Other questions managers should be asking employees is if there is anything they need to be aware of that might interfere with the employee's ability to work therapeutically with sex offenders, and their job performance. This was another factor identified by participants to impact on resiliency. Professionals may find this question intrusive, and therefore be reluctant to discuss this with their supervisor. It

has been suggested by O'Donovan, Halford and Walters (2011) that a positive supervisory alliance, where the supervisor is empathetic may encourage the employee to self-disclose. This indicates professionals may open up to supervisors about personal experiences if they have a good working relationship.

Linked to the above point, an implication of the findings from Chapter 3 is the TSI needs to be tested further to assess whether it is appropriate measure to use with sex offender treatment workers. This is because there is no predictive information about the TSI and trauma in sex offender treatment workers. If it is successfully able to detect secondary trauma symptoms in professionals it could be used with sex offender treatment workers. Managers could give sex offender treatment workers a battery of assessments that have been used to measure impact (i.e., the ProQOL and IES-R), including the TSI. This could be completed by employees if they agreed to it on a yearly basis during appraisals to assess psychological distress. The results could be discussed in the appraisal as well as supervision, and used to set goals/objectives. The items from the TSI could also be used in refresher training to increase awareness about the range of symptoms that could occur following experiencing secondary trauma.

#### Strengths and limitations of the thesis

While the thesis has made an important contribution to the literature on working therapeutically with sex offenders, a limitation of the thesis is that the pieces of research discussed throughout all of the chapters mainly derive from western countries like Australia, Canada, New Zealand, the UK, and the USA. There is little research on the impact on working with sex offenders from European countries. An explanation for the limited research in Europe on working therapeutically with sex offender has been proposed by Frenken

(1999). He suggested that sex offender treatment in Europe is still progressing, with there being significant differences between northern-western and southern-western Europe. To date, there is also no research conducted within the UK regarding the reliability and validity of the TSI.

Although the thesis aimed to find out how sex offender treatment workers cope and adapt, a limitation was that none of chapters explored how professionals *define* resiliency and coping. In particular, it would have been helpful to find out from participants who were interviewed in Chapter 4 what they understand by these terms. The inclusion of this question could have added to the thesis aims by helping to identify the factors that underpin both concepts. Asking participants this question may have encouraged them to carefully think about the differences between the two constructs. It could have also produced different factors on what makes workers resilient by prompting participants to consider them as separate constructs.

One of the strengths of the thesis is that it met the aims set out in Chapter 1. This thesis has added to the existing literature knowledge of the factors that contribute to resiliency in sex offender treatment, and how practitioners adapt to their roles when presented with challenges. This had not previously been done, as evidenced by the systematic review, and the studies discussed in Chapter 4. The thesis has also identified avenues for future research.

#### Future research and recommendations

In terms of future research, continued focus is needed on resiliency in sex offender treatment workers. In particular, the differences between resiliency and coping need to be investigated further in order to establish the unique characteristics of each construct. This is because the thesis has found that coping and resiliency overlap. The definition of resiliency within the

context of sex offender treatment work also needs attention. Currently, the definition refers to the ability to overcome adversity (Wolin & Wolin, 1993). A more refined definition specifically tailored to the adversities faced by sex offender treatment workers would be helpful so that sex offender treatment workers and organisations are aware of what it is, and how it differs from coping. This is an important area of research because once resiliency is clearly defined it may be easier to identify the factors that underpin resiliency, and the reasons why workers are able to adapt to their roles despite negative experiences.

Future research could also involve improving the consistency of findings on the impact of working with sex offenders across quantitative studies. Specifically, research in this area needs to ensure the tools measure the constructs reliably and consistently. Moreover, further consideration is required of whether the tools are able to measure the kinds of consequences sex offender treatment workers are likely to encounter. This could be achieved by revisiting existing measures or exploring alternatives, such as the TSI, through the use of validation studies.

### Conclusion

The thesis has fulfilled the aims of exploring how sex offender treatment workers are affected by their work, the coping strategies used, and what makes them resilient. The thesis has highlighted that the experiences of sex offender treatment workers are complex; they can involve both positive and negative emotions. Despite the negatives, the thesis has highlighted that coping strategies like supervision and support from colleagues help workers persevere with their roles, and continue to enjoy the work. To ensure workers remain well to work therapeutically with sex offenders it is essential to explore further what helps workers adapt to their roles so that those who may be struggling with the work can be supported.

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# APPENDICES

## Appendix 1 – Format of search terms

PsychINFO - 1987 to week four June 2014

1. ("sex\* offend\*" or rap\* or "sex\* devian\*" or "sex\* crimin\*" or pe?dophile or "child molest\*" or "sex\* predator\*" or "sex\* abuser\*" or (perp\* adj3 "sex\* aggression")).ti,ab.
2. exp therapists/ or exp clinicians/ or exp counselors/
3. psychologists/ or exp clinical psychologists/ or exp counseling psychologists/ or exp educational psychologists/ or exp experimental psychologists/ or exp social psychologists/
4. (therapist\* or "care professional\*" or "sex\* offender\* therapist\*" or psychologist\* or clinician\* or "treatment provider\*" or counse?or\* or facilitator\*).ti,ab.
5. 2 or 3 or 4
6. exp Vicarious Experiences/
7. exp Occupational Stress/
8. exp Emotional Trauma/
9. exp Fatigue/
10. exp Posttraumatic Stress Disorder/
11. exp Distress/
12. exp Countertransference/
13. ("vicarious trauma\*" or "secondary trauma\*" or burnout or distress or impact\* or fatigue or countertransference or exhaustion).ti,ab.
14. 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13
15. 1 and 5 and 14
16. limit 15 to (human and english language and yr="1990 -Current")
17. ("sex\* offend\*" or rapist\* or "sex\* devian\*" or "sex\* crimin\*" or pe?dophile or "child molest\*" or "sex\* predator\*" or "sex\* abuser\*" or (perp\* adj3 "sex\* aggression")).ti,ab.

