A thesis submitted in Partial Fulfilment of the Regulations for the degree of

DOCTOR OF CLINICAL PSYCHOLOGY (CLIN.PSYCH.D)

VOLUME 1

Research Component

WORKING WITH SEX OFFENDERS AND THOSE INDIVIDUALS WITH A LEARNING DISABILITY: THE IMPORTANCE OF PSYCHOLOGICAL FACTORS IN THE DELIVERY OF CARE

Amanda L. Walker

School of Psychology

Faculty of Science

The University of Birmingham

June 2011

ACKNOWLEDGEMENTS

I would like to express my deepest thanks and appreciation to Dr John Rose, my research supervisor, for his endless patience, support and guidance. He has made statistical analysis uncomplicated and brought a sense of humour to our supervision sessions.

My extended thanks go to Dr Su Thrift for her support with the planning of the study and in particular her motivation and drive for data collection, which made the study possible.

I would like to thank my friends, Lyns and Eddi for their continual encouragement throughout the duration of my clinical training and for reminding me of the need for a "work-life balance"! A particular thank you to Andrew who has "put up" with my absence and at times what has felt like a never ending work load.

Finally, a special thanks to my parents, who have constantly supported and encouraged me on the rollercoaster of a journey to become a Clinical Psychologist I hope this makes you proud.

OVERVIEW

This thesis is submitted in partial fulfilment to the requirements for the degree of Doctor of Clinical Psychology (Clin.Psych.D) at the University of Birmingham. It is divided into two volumes.

Volume I of the thesis represents the research component; this is presented in the form of three papers which are related to the psychological factors of working with sex offenders, some who have a learning disability. The first paper is a review of the literature exploring the psychological impact to those who work with sex offenders. This has been prepared according to the requirements of the British Journal of Learning Disabilities. The second paper consists of an empirical paper exploring staff attitudes to working with sex offenders who have a learning disability, a range of relevant influential factors are addressed. This has been prepared with the special issue of the Journal of Applied Research in Intellectual Disability in December 2010, in mind. The third paper is a brief public domain briefing paper which provides a brief summary and emphasises the key findings from both the literature review and empirical paper. This is intended for dissemination to a wider audience, in particular for those who partook in the research. This paper has been prepared according to requirements of the Journal of Intellectual Disability Research. Preceding these papers are the appendices which provide details of the measures used within the empirical paper.

Volume II of the thesis represents the clinical component and contains five clinical practice reports which reflect the main training of the Clin.Psych.D.degree. These include a cognitive and systemic formulation of a 9 year old boy presenting with low mood, a service evaluation exploring professionals views in relation to whether child

services meet the needs of those exposed to domestic abuse, a relapse prevention intervention with a 35 year old male suffering from schizophrenia, an integrative formulation and intervention of a 69 year old female presenting with depression and prolonged grief and a cognitive analytic therapy informed intervention with a staff team working with a 49 year old male with severe learning disabilities.

CONTENTS

Volume 1: Research Component

Public Domain: Clinical implications to the delivery of care when working with clients who have committed a sexual offence and may have a learning disability.

Volume 2: Clinical Component

Clinical practice report one: psychological models

Clinical practice report two: service evaluation

Clinical practice report three: single case experimental design

Clinical practice report four: case study

Clinical practice report five: case study

Volume 2 Appendices

Clinical practice report one

Clinical practice report two

Clinical practice report three:

Clinical practice report four

Volume 2 Figures

Clinical practice report one

Clinical practice report two

Clinical practice report three

Clinical practice report four

Volume 2 Tables

Clinical practice report two

Clinical practice report three

LITERATURE REVIEW

WHAT IS THE PSYCHOLOGICAL IMPACT ON INDIVIDUALS WHO WORK WITH THOSE WHO SEXUALLY OFFEND?

Amanda L. Walker

University of Birmingham

ABSTRACT

Background: Individuals who work with sex offenders can experience a selection of harmful effects, which hold clear implications for everyday working practices. Research exploring this area is sparse, whilst limited focus has been given to managing and preventing these harmful effects.

Method: The electronic databases of PSYCHINFO, EMBASE, OVID MEDLINE and WEB OF SCIENCE were used to conduct a systemic search of the literature to address what the psychological impact is on those who work with sex offenders, whilst considering moderating and protective factors which may influence this.

Results: Following exclusion criteria, a total of 8 relevant peer reviewed articles were found. A further 4 articles were obtained through other relevant sources.

Conclusions: The review considered various harmful effects of sex offender work. A selection of moderating factors which can potentially increase these effects are addressed, whilst protective factors which may reduce these harmful effects are emphasised. A Model of Awareness to guide clinical practice in this area is presented. Finally, methodological limitations and recommendations for future research are provided.

Key words: sex offenders, vicarious trauma, secondary trauma, compassion fatigue, stress, burnout, post traumatic stress disorder, compassion satisfaction, moderating factors, protective factors

INTRODUCTION

An increasing amount of research has begun to identify several types of impact that working with sex offenders can have on workers, including vicarious trauma, secondary trauma, compassion fatigue, post traumatic stress disorder (PTSD) and burnout (Moulden & Firestone, 2007). Some of these concepts were initially developed from the literature exploring the effects on those working with victims of sexual abuse or trauma work (Newall & McNeil, 2010), however they have recently begun to be considered in relation to those treating sex offenders. This has resulted in these concepts being defined in a number of different ways (Stamm, 1997). Subsequently, the terms have often been used interchangeably or grouped together (Newell & McNeil, 2010). Theoretical similarities exist between some of these concepts but there are also areas of distinct differences (Sexton, 1999). Therefore considering the concepts separately allows a more comprehensive understanding of their effects (Newell & McNeil, 2010). Prior to exploring the psychological impact on individuals working with sex offenders it is essential to agree a clear definition for each concept, which will then be used to consider the literature under review.

Definitions of Concepts and previous reviews

Drawing on several different psychological approaches and orientations, including object relations and social cognition theory, McCann and Pearlman (1990) conceptualised the term vicarious trauma. They describe this as a permanent "cumulative process" in which the therapist's inner experiences become negatively transformed as they listen and empathise with a client's trauma. This process is thought to promote changes in the therapist's personal and professional identify as

their view of themselves, others and the world changes in light of this information. Despite this original definition there remains much debate over what constitutes vicarious trauma.

Researchers have often conceptualised vicarious trauma and secondary trauma together, viewing these as reactions to the emotional demands which are placed upon therapists working with trauma material. Similar features are identifiable in each, however they can be distinguished via their different pathologies (Newell & McNeil, 2010). The concept of secondary trauma was developed by Figley (1995), this is thought to involve the emotional response which those hearing about trauma can experience; this response can be rapid and occur from a single exposure (Conrad & Kellar-Gulenter, 2006). In contrast, vicarious trauma is considered to develop as therapists undergo repeated exposure to traumatic material, thus producing cognitive disturbances and changes in their cognitive schema over the course of time (Sabin-Farrell & Turpin, 2003). Debate continues to remains as to whether vicarious and secondary trauma are separate notions or part of the same concept.

Joinson (1992) coined the term compassion fatigue, this is often used interchangeably in the literature with secondary trauma (Collins & Long, 2003). Figley (1995) proposed this concept was less stigmatising than secondary trauma, he described it as changes in a therapist's behaviour and emotions which arise from knowing about another's stressful or traumatic event. Collins and Long (2003) propose that these changes can be acute and sudden. Figley, (1995) argued that compassion fatigue closely resembled the presentation of PTSD, with some individuals experiencing intrusive, avoidance and arousal symptoms. Those individuals however, who have direct experience of a stressful and traumatic event,

are more likely to develop PTSD, whilst those individuals who are only exposed to the knowledge of the traumatic event and empathise with the person's emotional pain or experience their own emotional response are likely to develop compassion fatigue (Jenkins & Baird, 2002; Sabin-Farrell & Turpin, 2003; Sexton, 1999).

Stress is not a new concept, the term is often used to describe different stressors and the psychological impact and distress created by them, as such no universal definition exists (Pines & Keinan, 2005). Throughout this review the term stress is considered in its more broader occupational sense. Occupational stress is thought to occur when there is a discrepancy between the demands of the environment/workplace and the individual's ability to meet these (Henry & Evans, 2008). Ongoing experiences of stress are thought to develop into burnout (Pines & Keinan, 2005), this has been associated with and used to describe the effects of working with trauma (Sabin-Farnell & Turpin, 2003). The concept of burnout has allied with individuals who do "people work". It is considered to arise as a mode of defence to situations which are interpersonally demanding and create psychological strain (Jenkins & Baird, 2002). The most well-known and widely accepted definition of burnout has been that provided by Maslach (1982). She proposed that emotional exhaustion (being exhausted by ones job) can lead to a depersonalisation (individual's impersonal response) with clients, thus reducing ones sense of personal accomplishment (feeling of competency).

Burnout has been considered similar to secondary trauma and vicarious trauma in the sense that it arises from exposure to working with emotionally engaging clients; however it is better developed in theory and measure validation (Jenkins & Baird, 2002). It is also classified as a gradual process which can occur outside of the

trauma domain, thus differentiating it from secondary trauma and vicarious trauma (Conrad & Kellar-Guenther, 2006; Sabin-Farrell & Turpin, 2003).

Not all professionals exposed to high levels of suffering experience adverse effects. Stamm (1998) says that compassion satisfaction is considered a positive aspect to caring which may counter balance the negative aspects. Whilst Figley (2002) describes this as the sense of reward, efficacy and competency that one feels in their role as a helping professional.

The harmful effects of working with trauma have been addressed through the concepts of vicarious trauma, secondary trauma, compassion fatigue, PTSD, stress and burnout. Two previous reviews have considered these concepts in relation to sex offender work. Clarke and Roger (2002) explored a number of studies that considered the psychological effects of working with sex offenders. Some of the studies included in the review were unpublished doctoral dissertations or studies which had not been peer reviewed. The authors reported several different sources of stress including, repeated exposure to sexually explicit information, hostility and resistance of sex offenders and organisational factors. These stressors could often produce several negative cognitive, emotional and behavioural effects on therapists. The review considered these effects in relation to concepts, such as emotional exhaustion, depersonalisation, personal accomplishment, fatigue and stress. The authors concluded that the existence of distressing psychological symptoms on therapists who work with sex offenders is apparent. They question why these effects were only present in a fifth to a quarter of the samples in the studies which they reviewed. They highlight methodological shortcomings including an over-reliance on inadequate self-reports, use of retrospective and descriptive data and a lack of emphasis on individual differences. The authors provide an Integrated Model of

Personal and Professional Impact (IMPPI) which includes a selection of factors that are thought to have an effect on a sex offender therapist's well-being. These include static and changeable factors such as qualifications, individual coping style, occupation, age and gender. The authors suggest that the model holds the potential to be used as a means of assessing the psychological well-being of therapists whilst identifying the most appropriate method of support or intervention. The authors further proposed that the model could be used for selecting and training sex offender therapists. Its use in clinical practice, however remains to be tested.

A more recent review (Moulden & Firestone, 2007) which contains some overlap with Clarke and Roger's (2002) review, provides an explanation of vicarious trauma in relation to those working with sex offenders and describes mediating factors in its development. Summarising several studies the authors conclude that some therapists who work with sex offenders experience vicarious trauma at a "moderately to clinically significant" range. This suggests that the symptoms which some therapists experience are outside of the expected normal range for this type of work and potentially could be placing them at risk for the development of their own mental health difficulties. They suggest a "U" shaped relationship exists; with those therapists with the least and most amount of experience being more vulnerable to the development of vicarious trauma. This vulnerability is further increased if they work within a secure or prison environment. Positive and negative coping strategies were classified as the strongest predicators of vicarious trauma. The authors emphasise methodological limitations within the studies and acknowledge the difficulties that disparate definitions pose.

These previous reviews have illustrated that for those individuals who work with sex offenders, there are a number of different effects which they may experience. Clarke and Roger's (2002) review is limited in its validity and reliability by the inclusion of unpublished studies and studies not subject to peer review. Furthermore the review only considered the impact of working with sex offenders through concepts relating to stress and burnout. Moulden & Firestone, (2007) acknowledged the existence of secondary trauma, compassion fatigue and burnout, however rather than using these concepts separately to review their studies they encapsulate these into the concept of vicarious trauma; this is then used to review their literature. This could potentially infringe upon the reliability of their findings.

Summary of definitions and aims of current review

The concepts of vicarious trauma, secondary trauma, compassion fatigue, PTSD and burnout are frequently associated with the trauma domain. Ongoing debate exists within the literature relating to the definitions of these concepts; this has often resulted in them being used interchangeably. Despite this, the concepts hold various distinguishing and discriminating features.

Vicarious trauma often occurs when individuals undertake direct practice with a trauma population. Initially these individuals may experience various emotional and behavioural reactions, however as time progresses these reactions are often replaced by intrinsic cognitive changes. These cognitive changes can become dominant in an individuals thinking and can often relate to the views which they hold about themselves, others and the world, with a particular focus placed on aspects of safety, control and trust (Newall & MacNeil, 2010). Secondary trauma can also arise from direct practice or exposure to traumatic events, however the reactions in

secondary trauma are predominately focused on observable emotional and behavioural symptoms rather than intrinsic long lasting cognitive changes (Figley, 1995). Furthermore secondary trauma can arise more rapidly than vicarious trauma (Newall & MacNeil, 2010).

Compassion fatigue has often been associated with secondary trauma (Figley, 1995). This concept relates to the emotional and physical sense of fatigue that individuals can experience when they are consistently providing empathy to those who have suffered in some way (Figley, 2000). This concept is not exclusive to the trauma domain and unlike secondary trauma it is thought to occur over time rather than having a rapid onset (Figley, 2000).

PTSD is often closely related to compassion fatigue and secondary trauma, as individuals suffering from compassion fatigue and secondary trauma can display emotional and behavioural symptoms similar to those observed in PTSD (Newall & MacNeil, 2010). PTSD, however differs from these concepts in the sense that for it to develop direct exposure to the traumatic event is required, therefore just hearing about a traumatic event is unlikely to result in the development of PTSD (Newall & MacNeil, 2010).

Burnout is conceptualised as a multidimensional concept relating to the prolonged effects of working with job strain (Maslach, 1982). It has been associated with vicarious trauma, secondary trauma and compassion fatigue; nevertheless it is not exclusive to those working with trauma and is considered as a process which occurs over a great period of time (Conrad & Kellar-Guenther, 2006).

Taking into account the discriminating features of the above concepts, the following review will consider each concept as a separate phenomenon. The purpose of this

review, therefore is to reconsider the literature using a more objective and critical stance; applying the core definitions of vicarious trauma, secondary trauma/compassion fatigue, PTSD, burnout, stress and compassion satisfaction to peer reviewed articles. The review will undertake a systematic search of the literature to question what the impact is on those who work with sex offenders, whilst considering moderating and protective factors which may influence this impact. Initially the literature will be examined for methodological factors which may limit the outcomes of the studies.

SEARCH STRATEGY

A literature search was carried out in June 2010 using the following databases; PSYCHINFO, EMBASE, OVID MEDLINE and WEB OF SCIENCE to identify appropriate articles associated with the impact of working with sex offenders. Search strategies fell within three categories; first the type of impact, secondly the provider of the impact and lastly the recipient of this impact. The concepts used to search became present in the literature from the early 1990's, consequently to ensure that all relevant peer reviewed articles were obtained the date range entered within these electronic databases was 1990-2011. The reader should note that the use of $ ensures that the literature searched included both singular and plural terms e.g. sex offenders and sex offenders. (See table 1).

Table1. Search strategy for identifying appropriate articles

"Type of Impact"		**"Provider of Impact"**		**"Recipient of Impact"**
"Post traumatic stress disorder" or " PTSD" or "stress" or "mental health" or "emotional trauma" **OR** "well being" **OR** "quality of life" **OR** "occupational stress" **OR** "emotional trauma" or "vicarious trauma" or "vicarious experience$" **OR** "fatigue" or "burnout" **OR** "self-esteem" or "psychological stress" or "psychological distress" **OR** "compassion satisfaction" All above entered as keyword in abstract, title, table of contents or key concept	**AND**	"sex offender$" **OR** "sex offence$" **OR** "sexual perpetrator$" All above entered as keyword in abstract, title, table of contents or key concept	**AND**	"therapist$" **OR** "nurse$" or "doctor$" or "psychologist$" or "treatment provider$" or "health care assistant$" or "psychiatrist$" or "staff$" **OR** "caseworker$" OR "health personal" or "legal personal" or "lawyer$" or "judge$" or "jurist$" All above entered as keyword in abstract, title, table of contents or key concept
Total number of articles identified				80
Number excluded				72
Suitable articles				8
Additional articles identified from other sources				4
Total number of suitable articles included in review				12

Exclusion Criteria

To ensure that only original peer reviewed research was considered a number of articles were excluded as they were book chapters, dissertation abstracts or not published in English. Articles associated with criminal offences, juvenile offences, public protective orders and sexual abuse were also excluded as they did not relate specifically to sex offenders.