18. 5 and 4 and 17

19. ("sex\* offend\*" or rapist\* or "sex\* devian\*" or pe?dophile or "sex\* predator\*" or "sex\* abuser\*" or (perp\* adj3 "sex\* agression")).ti,ab.

20. 5 and 4 and 19

OVID EMBASE - 1988 to week four June 2014

1. (therapist\* or "care professional\*" or "sex\* offender\* therapist\*" or psychologist\* or clinician\* or "treatment provider\*" or counse?or\* or facilitator\*).ti,ab.

2. burnout/ or posttraumatic stress disorder/

3. fatigue/

4. counter transference/

5. exhaustion/

6. ("vicarious trauma\*" or "secondary trauma\*" or burnout or distress or impact\* or fatigue or countertransference or exhaustion or "occupation\* stress\*" or posttrumatic stress\*).ti,ab.

7. 2 or 3 or 4 or 5 or 6

8. ("sex\* offend\*" or rapist\* or "sex\* devian\*" or pe?dophile or "sex\* predator\*" or "sex\* abuser\*" or (perp\* adj3 "sex\* agression")).ti,ab.

9. 1 and 7 and 8

10. limit 9 to (english language and yr="1990 -Current")

OVID MEDLINE - 1946 to week four June 2014

1. (therapist\* or "care professional\*" or "sex\* offender\* therapist\*" or psychologist\* or clinician\* or "treatment provider\*" or counse?or\* or facilitator\*).ti,ab.
2. Stress, Psychological/ or Stress Disorders, Post-Traumatic/ or Burnout, Professional/
3. \*Burnout, Professional/
4. exp Burnout, Professional/
5. Stress, Psychological/ or Fatigue/
6. Fatigue/
7. "Countertransference (Psychology)"/
8. ("vicarious trauma\*" or "secondary trauma\*" or burnout or distress or impact\* or fatigue or countertransference or exhaustion).ti,ab.
9. 2 or 3 or 4 or 5 or 6 or 7 or 8
10. ("sex\* offend\*" or rapist\* or "sex\* devian\*" or pe?dophile or "sex\* predator\*" or "sex\* abuser\*" or (perp\* adj3 "sex\* agression")).ti,ab.
11. 1 and 9 and 10
12. limit 11 to (english language and yr="1990 -Current")

ISA Web of Science - 1990 to week four June 2014

Topic=((therapist\* or "care professional\*" or "sex\* offender\* therapist\*" or psychologist\* or clinician\* or "treatment provider\*" or counse?or\* or facilitator\*.)

AND

Topic=("vicarious trauma\*" or "secondary trauma\*" or burnout or distress or impact\* or fatigue or countertransference or exhaustion or "occupation\* stress\*" or posttrumatic stress\*.)

AND

Topic(("sex\* offend\*" or rapist\* or "sex\* devian\*" or pe?dophile or "sex\* predator\*" or "sex\* abuser\*" or (perp\* NEAR/3 "sex\* agression")).)

Appendix 2 – Reasons for exclusion

<b>Author(s)</b>	<b>Reasons</b>
Amen (2002)	Could not obtain.
Aylwin (2010)	Therapeutic alliance.
Binford (2008)	Includes those who work with victims.
Brown (2011)	Commentary.
Brown & Blount (1999)	Related to managers who supervise sex offender treatment programmes but do not deliver it.
Carmel & Friedlander (2009)	Explores how impact of working with sex offenders can have consequences for therapeutic alliance with the client.
Clarke & Roger (2007)	Focuses on validating a scale to use with people who work with sex offenders.
Collins & Nee (2010)	Largely focuses on factors that influence change in the offender.
Gerber (1995)	Commentary.
Hamilton (1998)	Focuses on offender perceptions.
Jones (2009)	Parent-child boundaries
Kearns (1995)	Commentary.
Lee, Wallace, Puig, Choi, Nam, & Lee (2010)	Sample includes therapists who work with victims.
Layton (1989)	Could not obtain.

Leicht (2008)	Book chapter.
Main (2008)	Could not obtain.
Marcus & Buffington-Vollum (2008)	Looks at how therapists' sexual fantasies tie in with offenders' wishes
Mitchell & Melikian (1995)	Commentary.
Moulden & Firestone (2007)	Review paper.
Moulden & Firestone (2010)	Review paper.
Newring & Wheeler (2010)	Book chapter.
Peaslee (2004)	Commentary.
Pence (1995)	Commentary.
Shelby, Stoddart & Taylor (2001)	Does not assess coping strategies or protective factors.
Simpson (2006)	Could not obtain.
Thorpe, Righthand & Kubik (2001)	Sample includes jurors who are not involved in therapeutic treatment of sex offenders.
Tyagi (2006)	Opinion paper.
Way & VanDeusen (2006)	Sample includes people who work with victims.
Way, VanDeusen & Cottrell (2007)	Sample includes people who work with victims.
Way, VanDeusen, Martin, Applegate & Jandle (2004)	Exclude as samples includes professionals who treat victims.
Wayne (1994)	Focuses on group treatment for the

	offender.
Weisman (2004)	Could not obtain.
West (1996)	Book chapter.

Appendix 3 - Qualitative appraisal tool

Quality Assessment Form- Qualitative Research

**Author(s):**

**Title:**

**Journal:**

**Year:**

Screening Questions	Outcome		Unclear (U)	Comments
	Yes (Y)	No (N)		
Was there a clear statement of the aims of the research?				
Is the qualitative methodology appropriate?				
Is it worth continuing?				

Questions	Scores			Unclear (U)	Comments
	Yes (2)	Partial (1)	No (0)		
<b>Detailed Questions</b>					
Was the research design appropriate to address the aims of the research? (Consider, have they discussed why the methods were used?)					

<p>Was the recruitment strategy appropriate to the aims of the research?</p> <p>(Consider, how were the participants selected and why were particular participants chosen for the research?)</p>					
<p>Were the data collected in a way that addressed the research issue?</p> <p>(Consider, is the process of how data collected and where from explained clearly).</p>					
<p>Is there discussion about why the methods were chosen?</p>					
<p>Is the form of data clear? (i.e. tape recorded interviews, focus groups).</p>					
<p>Has the relationship between the researcher and participants been adequately considered?</p> <p>(Consider if the researcher has considered own role and bias during the research</p>					

process?)					
Have the ethical issues been taken into consideration? (Consider if there was information about how participants were informed about the research, if issues like confidentiality were discussed and how they were dealt with, if approval was sought?)					
Was the data analysis sufficiently rigorous? (Consider if there is a description of the analysis process and if thematic analysis was used, is it clear how themes were categorised?)					
Is there enough data from participants to support themes?					
Is contradictory data taken into account?					
Is there a clear statement of					

findings? (Consider, are the findings clear and do they relate to original research aims?)					
Is there evidence for both for/against researchers' arguments?					
Is the credibility of the findings discussed?					
How valuable is the research? (Consider, if contribution of the research to knowledge and practice is discussed).					
Is there a discussion of the findings being transferred to other populations?					
Have future research been considered?					

Quality Score: /32

No of unclear:

Percentage:

Appendix 4 – Cross sectional appraisal tool

Quality Assessment Form- Cross sectional studies

**Author(s):**

**Title:**

**Journal:**

**Year:**

Screening Questions	Outcome		Unclear (U)	Comments
	Yes (Y)	No (N)		
Did the study address a clearly focused issue?				
Did the authors use an appropriate method to answer their questions/aims? (Consider, whether the method allowed the questions to be answered?)				
Is it worth continuing?				

Questions	Scores			Unclear (U)	Comments
	Yes (2)	Partial (1)	No (0)		

Detailed Questions					
Were the participants recruited in an acceptable way? (Consider if the recruitment process has been clearly described)					
Does the sample represent the population? (Consider the number of participants and demographic details)					
Is there any mention of ethical procedures adopted? (Consider consent, confidentiality and anonymity).					
Were the measures appropriate for answering the research questions?					
Has the validity and reliability of the measures been discussed?					
Have the measures been fully described?					

(Consider if information on scoring and what scores mean are discussed).					
Were the independent variables appropriate?  (Consider, do they assist with answering the questions, is there a clear rationale for them?)					
Is it clearly explained how the independent variables were included in the study?					
Are all the independent variables required to answer the research questions included?					
Are the confounding variables discussed?					
What are the results of the study?  (Consider, are they clear and do they relate back to the questions?)					
Are all independent variables discussed in relation to the					

measures?					
Have the appropriate statistical tests been used to analyse the results?					
How precise are the results? (Consider P-value, effect sizes and confidence intervals).					
Do you believe the results? (Consider, can the results be due to bias?)					
Are the results flawed due to design and methods?					

Quality score:

Number of Unknowns:

Percentage:

Appendix 5 – Mixed methods appraisal tool

Quality Assessment Form- Mixed methods studies

**Author(s):**

**Title:**

**Journal:**

**Year:**

Screening Questions	Outcome		Unclear (U)	Comments
	Yes (Y)	No (N)		
Are there clear quantitative and qualitative questions/aims?				
Did the authors use an appropriate method to answer their questions/aims? (Consider, whether the method allowed the questions to be answered?)				
Is it worth continuing?				

Questions	Scores	Unclear	Comments
-----------	--------	---------	----------

	Yes (2)	Partial (1)	No (0)	(U)	
<b>Detailed Questions</b>					
<b>Quantitative</b>					
Were the participants recruited in an acceptable way? (Consider if the recruitment process has been clearly described)					
Does the sample represent the population? (Consider number of participants and demographic details)					
Were the measures appropriate for answering the research questions? (Consider reliability and validity)					
Are the confounding variables discussed?					
Have the appropriate statistical tests been used to analyse the results?					
What are the results of the study? (Consider, are they clear and do					

they relate back to the questions?)					
<b>Qualitative</b>					
<p>Was the research design appropriate to address the aims of the research?</p> <p>(Consider, have they discussed why the methods were used?)</p>					
<p>Was the recruitment strategy appropriate to the aims of the research?</p> <p>(Consider, how were the participants selected and why were they chosen for the research?)</p>					
<p>Were the data collected in a way that addressed the research issue?</p> <p>(Consider, is the process of how data was collected and where from explained clearly).</p>					
<p>Was the data analysis sufficiently rigorous?</p> <p>(Consider if there is a description of data collection and analysis process?)</p>					
<p>How valuable is the research?</p> <p>(Consider, if contribution of the research to knowledge and practice</p>					

is discussed).					
<p>Has the relationship between the researcher and participants been adequately considered?</p> <p>(Consider if the researcher has considered own role and bias during the research process?)</p>					
<b>Mixed methods</b>					
<p>Is mixed methods design appropriate to answer the quantitative and qualitative research questions?</p>					
<p>Is there an integration of quantitative and qualitative data collection and results?</p>					
<p>Is appropriate consideration given to the limitations and strengths of integration?</p> <p>(Look at rationale for using the method and discussion)</p>					
<b>Ethical considerations</b>					
<p>Have the ethical issues been taken into consideration?</p> <p>(Consider if there was information about how participants were</p>					

informed about the research, if issues like confidentiality were discussed and how they were dealt with, if approval was sought?)					
--	--	--	--	--	--