RESULTS

The articles which were identified for review are summarised in Table 2. Details relating to sample size, methodology, measures used to assess the different types of effects, outcomes and methodological limitations are provided. This review does contain some overlap with relevant papers that were included in Moulden and Firestone's (2007) review, these are indicated in table two by a* and have been re-considered in line with the objective of this review.

Evidential Quality

To ensure the evidential quality of each study was explored through a standardised method, a quality assessment tool was used to review each study. After considering a number of potential quality assessment tools the "Quality Index" (Downs & Black, 1997) was chosen. This tool consists of 27 items relating to five quality domains, including; Reporting, External Validity, Internal Validity-bias, Internal Validity-confounding and Power. It provides comprehensive coverage of a selection of domains in assessing quantitative studies, whilst also obtaining sound psychometric properties. Table 3 provides an overview of the scoring criteria.

As the review contained two qualitative studies the Quality Index was not an appropriate tool to use therefore, the quality of these studies was assessed through using some of the guidelines developed from a comprehensive literature review by Sale and Brazil (2004). The guidelines do not contain a scoring system; rather they make reference to three quality domains, including internal validity, external validity and reliability. With regard to internal validity the guidelines propose that qualitative studies should contain quotations, state how informed consent was gathered, address any ethical issues and consider consent procedures. For a study to achieve sound external validity it should have a statement of purpose, clear research questions and descriptions of the research setting whilst describing sampling procedures, data collection and analysis. To achieve reliability, it is necessary for each study to undergo an audit of process which is conducted by an external source. Throughout the review references will be made to these quality assessment methods.

Table 2: Summary of articles

Author	Summary of research	Sample	Methodology	Measures Used	Outcomes	Methodology limitations
Brown & Blount (1999)	Occupational stressors of managers identified through interviews. Types of stressors and mediating variables explored	n= 21 Sex Offender Treatment Managers from HM prison service in England and Wales 84% response rate	Mixed Design (pilot interviews used to develop a questionnaire)	Stress questionnaire developed from interviews General Health Questionnaire (Goldberg & Williams, 1988)	Multidimensional scaling techniques implemented which revealed three stressor foci: intrinsic job factors, other people, personal. Mediating variables to stress levels associated with experience, supervision and policy related issues	Small sample Uncertain psychometric properties of own stress questionnaire Findings may be context specific

Table 2: Continued

Author	Summary of research	Sample	Methodology	Measures Used	Outcomes	Methodology limitations
Carmel & Friedlander (2009)	Study exploring the impact of burnout, compassion fatigue, secondary trauma symptoms and compassion satisfaction in relationship to therapists own perception of therapeutic alliance	n = 106 therapists working in any therapeutic setting (inpatient, outpatient, community) with male clients who have committed asexual offence. USA based sample Mailed Survey 21.2% response rate	Quantitative	Working Alliance Inventory – Short Form (Hovath & Greenberg, 1989) *(Strength of therapeutic relationship with recent male client)* Professional Quality of Life Scale –Revised (Stamm, 2005) *(Compassion Fatigue, Burnout & Compassion Satisfaction* Impact of Event Scale –Revised (Weiss & Marmar, 1995) *(used as a measure of Secondary Trauma)*	Descriptive Analyses: Low mean scores on: secondary trauma Compassion fatigue High level of compassion satisfaction Hierarchal Regression analysis: More experience resulted in the perception of stronger therapeutic alliances Compassion satisfaction significant predictor of alliance	Low response rate Authenticity of therapists perception of working alliance with male client Descriptive study

Table 2: Continued

Author	Summary of research	Sample	Methodology	Measures Used	Outcomes	Methodology limitations
*Ennis & Horne (2003)	Exploratory study considering level of psychological distress among therapists who work with sex offenders. Consideration given to the social support mechanisms which may alleviate therapists risks	n= 59 mental health professional working for 3 hours or more each week with sex offenders. In mental health agencies, private practices in USA and Canada Mailed Survey 18.7 % response rate	Quantitative	The Los Angeles Symptom Checklist (King et al., 1995)*(post traumatic distress)* Clinician Survey *(clinician's perceptions of perceived support from family and peers)*	Persons correlation indicated no significant relationship between number of hours spent working with sex offenders and psychological distress Linear Regression Analyses revealed that greater perceptions of peer support were significantly associated with lower levels of post traumatic stress disorder and psychological distress symptoms	No control group Generalisation of outcomes Low response rate Respondents may be unrepresentative of overall sample

Table 2: Continued

Author	Summary of research	Sample	Methodology	Measures Used	Outcomes	Methodology limitations
*Farrenkopf (1992)	Exploratory study investigating the personal impact on therapists working with sex offenders	n= 24 Oregon (USA) Mental Health therapists working with criminal clients and sex offenders 69% response rate	Mixed Design (pilot interviews used to develop a questionnaire)	Pilot interviews structured into a questionnaire survey. Questions related to personal impact, differences in genders, personal coping mechanisms and demographic information	Descriptive: Impact of work:- changes in emotions Gender:- differences arose Phases of impact:- Development of adjustment phases therapists undergo	Small sample. No details provided on how sample was recruited No information on methods used for authenticating qualitative results. Descriptive Phases of impact:-circular or sequential notion?

Table 2: Continued

Author	Summary of research	Sample	Methodology	Measures Used	Outcomes	Methodology limitations
Hatcher & Noakes (2010)	Exploratory cross sectional study examining compassion fatigue, burnout, compassion satisfaction and vicarious traumatisation in sex offender treatment providers	n= 48 clinicians providing treatment to sex offenders across different parts of Australia in correctional settings Mailed survey 40.1 % response rate	Mixed Design	Professional Quality of Life Scale (Figley, 1995) *(compassion fatigue, compassion satisfaction and burnout)* Impact of Events Scale – Revised (Weiss & Marmar, 1995) *(used as a measure of vicarious trauma)* Quality of Work Life Survey (Armstrong & Griffin, 2001) *(environmental factors)* Qualitative Questions*(impact of work/ coping)*	Low levels of vicarious trauma, low-moderate levels of compassion fatigue and burnout, moderate levels of compassion satisfaction reported. Regression Analysis indicated environmental safety and role problems significantly predicted compassion satisfaction and fatigue. Content analysis used on qualitative date:	No information on who conducted analysis on qualitative results and inter-rater reliability methods. Generalisation

Table 2: Continued

Author	Summary of research	Sample	Methodology	Measures Used	Outcomes	Methodology limitations
Kadambi & Truscott (2003)	Survey to assess presence of vicarious trauma. Mitigating variables to this explored and relationship of vicarious trauma to burnout examined.	n= 73 therapists working with sex offenders in Canada Mailed survey 33.1% response rate	Quantitative	Treatment Provide Survey*(demographic information; designed for study)* Traumatic Stress Institute Belief Scale – Revised (Pearlman, 1996)*(vicarious trauma)* Impact of Event Scale (Horowitz, Wilner & Alvarez, 1980) *(central features of ptsd including intrusion and avoidance symptoms)* Maslach Burnout Inventory (Maslach, 1996) *(burnout)*	T-Test revealed presence of vicarious trauma was similar to reference group of mental health professionals. Regression analyses indicated that therapists with venue to address personal impact of work reported lower vicarious trauma. 24% reported moderate to severe stress	Descriptive study No details of environmental settings in which therapists worked

Table 2: Continued

Author	Summary of research	Sample	Methodology	Measures Used	Outcomes	Methodology limitations
Scheela (1999)	Personal self account on the experiences of working with sex offenders	n= 1 (authors own account)	Quantitative	n/a	Personal account offering insight and reflections on experiences of working with sex offenders. Emphasis is on placed the various challenges difficulties and rewards of this work Insight provided regarding possible coping strategies	Individual personal account limits reliability and generalisation of findings Outcomes limited further by authors experience being restricted to male sex offenders and one work establishment