Quality Score: /32

No of unclear:

Percentage:

## Appendix 6- Data extraction form

Authors(s):

Title:

Journal:

Year:

### **Method**

Type of study:

Recruitment process:

Samples size:

Characteristics of participants (age, profession):

Quantitative:

Measures used (Dependent variables):

Validity of measures:

Independent variables:

Qualitative:

Data collection method:

Analysis method:

### **Results/Analysis**

Quantitative:

Statistical tests:

Findings (What was the impact for professionals working therapeutically with sex offenders, what factors predict the impact, what were the protective factors, what coping strategies were adopted?)

Qualitative:

Main themes:

Overall findings:

Quality score:

Unknown:

Percentage:

Appendix 7 – Examples of items included in the Trauma Symptom Inventory

**In the last 6 months, how often have you experienced:**

(Item 8) Flashbacks (sudden memories or images of upsetting things)

(Item 17) Feeling depressed

(Item 22) Periods of trembling or shaking

(Item 28) Getting into trouble because of sex

(Item 29) Not feeling like your real self

(Item 37) Getting angry when you didn't want to be

(Item 48) Intentionally hurting yourself (for example, by scratching, cutting, or burning) even though you weren't trying to commit suicide

(Item 59) Staying away from certain people or places because they reminded you of something

(Item 67) Trying to block out certain memories

(Item 68) Sexual problems

## Appendix 8- Thank you sheet

Thank you for taking time to complete the online questionnaire. Your responses have been submitted to the researcher.

A follow up study to this research will be conducted within the next 12 months. This will involve a small subset of participants volunteering to be interviewed in more depth for no more than 60 minutes. If you are happy to be contacted for a telephone interview, please e-mail the researcher directly on [dxb109@bham.ac.uk](mailto:dxb109@bham.ac.uk) where your details will be kept for the researcher to contact you at a later date.

The questionnaire you have completed required participants to think about their experiences of working with sex offenders. If you have experienced any of the issues covered in the questionnaire or are concerned about the impact of your work please refer to the list below showing relevant organisations that can provide support and advice.

### **Support Agencies**

#### Samaritans

Telephone: 08457 90 90 90

E-mail: [jo@samaritans.org](mailto:jo@samaritans.org)

Post: Chris PO BOX 9090, Stirling, FK8 2SA.

Website: [www.samaritans.org](http://www.samaritans.org)

#### Support Line

Telephone: 01708 765200

E-mail: [info@supportline.org.uk](mailto:info@supportline.org.uk)

Post: Support Line, PO BOX 2860, Romford, Essex, RM7 1JA.

Website: [www.supportline.org.uk](http://www.supportline.org.uk)

If you like to withdraw your data you can anonymously contact the researcher's supervisor up to one month after the questionnaire closes (end date 31st March 2013) on 0121 414 4925 and quote your unique identification number and the title of the study. Please ensure you have written the identification number which you created at the start of the survey, as without it you will be unable to withdraw. A reason for withdrawing will not be required and the data will be immediately deleted.

Once Again Thank You For Your Time.

Appendix 9- Invitation e-mail

Dear NAME

I am contacting you in relation to e-mail that was sent to you last year inviting you to take part in a piece of research exploring the impact of working therapeutically with sex offenders. You provided me with your e-mail address to be contacted for an in depth interview lasting up to 60 minutes.

Please find attached an information sheet regarding the research and a consent form. If you still wish to take part, please complete the consent form electronically and e-mail it back to the researcher. I will then contact you to arrange a mutually convenient time for the phone interview.

If you require any further information about the research before deciding to take part, please do not hesitate to reply back to this e-mail. I will be more than happy to answer any questions you may have. Alternatively, you can e-mail my supervisor [REDACTED] [REDACTED] if you would prefer to discuss it with her.

Should you no longer wish to take part, please can you e-mail me back in order to remove you from my records. You will not be required to provide a reason.

I would like to thank you for taking the time to read this e-mail and look forward to hearing from you soon.

Kind regards

Deepraj Bains

University of Birmingham

## Appendix 10- Information sheet

As previously mentioned you are being invited to take part in the follow up research to the questionnaire in 2013. Those of you who were working therapeutically with sex offenders last year were being asked to complete an online survey asking you to rate a number of statements related to the impact of your work. Before you decide to participate in the follow up research, please take your time to read through the following information carefully, and discuss it with others if you wish.

The purpose of this research is to explore your personal experiences of working therapeutically with sex offenders. The interview will focus on the positives and negatives of your work, coping strategies, protective factors and resiliency. The findings from this research will provide an insight into how sex offender treatment workers adapt to their role and overcome any negative affects of their work. The data obtained will assist with identifying the factors which make people resilient. This will be useful to employers to support staff at risk of suffering psychologically from their work and preventing vicarious traumatization from occurring in others by encouraging them or the organisation to adopt the factors conducive to resiliency.

Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you do choose to take part in the research you will be asked to electronically complete the consent form attached and send it back via e-mail to the researcher. There will be a box on the consent form you can tick if you would like to receive a summary of the results by e-mail. You will then be contacted to arrange a suitable time for a telephone interview to take place. The interview should last no longer than 60 minutes. At the end of the interview you will be given an opportunity to ask the researcher any questions you may

have. The interviews will be transcribed verbatim and analysed using qualitative methods and will be published in a doctorate thesis potentially in a journal.