Table 2: Continued

Author	Summary of research	Sample	Methodology	Measures Used	Outcomes	Methodology limitations
Scheela (2001)	Qualitative study hoping to learn more about the experiences of a group of therapists working with sex offenders in an outpatient program	n= 17 sex offender treatment therapists working on an outpatient treatment program in the USA	Qualitative Unstructured face to face interviews lasting approximately 2 hours per participant	n/a	Constant comparative analysis used. Selection of categories and subcategories emerged (beginning, changes, impact, attitudes(negative/positive) coping strategies) Links with Farrenkopf's (1992) progressive stage model	Possible outcome bias:- researcher worked within place of research. No details provided on attempting to increase reliability or validity of outcomes Small sample

Table 2: Continued

Author	Summary of research	Sample	Methodology	Measures Used	Outcomes	Methodology limitations
*Shelby, Stoddart & Taylor (2001)	Exploratory study assessing burnout amongst sex offender treatment providers. Identification of factors contributing to increased levels of burnout	n= 87 mental health providers working with sex offenders in both inpatient and outpatient settings in the USA Mailed survey 58% response rate	Quantitative	Maslach Burnout Inventory (Maslach, Jackson & Leiter, 1996) *(burnout)* Demographic questionnaire	Comparisons to mental health workers via T-tests indicated higher emotional exhaustion, depersonalisation and personal accomplishment Comparisons to social service workers via T-tests indicated higher personal accomplishment Regression Analyses: inpatient settings significant	Self- report measure could bias results Respondents may have been unrepresentative due to completion of mailed survey No control group

Table 2: Continued

Author	Summary of research	Sample	Methodology	Measures Used	Outcomes	Methodology limitations
*Steed & Bicknell (2001)	Exploratory study to explore the existence of secondary traumatic stress(STS) in therapists working with sex offenders	n= 67 therapists working with sex offenders in Australia 38 % response rate	Quantitative	Compassion Satisfaction/ Fatigue Self-Help Test (Figley, 1995) *(compassion fatigue, compassion satisfaction and burnout)* Impact of Events Scale – Revised (Weiss & Marmar, 1995) *(Secondary Trauma)*	Descriptive statistics revealed that 46.2% showed moderate- high risk of compassion fatigue 19.4% reported moderate levels of burnout 97% reported low levels of satisfaction Quadratic trend analysis revealed least and most experienced therapist experience most avoidance when dealing with stress/trauma	No details provided on recruitment process or details on settings in which participates worked Appropriate use of measures? Small sample this may have impacted upon lack of significant outcomes

Table 2: Continued

Author	Summary of research	Sample	Methodology	Measures Used	Outcomes	Methodology limitations
*Thorpe, Righthand & Kubik (2001)	Study exploring levels of burnout in professionals working with sex offenders in clinical, forensic and human services settings.	Pilot study: n= 17 clinicians who provided sex offender evaluation in the USA Study: n= 70 clinicians, jurists, frontline caseworkers, supervisor all working with sex offenders	Quantitative	The professional Impact Questionnaire (Righthand, Thorpe & Kubik, 2000) *(developed from clinicians response to watching a interview with a sex offender and answers being developed into a questionnaire which assesses professional performance, coping strategies and emotional reactions)*	Psychometric properties for the professional Impact Questionnaire (Righthand, Thorpe & Kubik, 2000) were satisfactory but not limited Correlations revealed greater negative impact, more adverse impact on professionals performance. Level of burnout higher with more contact	Justification for the development of a new questionnaire is limited Outcomes are based on correlational relationships

Table 2: Continued

Author	Summary of research	Sample	Methodology	Measures Used	Outcomes	Methodology limitations
*Way et al., (2004)	Comparison study exploring vicarious trauma in clinicians treating survivors of sexual abuse and those who treat sex offenders	n= 347 clinical members of 2 professional membership organisation in the USA. 95= clinicians working with survivors of sexual abuse 252= clinicians working with sex offenders Mailed Survey 33% response rate	Quantitative	Impact of Event Scale (Horowitz, Wilner & Alvarez, 1980) *(used as a measure of vicarious trauma)* The Childhood Trauma Questionnaire (Bernstein & Fink, 1998) *(multiple forms of childhood maltreatment)* Demographic Coping question (self designed)	Descriptive statistics indicated that vicarious trauma was present in both groups, overall 52% scored within clinical range. T-Tests showed clinicians treating survivors more likely to employ professional support and personal coping strategies Regression Analyse: different demographic variables: significant effect	Cross sectional study therefore difficult in determining cause-effect relationships Retrospective data Lack of heterogeneity in sample Generalisation Questionable?

Table 3. The Quality Index. Scoring Criteria (Downs & Black, 1998)

Criteria	Points		
Reporting	Yes	No	
1. Clear hypothesises/aim/objective	1	0	
2. Main outcomes to be measures described?	1	0	
3. Characteristics of the patients described?	1	0	
4. Interventions of interest clearly described?	1	0	
5. Principle confounders described?	1	0	
6. Main findings clearly described?	1	0	
7. Estimates of the random variability reported?	1	0	
8. Have important adverse events that may be a consequence of the intervention been reported?	1	0	
9. Have the details of the participants lost to follow-up been described?	1	0	
10. Probability findings been reported?	1	0	
External Validity			Unable to determine
11. Is the sample representative of the population?	1	0	0
12. Are the participants representative of the population?	1	0	0
13. Does the intervention have ecological validity?	1	0	0
Interval Validity- Bias			
14. Attempt to blind participants to the intervention?	1	0	0
15. Attempt to blind those who measuring the main intervention outcomes?	1	0	0
16. Unplanned statistics?	1	0	0
17. Does the study adjust for different lengths of follow-up?	1	0	0
18. Were the statistical analysis appropriate?	1	0	0
19. Was compliance with the intervention reliable?	1	0	0
20. Main outcome measures accurate (reliable and valid)?	1	0	0
Internal Validity – confounding (selection bias)			
21. Participants recruited from the same population?	1	0	0
22. Participants recruited over the same period of time?	1	0	0
23. Participants randomised to intervention groups?	1	0	0
24. Was randomisation concealed to participants?	1	0	0
Criteria	1	0	0
25. Adjustment for confounding variables?	1	0	0
26. Losses of participants to follow-up taken into account?	1	0	0
Power			
27. Sufficient power to detect clinically significant effect?	1	0	0

METHODOLOGICAL LIMITATIONS

Appropriate Definition and measurement

When describing the harmful effects of working with sex offenders the studies reviewed have referred to a range of concepts, which they have defined and measured in various ways. Some studies have described a specific concept such as vicarious trauma, but rather than using an established measure to assess this have employed an alternative measure relating to a different area of the trauma domain (Hatcher & Noakes, 2010; Way et al., 2004). These issues can create implications for the authenticity of findings and provide limitations to the generalisation of outcomes.

Data measurement and analysis

Studies exploring the harmful effects of working with sex offenders have used both qualitative and quantitative research methodologies. There are a number of limitations to each of these methods.

Qualitative

This review contained two qualitative studies, which consisted of staff interviews (Scheela, 2001) and a personal account of working with sex offenders (Scheela, 1999). Two quantitative studies (Brown & Blount, 1999; Farrenkopf, 1992) used semi-structured interviews to develop questionnaires, which were then used to assess the harmful effects of working with sex offenders. A further two quantitative studies (Hatcher & Noakes, 2010; Kadambi & Truscott, 2003) incorporated aspects

of qualitative methodology in the form of open-ended surveys to extend their quantitative findings.

Qualitative methodology has the potential to generate greater, more in-depth information (Robson, 2002), which can provide valuable insight into a research area. The disadvantages of this methodology however, lie in its production of non-standardised outcomes, whilst its analysis is often criticised for being subject to researcher bias (Denscombe, 1998). Consequently, this holds implications for generalising the findings from these types of studies.

Each of the qualitative studies reviewed enabled more in-depth information relating to the harmful effects of work with sex offenders and various moderating and protective factors. All of these studies however, failed to provide information relating to the process involved in the development of their questions for use within either interviews or open-ended surveys. Furthermore four studies (Brown & Blount, 1999; Farrenkopf, 1992; Hatcher & Noakes, 2010; Kadambi & Truscott, 2003) did not state who conducted the analysis on the qualitative data. The reader, therefore is left questioning the skill and ability of the analyser, whilst the reliability and validity of the findings may have been comprised.