The questions asked during the interview will require you to think about how you may have been impacted by your experiences of working with sex offenders. There is a possibility this may cause distress. Details of appropriate support agencies can be found at the end of this information sheet. In addition, if you choose to take part in the research the details can be provided to you at the end of the interview should you request them. During the interview, if you wish to withdraw you can do so without providing a reason and the interview will be terminated. Any data collected will be deleted. If you decide to withdraw after the interview, please e-mail the researcher within two weeks from the date of the interview. Again your interview will be deleted and destroyed. All data will be kept confidential and anonymity protected by the use of pseudonyms. Any quotes included in the research will not include anything that could reveal your identity.

All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The University of Birmingham Ethics Committee have reviewed this proposal.

I would like to take this opportunity to thank you for taking the time to read the information sheet.

### **Support Agencies**

#### Samaritans

Telephone: 08457 90 90 90

E-mail: [jo@samaritans.org](mailto:jo@samaritans.org)

Post: Chris PO BOX 9090, Stirling, FK8 2SA.

Website: [www.samaritans.org](http://www.samaritans.org)

### Support Line

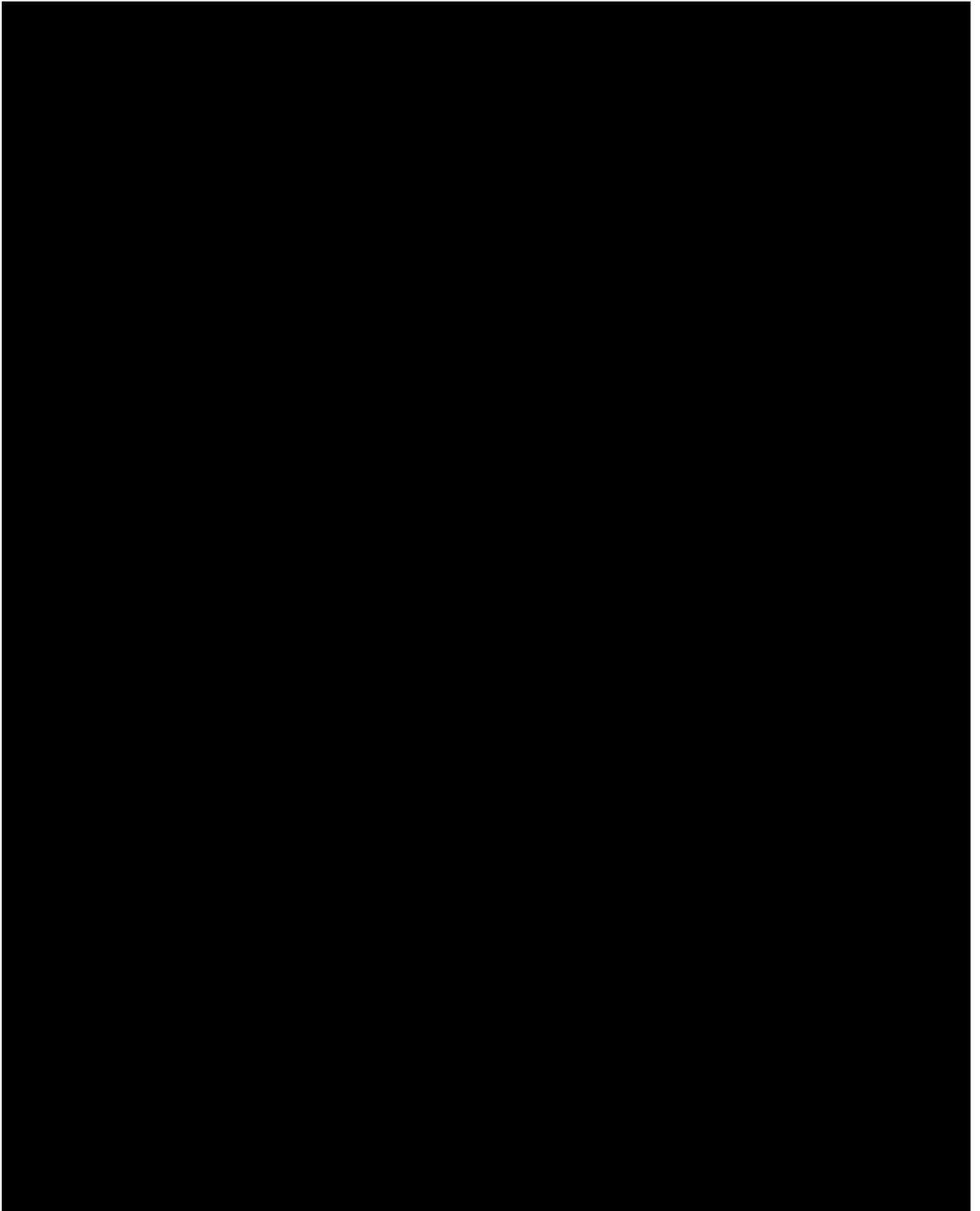
Telephone: 01708 765200

E-mail: [info@supportline.org.uk](mailto:info@supportline.org.uk)

Post: Support Line, PO BOX 2860, Romford, Essex, RM7 1JA.

Website: [www.supportline.org.uk](http://www.supportline.org.uk)

Appendix 11- Consent form



## Appendix 12- Interview schedule

### Opening the interview:

- Introduce myself and re-cap through the aims of the research.
- Advise the interviewee approximately how long the interview will take.
- Ask the interviewee if they have any questions before the interview starts.
- Remind the interviewee to not disclose any personal information about clients.