Quantitative

In this review the quantitative studies have used self-report questionnaires to collect information about the harmful effects of working with sex offenders. Questionnaires are often used to generate large amounts of standardised data (Robson, 2002). Disadvantages of using questionnaires relate to their traditional low response rates, missing data and often biased responses (Denscombe, 1998). The use of mailed

surveys can further reduce response rates and it is likely that responses are restricted to those motivated and interested individuals (Robson, 2002). These limitations can pose challenges for the reliability and validity of the data collected and can restrict the representation and generalisation of findings. In applying this to the studies reviewed; it is likely that these limitations have had some bearing on the outcomes of the studies, but this was only acknowledged by two studies (Carmel & Friedlander 2009; Hatcher & Noakes, 2010)

Using outcomes from self-report measures some studies have categorised harmful effects into levels of “low”, “moderate” or “high”. Some studies nevertheless, failed to provide an explanation relating to how this level was determined or what these differing levels clinically represent. As a result it is difficult to establish the precise incidence of harmful effects in those who work with sex offenders.

To explore whether the harmful effects of working with sex offenders are related to various moderating and protective factors, some quantitative studies made use of correlation analysis. Although this enabled an association between these variables to be established, identifying specific causes and effects was not possible. Additionally, ascertaining the prospective and longitudinal role of these variables was impossible.

Sample Considerations

Sample sizes are important in ensuring that statistical findings accurately represent the findings of a specific population, therefore larger sample sizes are advised (Denscombe, 1998). Only four studies in the review recognised and acknowledged the limitations of low response rates and small sample sizes on their findings

(Hatcher & Noakes, 2010; Shelby, Stoddart & Taylor, 2001; Steed & Bicknell, 2001; Way et al., 2004).

The majority of the studies reviewed contained participants working with sex offenders in the USA, Canada or Australia. The criminal and mental health systems are likely to be different, whilst the expectations, working practices and support available for clinicians may vary. Therefore generalising the outcomes from these studies to other jurisdictions proves problematic. Nevertheless, this review has shown that there were similarities between the findings which suggests the harmful effects of working with sex offenders and the associated moderating and protecting factors may occur at a universal level.

Evidential Quality

Quantitative Studies

In order to consider the evidential quality of each of the quantitative articles the Quality Tool Index scoring criteria was applied to each. Table 4 outlines the total scores for each study, whilst providing an overview of how these scores were achieved across the five quality domains.

Table 4. Quality Index Scoring Criteria applied to each quantitative study, illustrating total and individual domain scores

Study	Total	Reporting	External Validity	Internal Validity - bias	Internal validity-confounding	Power
	28	12	3	7	6	1
Kadambi & Truscott (2003)	18	10	3	2	2	1
Shelby, Stoddart & Taylor (2001)	18	8	3	3	3	1
Hatcher & Noakes (2010)	16	8	3	2	3	0
Carmel & Friedlander (2009)	15	7	3	3	1	1
Way et al., (2004)	14	7	2	2	2	1
Brown & Blount (1999)	13	5	3	2	2	1
Steed &Bicknell (2001)	13	7	3	2	1	0
Ennis & Horne (2003)	11	7	2	1	1	0
Thorpe, Righthand & Kubik, (2001)	8	6	0	1	1	0
Farrenkopft (1992)	8	3	2	1	2	0

In order to consider the evidential quality of each study these were allocated into one of three categories depending on their total score. These categories related to high

scores (19-28 total points), medium scores (10-18 total scores) and low scores (0-9 total scores). Seven of the studies fell into the medium category (Brown & Blount, 1999; Carmel & Friedlander, 2009; Ennis & Horne, 2003; Hatcher & Noakes, 2010; Kadambi & Truscott, 2003; Shelby, Stoddart & Taylor, 2001; Steed & Bicknell, 2001; Way et al, 2004), two into the low category (Farrenkopft, 1992; Thorpe, Righthand & Kubik, 2001) and none into the high category. Based on the outcomes of this the overall evidential quality of the studies included within the review is generally poor. The majority of studies have failed to clearly define what it is they are intending to measure, they have often employed inaccurate measures, chosen samples which are too small to achieve significant effects or have implications for generalisation. Additionally most studies have failed to consider or measure for potential confounding variables which may have an impact upon those working with sex offenders. Discussion centring upon the evidential quality of these studies is provided in detail in Appendix A and is interwoven within the commentary of the review.

Qualitative Studies

Two qualitative studies are included in the review, these are both provided by Scheela (1999, 2001), who offers her own and others accounts of working with sex offenders. When applying Sale and Brazil's (2004) quality guidelines to Scheela's (1999) study this achieves high internal validity. She fails, however to describe how she decided to include specific examples in her study furthermore, she did not consider how her own experiences may compare to others, comprising the overall external validity and reliability of her findings.

In comparison her study which collected the experiences of those working with sex offenders (2001) evidenced the process of consent, ethical concerns and provided participants' quotations throughout, thus enabling sound internal validity to be achieved. The study held robust external validity as it provided a clear statement of purpose, concise research questions, justified its use of a qualitative methodology, offered a description of the study's context, detailed the sampling process and described the data analysis implemented. The overall evidential quality of the study was high, Scheela was however, not successful in providing any criteria to assess the reliability of her findings.

HARMFUL EFFECTS OF WORKING WITH SEX OFFENDERS

Each study has reported some type of harmful effect associated with working with sex offenders. Clarke and Roger (2002) advocate that only a fifth to a quarter of the individuals in the samples which they reviewed report these symptoms, whereas Moulden and Firestone (2007) conclude that some sex offender therapists in the studies they reviewed held "moderate to clinically significant levels" of vicarious trauma. Each article is reviewed in relation to the type and intensity of harmful effects. Qualitative studies are presented first followed by the findings drawn from quantitative studies.

General effects

Two studies used a qualitative perspective to explore the harmful effects (Scheela, 1999; Scheela, 2001), these are more exploratory in nature and used participants stories to understand the impact of working with sex offenders.

In Scheela's (1999) self reflective personal account, she described several difficulties and negative effects of sex offender work; these encapsulated hearing about horrendous events, feeling frustrated and disillusioned whilst becoming more concerned over safety. She concluded that although her experience had been challenging, it had also been rewarding with positive effects relating to observing adaptive change in clients and experiencing compassion for these individuals. This case study offers a unique perspective on the effects of sex offender work. When considering Sale and Brazil's (2004) quality guidelines the overall value of her

findings are restricted by an absence of external validity and reliability, thus limiting their generalisation.

Scheela (2001) used unstructured interviews with 17 sex offender therapists which were analysed using constant comparative analysis. From this the positive and negative effects of working with this client group were classified into personal and professional categories. On a personal level, therapists described several concerns relating to feelings about their own safety, whilst describing emotional changes in which they became desensitised, detached and hardened and constantly worried that their clients would re-offend. On a professional level therapists emphasised that the negative attitudes held by society, staff and the media regarding sex offenders contributed to the difficulty of their work. Positive effects included the challenge of the work, contributing to the future safety of the community and observing positive changes. The study did not report the percentage of those interviewed which reported these effects. Furthermore when applying Sale and Brazil's (2001) quality criteria the study fails to account for the reliability of its findings, consequently this restricts their generalisation.

Hatcher and Noakes's (2010) used an open-ended survey in which therapists were asked "what they considered the impact was of working with sex offenders". Outcomes identified sixteen different types of impact which they then classified into two themes. The first theme was entitled; "changes to perceptions of humanity" and was reported by 72% of the 48 participants. The themes related to harmful effects including increased vigilance regarding safety and the heightened awareness that people could be harmful or deceptive. Positive effects were described as a greater awareness and understanding regarding sex offenders motivation and the need to accept these individuals into communities. The authors concluded that within this

theme there was some evidence to indicate changes in clinicians' cognitions surrounding their beliefs about the world and others which may be suggestive of vicarious trauma. The second theme entitled "changes directly affecting the self" was reported by 70% of the sample. This theme encapsulated the individual, personal and professional effects of working with sex offenders. Positive and negative effects surrounding therapists own levels of intimacy in personal relationships were reported. Individual changes included, feelings of frustration, distress and irritability and increased levels of confidence.

Vicarious trauma

Three studies reported the presence of vicarious trauma (Hatcher & Noakes, 2010; Kadambi & Truscott, 2003; Way et al., 2004). Using a cut-off score of 26 on the Traumatic Stress Institute Belief Scale-Revised (Pearlman, 1996), Kadambi & Truscott (2003) reported "low" levels of vicarious trauma within their sample. When comparing their findings to a criterion reference group of mental health professionals; no significant differences were found between these groups. With regard to the evidential quality of this study, it achieved one of the highest scores within the review. It was well designed and measured for potential confounding variables that could have influenced the level of vicarious trauma that sex offender therapists experienced. Its findings therefore, can be considered to have greater authenticity in comparison to other studies.