### Background information:

- Can you tell me what your role is?
- What does your role entail? What are your duties and responsibilities? On what basis do you work with sex offenders (i.e. individual work, group work)?
- How often do you have direct contact with sex offenders?
- Are there other client groups you work with?
- What type of setting do you work in?
- How long have you worked with sex offenders?
- What were you doing before your current post?
- Why did you choose a career working with sex offenders? How did you come to this decision?
- Have there been any points during your career of working with sex offenders when you left the role? If so why?

### Main interview questions:

- How have you been affected both positively and negatively by working with sex offenders?
  - What aspects of the role have led to those feelings?

- Can you tell me about the aspects of your job you most enjoy?
- If you have been affected negatively, what aspects of your life has your work impacted on? What aspects of your job do you feel have led to the negative impact? What aspects of your job has it impacted on?
- What aspects of working with sex offenders is most difficult and why?
- Can you tell me if your therapeutic work with sex offenders has been affected?
  - In what ways has it?
  - If it has not impacted on your work with clients how have you managed this?
- How have you coped with these difficulties? How have you adapted to your role?
  - What strategies did you use?
  - Did they help?
  - Have you taken time off work as annual leave or sick leave to deal with the impact?
  - What if anything would help you to adapt to your role?
- How did you feel about the support you were given from your employer?
- Do you feel valued by your employer for the work you do?
- Were there opportunities to discuss your concerns during supervision?
- How have colleagues supported you with your work?
- Have your family/friends been affected by the impact of your work?
- Have you witnessed other people being affected by working with sex offenders?
  - If yes, how does this make you feel about your role?
  - Has it questioned your career options or why you chose to do the role?
- Can you tell me what you think helps to prevent people from suffering from working with sex offenders?

- Describe any preventative measures you think would be useful for people who work with sex offenders?

#### Closing the interview

- Do you have any further comments you would like to share about working with sex offenders?
- Do you have any questions you would like to ask me about the research?
- Advise the participant what will happen next and when they will likely receive the summary of the results if they have requested it.
- Thank the interviewee for their time.

Appendix 13- Full structure of the themes

<b>Research questions</b>	<b>Superordinate Theme</b>	<b>Participants contributing to this theme</b>	<b>Subthemes</b>	<b>Participants contributing to this sub-theme</b>	<b>Key cross-references  Page/line number</b>	<b>Indicative quotes</b>	<b>Notes and interpretation</b>
<b>Positive impact of working with sex offenders</b>	Rewarding and satisfying	All participants	Privileged to be working with sex offenders	Participant 1, 2, 3, 4	P1 (11/527, 22/1089), P2 (3/100), P3 (14/701), P4 (10/489)	‘I feel very honoured and privileged to be in this position that people let me into their lives, they trust me’ (P1)  ‘It’s very	Proud

			Involved in the process of change	Participant 1, 3, 6, 8, 9	P1 (11/515), P3 (4/151, 178, 190, 6/270, 14/703) P6 (4/166), P8 (4/167, 190), P9 (3/125, 143)	satisfying to see progress in the guys' (P9). 'actually the rewards for me are in being connected to other peoples' personal change' (P3)	Fulfilment, accomplished, rewarding, satisfying
			Preventing further abuse	Participant 1, 2, 7, 8, 9	P1(12/585), P2 (4/158, 162), P7(9/445), P8 (4/161, 5/212), P9 (3/142)	'I think doing the work that I've been doing I'd like to think that I have	Rewarding,

						<p>helped to protect some families from abuse' (P7)</p> <p>'I have this sense the strong sense that I the work that I'm doing is important and that it, it saves another child from being abused' (P8)</p>	<p>fulfilment, proud, feel work is important</p>
	Building therapeutic and	Participant 1, 4, 8	N/A	N/A	P1(6/296, 297), P4 (8/369, 373),	'So if you've got good	Satisfaction, confidence in

	collaborative relationships				P8 (5/243)	rapport with somebody that you're working with you're going to be able to work therapeutically a lot better with them' (P4)	ability to build relationships, accomplished, proud, makes the job easier
	Opportunity to tailor treatment to client needs	Participant 6, 9	N/A	N/A	P6 (3/110, 6/259). P9 (4/179	'the role I'm in allows me to work sometimes in groups	Flexible Work is varied and diverse Rewarding Opportunity to

						<p>sometimes individually and sometimes a mixture that allows us to work with areas of deficit rather than trying to find everybody the same stuff'</p> <p>(P6)</p>	<p>develop</p> <p>Keeps P6 and P9 motivated and focussed</p> <p>Work is enjoyable</p> <p>Helps client get the treatment they need</p> <p>Both these participants have previously worked with rigid programme which they</p>
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							disliked
<b>Negative impact of working with sex offenders</b>	Intrusive thoughts	Participant 1, 5	Offence/victim thoughts	Participant 1, 5	P1 (7/308, 311), P5 (3/125, 4/152, 7/314, 329)	‘kind of sometimes remembering aspects of the offence at times, you know intrusive thoughts at times’ (P1) ‘when I go home that certain phrases or images keep appearing in my head and	Both these participants are psychologists  Distressing, interferes with home life

						that that's things usually take me a few days to get rid of' (P5)	
	Working with difficult, resistant and challenging clients	Participant 2, 3, 4, 5, 6, 8	N/A	N/A	P2 (7/309), P3 (8/362, 364), P4 (6/259, 266, 17/809), P5 (6/270), P6 (4/173, 5/243), P8 (5/225),	'I kind of think one of the most difficult things is when I have to work with someone who are erm very er convinced that their way of acting and seeing things is	Frustrating, draining, lose patience, worry that clients are not understanding which could lead to re-offending Suspicious of these clients