Hatcher & Noakes' (2010) found that 6-8% of their 48 participants were displaying mild levels of vicarious trauma, with 92-94% of the sample falling in the "sub-clinical" range. This suggests that these individuals were showing symptoms which were at a "threshold" for the development of vicarious trauma. This was established using

the median scores of the Impact of Events Scale-Revised (Weiss & Marmar, 1995). Using the same measure and methodology, Way et al., (2004) reported that 52% of their sample presented within the clinical range. This implied they were experiencing levels of vicarious trauma which were above the expected range when compared to a normal sample of therapists. Although the latter two studies report the presence of vicarious trauma within their sample, the use of a PTSD measure makes the validity of their findings questionable. When compared to other studies within the review, both these studies achieved medium quality scores. Each study alluded to the impact of confounding variables on the level of vicarious trauma experienced, however they were unsuccessful in specifically measuring all of these. The overall quality of the studies is consequently reduced and their findings should be interpreted with caution.

Compassion Fatigue

Two studies reported the existence of compassion fatigue, with the intensity of this ranging from low-moderate (Hatcher & Noakes, 2010) and moderate (Carmel & Friedlander, 2009). In relation to the quality of their outcomes, both studies achieved average quality marks, therefore the significance of their quality is questionable.

Secondary Trauma

The existence of secondary trauma was reported by two studies (Carmel & Friedlander, 2009; Steed & Bicknell, 2001). The intensity of this varied from moderate (Carmel & Friedlander, 2009) to high (Steed & Bicknell, 2001), these levels were determined using the measures mean scores. Each of these studies used different questionnaires with varying psychometric properties. Carmel and Friendlander (2009) used a questionnaire traditionally designed to measure PTSD

(Impact of Events Scale-Revised, Weiss & Marmar, 1995) to assess the symptoms of secondary trauma. Whereas, Steed and Bicknell (2001) operationalised secondary trauma as consisting of compassionate fatigue and burnout, consequently this holds implications when considering the validity of their outcomes. Furthermore this contributed to the overall medium evidential quality score which the study received.

PTSD

One study reported the presence of PTSD in their sample of therapists (Ennis & Horne, 2003). Using the Los Angeles Symptom Checklist (King et al., 1995) they suggested that there were low levels of PTSD in their sample. They did not however, use reference groups or compare their outcomes to other studies or professional groups. Furthermore they fail to illustrate what different scores on the measure indicate in relation to the PTSD severity. The Impact of Event Scale (Horowitz, Wilner & Alvarez, 1980) is frequently used as a measure of PTSD, the authors do not however state why they never used this. These limitations contributed to the medium quality score which the study achieved when a quality assessment tool was applied.

Stress

Brown and Blount (1999) reported that 43% of their sample reached the critical threshold for psychological distress as indicated by the General Health Questionnaire (Goldberg & Williams, 1998). This measure has been widely used in studies of occupational well-being and has high levels of reliability and validity (Jackson, 2007). Despite this, the authors made no attempts to use reference groups to compare their outcomes. Furthermore the authors failed to consider or

measure any potential confounding variables which may have influenced this level of distress. This has consequently, impacted upon the medium score which the study was given regarding the quality of its evidence.

Burnout

Farrenkopf (1992) reported 25% of his sample felt that they had experienced high stress, exhaustion, depression and "burnout". It was not clear how the figure of 25% was established, the findings were based on the author's own self-designed survey which produced frequencies and percentages and consequently, did not show any significant clinical outcomes. Furthermore the author failed to account for any extraneous variables which may have affected the overall level of burnout. As a result of some of these limitations the study received a low evidential quality score. Its findings therefore should be considered with extreme care. Using a well established measure of burnout, the Maslach Burnout Inventory (Maslach, Jackson & Leiter, 1996), Shelby, Stoddart and Taylor (2001) reported high levels of emotional exhaustion and depersonalisation in their sample, whilst Kadambi & Truscott (2003) found moderate levels. Both studies reach these conclusions through comparing the results obtained with appropriative reference groups. These studies used accurate measures and assessed potential variables which may have held a confounding effect on the level of burnout reported. Consequently, when a quality assessment tool was applied, they both achieved medium scores, suggesting their findings were of a relatively average qaulity.

Hatcher and Noakes (2010) found low levels of burnout and Carmel and Friedlander (2009) reported moderate levels, whilst Steed and Bicknell (2001) described moderate to high levels of burnout in 19.4% of their sample. These studies did not compare their outcomes to established norms or other samples. Low levels of

burnout are reported by Thorpe, Righthand and Kubik (2001), the authors created their own burnout measure rather than utilising an established scale. They offer no justification for this and although the initial psychometric properties were acceptable, the long term usage of this measure remains questionable. These limitations actively contributed to the low evidential quality score which the study achieved.

Compassion satisfaction

Steed and Bicknell (2001) found moderate levels of compassion satisfaction in 3% of their sample, whilst the remaining 97% reported low levels of satisfaction in their work; no possible explanations were provided. Two studies (Carmel & Friedlander, 2009; Hatcher & Noakes, 2010) reported moderate to high levels of compassion satisfaction in their samples. This suggested the majority of their samples felt a sense of reward, efficacy and competency in their work with sex offenders.

MODERATING FACTORS

Seven studies attempted to consider which moderating factors may potentially increase the harmful effects of working with sex offenders (Brown & Blount, 1999; Farrenkopf, 1992; Hatcher & Noakes, 2010; Shelby, Stoddart & Taylor, 2001; Steed & Bicknell, 2001; Thorpe, Righthand & Kubik, 2001; Way et al., 2004)

Individual influences

Age

Only one study found a significant influence between age and harmful effects. Way et al., (2004) compared the presence of vicarious trauma in clinicians treating survivors of sexual abuse and those treating sex offenders. They found younger clinicians treating sex offenders reported higher levels of vicarious trauma, as indicated via the avoidance sub-scale of the Impact of Events Scale (Horowitz, Wilner & Alvarez, 1979). They suggest that those clinicians who are most negatively affected may prematurely leave the occupation, this finding has not been supported by other studies and replication is required.

Level of Experience

A clinician's level of experience working with sex offenders has often thought to be related to whether they observe any harmful effects from this work. Steed and Bicknell (2001) measured secondary trauma through the Impact of Events Scale-Revised (IES-R) (Weiss & Marmar, 1995), their outcomes found a "U" shaped relationship between the therapist's level of experience and secondary trauma. This suggested that those therapists who had the least and most years experience were more likely to experience greater levels of secondary trauma. This finding was,

nevertheless limited by the fact that it was only significant for the avoidance sub-scale of IES-R, consequently replication by further studies with larger samples is necessary.

Using a questionnaire survey Brown and Blount (1999) considered the level of stress experienced by sex offender treatment managers. They found a significant relationship between the length of a manager's experience and their levels of stress. The type of stressor varied depending on the manager's level of experience: those with least experience (2 years and under) related their stress to perceptions of personal safety and organisational challenges regarding supervision. Managers with two to four years experience associated their stress with high workloads and the impact this had on their personal life. In contrast, managers with five or more years experience associated their stress to issues related with structural and policy matters. These findings suggest a number of possibilities. As a managers career progresses, their role may change which in turn can hold implications for the type of stressors which they may encounter. Alternatively, as managers gain more experience they may learn to cope more effectively with certain aspects of their job but their worry may become attributed to other stressors. Unfortunately the authors did not ask managers in each category how they coped with these specific stressors.

When applying the quality assessment tool to both Steed and Bicknell's (2001) and Brown and Blount's (1999) studies they achieved medium quality scores. This suggests that the overall standard of their study and findings were of an average level and held scope for much improvement.

Shelby, Stoddart and Taylor (2001) found no association between level of experience and levels of burnout in those working with sex offenders. Whilst Kadambi and Truscott (2003) found that the length of time therapists had worked with sex offenders was not significantly related to their level of vicarious trauma. Through using a quality assessment tool the findings from these studies obtained a medium quality score, consequently their outcomes can be considered as fairly standard and improvements could be made.

Gender

Gender has frequently been hypothesised as an important factor relating to the impact of working with sex offenders, however four studies (Ennis & Horne, 2003; Hatcher & Noakes, 2010; Shelby, Stoddart & Taylor, 2001; Thorpe, Righthand & Kubik, 2001) found no significant association with harmful factors. Brown and Blount (1999) found some variation in the frequency of stressors experienced by females and males; though none of the differences were significant.

Qualitative studies found that males had a heightened awareness over male abusive behaviours, whilst females felt more vulnerable, showed greater concern over their own and children's safety (Farrenkopf, 1992; Scheela, 2001). None of the qualitative papers attempted to associate gender with any specific harmful effect.

Profession

A small number of studies have considered whether an individual's professional status makes them more vulnerable to potential harmful effects. Steed and Bicknell (2001) found that psychologists showed significantly lower levels of secondary trauma when compared to social workers. Whilst Thorpe, Righthand and Kubik

(2001) investigated the role of burnout in social workers, psychiatrics, psychologists, attorneys, caseworkers, judges and department of homeland security (DHS) administrators, all of whom were working with sex offenders in the USA. Their outcomes indicated that caseworkers reported greater levels of burnout than attorneys and judges. They suggested that this may be related to these individuals spending greater periods of time with sex offenders, however the authors failed to measure this. Furthermore the overall evidential quality of this study proved to be poor, consequently the accuracy of its findings should be considered with vigilance.

Organisational influences

Setting

Shelby, Stoddart & Taylor (2001) explored factors associated with burnout in mental health providers working with sex offenders in either outpatient or inpatient settings. They identified the only significant factor to be the environment in which providers worked. Those working within inpatient settings reported higher levels of EE and DP and lower levels of PA. The authors suggest that these individuals were likely to experience greater direct exposure to the most difficult types of sex offenders which increased their vulnerability. The study also measured for other relevant factors which may have influenced a therapist's level of burnout including, number of years experience, therapy used and percentage of sex offenders on their case load. This contributed to the study achieving a fairly high medium quality rating in contrast to other studies.

Hatcher and Noakes (2010) compared the impact of inpatient or community settings on clinicians levels of compassion satisfaction, compassion fatigue and burnout. No significant differences between these groups were found, the authors acknowledge this may have been related to their small sample size, which reduced the overall quality of their study.

Organisational Support

Studies have considered the type of organisational influences which may increase the harmful effects of sex offender work. Farrenkopft (1992) reported that 6 of his 24 participants reported levels of stress relating to non-supportive colleagues and friends. Brown and Blount (1999) found that approximately one third of their sample

identified sources of stress associated with organisation issues including an absence of effective team work, lack of supervision, no clear policy guidelines, lack of understanding from their managers and a general lack of support. Many participants felt they had no place to "off load" which contributed to their feelings of stress. The authors failed to collect data on the number of participants who cited these stressors, therefore the frequency of these difficulties were not known. Hatcher and Noakes (2010) found three significant correlations between levels of burnout with organisation support, environmental safety and role problems. These outcomes suggested some association between a clinician's environment and burnout when working with sex offenders.

PROTECTIVE FACTORS

Eight studies considered various protective factors which may assist in minimising or preventing the harmful effects of sex offender work (Carmel & Friedlander, 2009; Ennis & Horne, 2003; Farrenkopf, 1992; Hatcher & Noakes, 2010; Kadambi & Truscott, 2003; Scheela, 2001; Thorpe, Righthand & Kubik, 2001; Way et al., 2004)

Individual Influences

Working Alliance

Carmel and Friedlander (2009) considered how therapists perceived their working alliance with male sex offenders and whether this had any impact upon symptoms of burnout and secondary trauma. Their findings suggested that positive working alliances were indicative of high levels of compassion satisfaction and low levels of secondary trauma and burnout. Age, years of general experience and years of working with sex offenders significantly correlated with perceived working alliances. Regression analyses revealed that perceived working alliances were strongest for those therapists whom had more experience working with sex offenders, however the strongest unique predictor of this was compassion satisfaction. The research design used means it is impossible to establish whether therapists with high compassion satisfaction find it easy to establish working alliances or if those who establish productive working alliances are more likely to feel satisfied in their work. This study suggests that those sex therapists that have more experience and greater working alliances with sex offenders are less likely to experience the harmful effects of this work. . When applying a quality assessment tool to this study, it achieved an average value. The study's inclusion of potential confounding variables which could

impact on the adverse and positive effects of working with sex offenders increased the study's quality. Nevertheless, replication of these outcomes is necessary

Personal coping strategies

Scheela's (1999) personal account suggests that effective coping can be aided through greater understanding of the sex offenders offence but, this may be subject to an individual's perspective. When applying the Sale and Brazil's (2004) guidelines to assess the quality of the findings, this study held limitations relating to poor external validity and reliability. Its outcomes therefore, should be considered with caution.

Participants in Scheela's (2001) qualitative study reported a wide variety of personal coping mechanisms including activities, hobbies, exercise and humour. Of paramount importance was the need to maintain boundaries between their professional and personal life through having "time-out". This is recognised as an important strategy by those who work with trauma (Sexton, 1999). Although this study achieved sound internal and external validity, the reliability of its findings was questionable. Additionally the author did not expand on what constituted "time-out" or whether therapists felt they were successful in achieving this. Moreover the percentage of participants who were using each coping strategy was not provided, whilst the existence of negative coping strategies was not explored or acknowledged.

Hatcher and Noakes (2010) asked participants working with sex offenders what coping strategies they used in their work, 94% reported the use of personal coping strategies which all were positive in nature. These were diverse and included relaxation, having fun, engaging in hobbies and balancing work and home life. Of

the 48 participants, 30% reported using cognitive strategies including self-talk or re-directing their thoughts, 6% found it helpful to express their feelings, whilst 4% actively attempted to change community attitudes. Farrenkopf (1992) found a quarter of his sample described managing this type of work through a negative coping strategy by adjusting their attitudes in which they became detached from their clients. Over half his sample had considered decreasing or terminating their work with sex offenders in order to avoid burnout. Both studies used a self-designed survey to assess personal coping strategies rather than using established measures. This resulted in the outcomes being presented in terms of frequencies and percentages rather than clinically significant effects, which when applying a quality assessment tool reduced the overall quality of the study.

Qualitative studies and those using open-ended surveys have provided some awareness of the type of personal coping strategies that individuals use but, they failed to explore if individuals found their coping strategies effective in preventing or reducing potential harmful effects. Two quantitative studies offer some insight into this. Thorpe, Right and Kubik (2001) found those professionals who used positive coping strategies to manage their work with sex offenders experienced less harmful effects. The authors did not state what constituted a positive coping strategy. Additionally not all their sample were working with sex offenders, hence reducing the quality of their outcomes.

Using a self-developed survey Way et al., (2004) provided participants with a selection of coping strategies and asked them to indicate which they had used in the last six months to cope with their work. These coping strategies were divided into three types; negative personal strategies, positive personal strategies and positive professional strategies. Clinicians favoured the use of positive professional

strategies which included consultation, supervision and peer support. They showed that higher rates of vicarious trauma were associated with greater use of positive personal coping strategies, which included the use of exercise and social support. This suggests that although, clinicians favoured the use of positive professional coping strategies their personal coping styles may be more effective in reducing harmful effects.

Organisational influences

Professional coping strategies

Farrenkopf (1992) found that 38% of his sample reported an absence of effective support systems for working with sex offenders. They suggested the need for increased levels of supervision, more staff support, opportunities for training and greater financial support for treatment programs. The study did not consider if therapists were currently using these or whether they had a direct influence on reducing potential adverse effects created by this client work. Moreover when referring to the quality assessment tool, this suggested that the quality of evidence underlying these conclusions was considered as very poor.

Kadambi & Truscott (2003) reported that therapists who perceived themselves to have a venue to address the personal impact of working with sex offenders showed significantly lower levels of vicarious trauma. The study explored this further through an open-ended survey, whose findings showed that therapists valued a selection of professional coping strategies in managing the harmful effects of their work. These included clinical team meetings, meetings with colleagues, debriefing periods with team members and supervision. Therapists in Scheela's study (2001) reported similar preferences. They emphasised the importance of supervision, peer

support, shared responsibility, ongoing learning and the need for diversity in their work. In each study the frequency by which each strategy was used by participants or if differences existed in the effectiveness of methods was not known.

Hatcher and Noakes (2010) found that those working with sex offenders emphasised the use of professional coping strategies in managing the harmful effects of their work. Examples included revising their caseload, increasing their professional skill level and particularly favourable was the use of colleague support and supervision. The use of colleagues were valuable for sharing experiences, exploring different coping styles, normalising the work, debriefing and discussing ideas and, providing emotional support. Nevertheless 16% of their sample reported negative experiences of using collegial support and 4% of the sample stated it was unnecessary. The authors divided participants into four groups to represent the frequency of their supervision (once a week, once a fortnight, once a month or never). This was then explored in relation to compassion satisfaction, compassion fatigue and burnout. Findings showed no significant relationships between these variables. This may, however have been a reflection of the small number of participants in each of the groups.