						the right way of doing things’ (P5)	
	Clients re-offending	Participant 1, 2, 4, 8	N/A	N/A	P1 (7/316, 324), P2 (11/545), P4 (7/315), P8 (4/199, 5/201)	‘it has a couple of times and you know that can be very devastating in terms of how you feel’ (P1) ‘when someone reoffends absolutely that that grieves me’ (P8)	Worry, anxiety, sense of personal responsibility, opportunity to learn and develop
	Fatigue from the	Participant 1, 6	N/A	N/A	P1 (5/209), P6	‘I’m finding at	Work is

	work				(2/87, 93)	times a little bit relentless' (P1) 'I think it was just kind of got tired of the cynicism and you know it's quite heavy going emotionally I think doing this job' (P6)	demanding and difficult  Can be draining especially when very little change happens
	Growing frustration of unjust support for victims in	Participant 2	N/A	N/A	P2 (3/113, 145, 4/179)	'what also started to frustrate me was that erm I	Victims are more deserving of treatment, frustrations over

	<p>comparison to sex offenders</p>					<p>was putting so much energy and effort and time into working with offenders and I was thinking you know that that the victims here their victims have probably had nowhere near as much contact with psychologists,</p>	<p>victims getting less support, guilt.</p> <p>This participant wanted to get onto the Doctorate in Clinical Psychology so could be a career development opportunity</p>
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						therapists and all sorts' (P2)	
	Change in world view	All except participant 8 and 9	Desensitisation	P1, P3, P5	P1 (4/197-199), P3 (5/213, 221, 247), P5 (5/225)	'nothing really shocks me in term kind of sexual deviance sexual violence' (P1)  'I suppose I sometimes worry I that I'm just getting a bit blasé about it' (P3)	P8 and P9 both very positive about the work and spoke about not experiencing negatives at all.  Worried about desensitisation  If still get strong emotions reminds P3 about the victim and

						‘I sometimes wonder if I’ve become more jaded’ (P5)	purpose of the job.
			Gender roles	Participant 3, 7	P3 (6,293, 12/558) P7 (6/260, 263)	‘it’s heightened my kind of social awareness and erm understanding of the role that gender plays in dominants and control of family and in a	Discrimination against women and children – As a male P3 may feel anger and frustration that men harm vulnerable people

			Sexualisation of women	Participant 1	P1 (8/350, 358, 373, 380)	institutions’ (P7) ‘how sexualised women can b in celebrity land and you now in in the media’ ‘as a society it’s almost like we have now developed this attitude that we’re entitled to sex, we deserve it that	Angry and frustrated Impacts on young generation and cognitive distortions of men Hopeless and no control over society and media
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			Vulnerability	Participant 2	P2 (10/452, 462, 493)	that it's ours to be taken and I just feel like screaming no it's absolutely no' (P1)  'so that idea of me being able to protect myself is something oh no no you actually couldn't' (P2)	Fear that cannot protect herself  Realisation anyone can be a victim  Increase empathy for victims
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			Human suffering	Participant 5	P5 (4/151)	‘Negatively erm I think that it has it has changed erm my view on what people are capable of doing to other human beings’ (P5)	Increase in knowledge and awareness More realistic world view
			Suspiciousness	Participant, 5, 5, 6	P4 (8/386), P5 (4/159, 168), P6 (3/132)	‘sort of being overprotective of of your children or suspicious of	Two of these participants (P4, P5) have children

						anybody else’ (P4) ‘if I go to a playground with my children I I look at the bystanders in a different way than other people do’ (P5)	Interferes with home life  Impacts of parenting  Wary and vigilant
<b>Coping</b>	Support networks	All participants	Collegial support	Participant 1, 2, 3, 4, 5, 6, 8	P1 (10/450, 461, 494, 502), P2 (8/356, 9/417), P3 (9/442, 11/524, 558),	‘I think the best and the absolute best strategy of all is collegial	Obtain support and guidance  Reassurance, confirmation and

					<p>P4(13/632, 14/647), P5 (6/252, 10/466), P6 (7/348,8/360), P8 (11/544, 12/550)</p>	<p>support’ (P1)  ‘What really helped me doing that group was the relationship I had with my colleagues’  (P2)    ‘in order to stay in the work and to keep exposing yourself as a in</p>	<p>validation of feelings    Feel listened to    Can be open about feelings    Valued by team    P3 and P8’s  support came more from the team    Opportunity to</p>
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			Formal supervision	All except participant 3 and 8.	P1 (10/476, 14/647), P2 (11/530, 12/573), P4 (13/622), P5 (10/478), P6 (7,333), P7 (7/315), P9 (4/189, 6/266)	'In order to stay in the work and to keep exposing yourself as a worker to the kind of most awful things that people do to each other you need a way ventilating it you know having it erm dealt with in supervision'	learn, develop and share concerns  Validation  Feel supported and listened to  Catharsis
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						(P7)	
	Humour	Participant 1, 2, 3, 5	N/A	N/A	P1 (10/453), P2 (8/376, 387), P3 (10/487, 491, 495), P5 (6/261)	‘one of the most amazing about this work is our use of black humour’ (P1) ‘Then in debrief we would laugh about it that that helped with the frustrations’ (P2)	Creates positivity within the team, turns negative into positives, reduces frustration, a way of team cohesion A way of expressing feelings
	Engaging in self-reflection	Participant 1, 5, 6, 7, 9	N/A	N/A	P1 (13/601, 637), P5 (5/248),	‘It’s absolutely vital and I think	Allows you to monitor feelings,

					P6 (9/424), P7 (20/975, 21/1001), P9 (8/358)	that you now it should be one of the biggest things everybody self-awareness' (P1) 'I think the biggest thing for me is the reflective practice bit' (P9)	know limitations, and take action Provides clarity A way of learning and improving
	Understanding the function of behaviour	Participant 3, 4, 8	N/A	N/A	P3 (9/410, 10/482), P4 (7/307, 8/376), P8 (11/510)	'I tend to think about well where's that coming from,	Helps to make sense of situation – establish reasons

						<p>why he's like that, what erm what has he said that helps help with it' (P3)</p> <p>'way that I work with people like that I try to sort of get underneath the presentation of what he's really going on for this person' (P4)</p>	<p>why things are happening</p> <p>Offers clarity and helps to decide what to do next</p>
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	Remind oneself of the importance of the work	Participant 5, 6, 8, 9	N/A	N/A	P5 (9/447), P6 (9/403), P8 (4/156), P9 (10/492)	‘It’s more because you know sexual abuse is horrible and I’m working for the victims and a very roundabout way’ (P6) ‘I only have to ask myself that question to realise that what I’m doing is important	Helps to focus on the job  Provides sense of purpose and motivation  Committed and perseveres despite challenges
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						that I can't not do it' (P8)  'I value what I do. I know it's worth' (P9)	
	Faith in God	Only participant 8	N/A	N/A	P8 (10/495, 11/505)	'I have a strong Christian faith and that and that's erm and a part of that and and I play music' (P8)	Sustains the participant  Helps P8 to accept what has happened and learn from it
	Self-care	Participant 1, 2, 3, 4, 6, 8, 9	Being aware of personal limitations	P1	P1E (5/229)	'the longer I am in this field the more I realise my limitation	Helps P1 to know what she can and cannot cope with

			Taking slow steps	P2	P2 (8/391, 397)	and what's achievable and what's not and needing to manage that so you don't get burnout' (P1)  'I think it was just about pacing yourself and things erm to manage the frustrations' (P2)	P2 works with learning disability sex offenders- taking manageable steps- prevents frustration
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			Interests outside of work	Participant 1, 6, 8, 9	P1 (14/675, 15/700), P6 (7/326, 337), P8 (10/493, 495), P9 (9/409, 419)	‘I always have something to do some hobbies whether it’s an acting class, or something to do with music, or just something totally different’ (P6)	Takes mind off work, something to look forward to.
			Boundaries between work and home	Participant 1, 4	P1 (14/689, 16/771), P4 (12/555, 12/571)	‘I think it is making sure that erm outside of work is okay and you’re not	Offers separation

						blurring the boundaries between work and home' (P4)	Focussing on personal life than just work
			Realistic expectations	Participant 3, 4, 6, 8, 9	P3 (8/379, 8/389), P4 (12/551), P6 (5/248), P8 (7/321), P9 (11/502)	'I need to lower my expectations erm so not feel completely frustrated by by him' (P3) 'It's recognising that this might happen I think	Prevents frustration and disappointment  Being prepared  Acceptance

						in first instance and foremost you need to be aware that this might happen' (P4)	
<b>Resiliency</b>	Genuine interest in working with sex offenders	Participant 1, 5, 7, 8	N/A	N/A	P1 (22/1066, 1076), P5 (8/397, 9/400) P7 (4/185, 197, 5/219, 16/772), P8 (9/421)	'I think if you've got any interest in the area it's great if you don't I wouldn't go into it' (P1)  'usually the ones who erm	Motivated and committed to working with sex offenders  Passionate about the work  Work is

						<p>who continue being good at what they do, who have genuine er care for the patients and and actually want want to help them and and become better at their job’ (P5) ‘I enjoyed doing that kind of work. It was</p>	<p>enjoyable  Want to help sex offenders</p>
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						a kind of discovery I was interested in it' (P7)	
	Optimism and hope	Participant 3, 5, 6, 8	Viewing client as a human	P5, P6, P8	P5 (0/428, 430, 432), P6 (5/218, 224) P8 (9/442, 10/474, 13/610	'I read as a person, as an individual not as a sex offender' (P8)  'I see them as people in a horrible place you know done horrible thing but actually there's a lot	Helps you to work with clients if you like them  Assists with building therapeutic relationships

						<p>more to them  than just that'  (P6)  'in order to help  them we have  to find  something we  can like about  him' (P5)</p>	
			<p>Believing that  sex offenders  can change</p>	<p>P3, P6</p>	<p>P3 (6/257), P6  (9/441)</p>	<p>'I'm conscious  that actually  there's quite a  good chance  that this man's  going to</p>	<p>Positivity about  work  Helps to remain  committed to the  work</p>

						develop into a more positive way either in the next hour or the next ten months' (P3)	Motivation
	Belief can overcome obstacles	Participant 1, 6	N/A	N/A	P1 (18/857), P6 (9/443)	'I almost feel like I could be faced with anything or and have a sense of roughly how to deal with it' (P1)	Motivated Perseverance Committed
	Ability to detach from work	Participant 4, 9	N/A	N/A	P4 (8/376, 379, 10/465, 12/574),	'I think you need to be	Boundaries between work

					P9 (12/593)	detached erm for I need to be detached from from from that really' (P4) 'I think detached copers do much better. Ruminators don't do very well at all' (P9)	and home
	Circumstances outside of work	Participant 4, 9	N/A	N/A	P4 (14/664, 676), P9 (11/540)	'I think it's very much what's going on your personal life that will	P4- going through difficult personal situation

						<p>that will affect’ (P4) ‘I think at different times people when other things are going on in their lives people’s levels of resilience vary’ (P9)</p>	<p>P9- witnessed others experiencing difficult situations outside of work</p>
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