Ennis and Horne (2003) used their own self designed survey to assess therapists' perception of their peer and family support. Findings showed that those therapists who felt supported by their colleagues shown significantly less PTSD symptoms. The authors conclude that this type of support may help "buffer" against the potential harmful effects.

The studies which have used open-ended surveys offer some insight into the importance of professional coping strategies. Some studies have provided

outcomes in terms of frequencies and percentages; however none of the studies above have used a well developed measure to assess professional coping strategies, hence no clinically significant effects were established. Consequently when applying quality assessment tools to them this reduces their overall value.

CONCLUSIONS

In considering the overall outcomes of the studies reviewed, it is clear that those working with sex offenders are at risk of harmful effects, including vicarious trauma, secondary trauma/compassion fatigue, PTSD, stress and burnout. Nevertheless, determining the incidence of this is problematic and is restricted by the methodological limitations of the studies. The review found evidence of various positive effects of sex offender work, with clinicians reporting increased levels of understanding, awareness, confidence and compassion satisfaction.

Several studies emphasised the importance of moderating factors in increasing the potential harmful effects of sex offender work. These consisted of various individual variables such as level of experience and professionals status. Whilst qualitative studies revealed that the organisational component of an individuals environment was important, with many clinicians emphasising that an absence of team work, supervision and clear policies often increased their vulnerability.

The importance of protective factors in minimising the harmful effects of working with sex offenders was explored by several studies. Findings showed that these factors included individual and organisational elements. The importance of individual coping strategies was highlighted. Although these were often associated with managing harmful effects, the success of them in actually reducing these effects was rarely measured. The majority of studies reported positive coping strategies; this poses the question of whether individuals do not engage in negative forms of coping or if they were reporting in a socially desirable way when asked about their coping strategies. Organisational factors such as the use of colleague support and supervision were emphasised, a small number of quantitative studies suggested a significant association of these in the reduction of harmful effects. All findings should, however

be considered with caution, as when the evidential quality of the studies were assessed overall these appeared fairly poor.

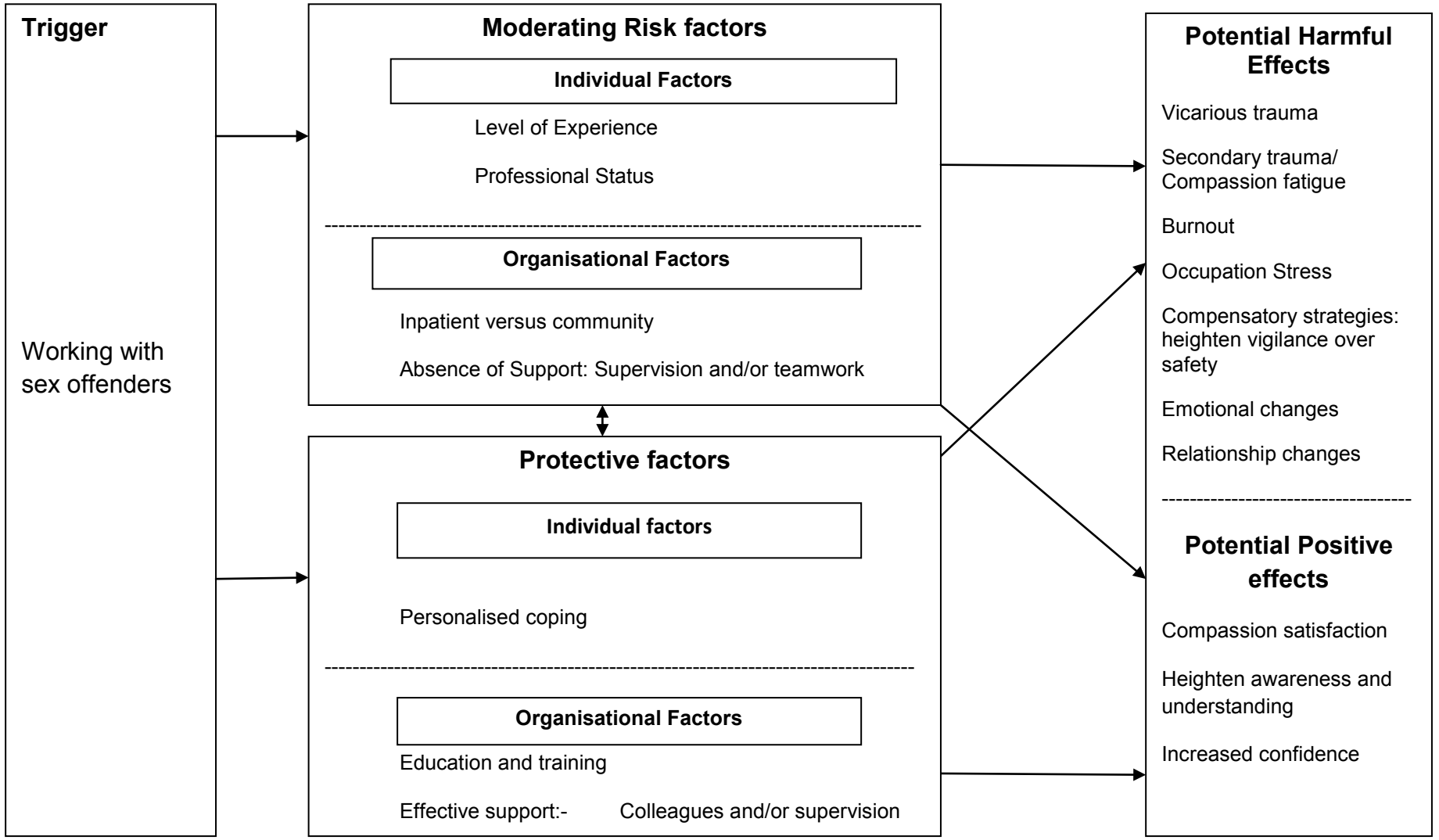
In reflecting on Clarke and Roger's (2002) previous review, they developed their findings into the IMPPI for use in clinical practice. This model can be used as a basis to build and consolidate the main findings from this review into a framework described as a Model of Awareness (see figure 1). Clarke and Roger's (2002) model describes static, stable and dynamic therapist factors including age, gender, occupation, coping style and peer support. In the Model of Awareness these relate to the moderating and protective factors, which incorporate both individual therapist factors but also wider organisational factors. Clarke and Roger's (2002) model showed how therapist factors could be changed through the process of working with sex offenders, resulting in either positive or negative psychological outcomes. In the Model of Awareness the potential negative and positive effects of sex offender work are illustrated, whilst the arrows acknowledge that even if a therapist makes use of protective factors this may not ultimately assure they will experience positive effects. As such, those therapists who show risk factors for experiencing harmful effects of sex offender work may not develop negative effects. This highlights the notion of resilience, which relates to how individuals adapt and adjust to traumatic events, with not all individuals experiencing adverse effects as a result of those events (White, Davis & Warren, 2008). Not all those who work with sex offenders experience harmful effects, it is possible that these individuals may be more resilient to the potential effects of this work. Hatcher and Noakes (2010) acknowledge the concept of resiliency, however none of the studies reviewed explored this, hence suggesting an interesting avenue for future research.

The Model of Awareness could be used as a means to guide the assessment of potential risks involved with sex offender work, whilst providing awareness relating to possible preventative procedures which could be implemented to manage potential difficulties. However, responsibility for these factors needs to be clarified: does this lie with individual clinicians, their employing organisation or a collaboration of both? It is also questionable as to when an individual should be made aware of these factors? Should this be within the remits of their academic training or as their clinical experience develops?

To date the outcomes of the literature and the model are restricted by methodological limitations of the research. Although, some clinical applications can be implied from the model, in order to make more definite conclusions of the psychological impact on those who work with sex offenders and to develop models for clinical use further research is required.

Future studies should focus on providing clear definitions relating to the concepts of the harmful effects which they intend to measure. They should choose appropriate ways of measuring these harmful effects and provide justification for this. The inclusion of comparison groups would enable greater awareness into the incidence of harmful effects in relation to therapists working with other challenging client groups. Finally, longitudinal studies would allow insight into the long term effects to those working with sex offenders.

Figure 1: Model of Awareness



REFERENCES

Brown, J & Blount, C. (1999). Occupational Stress among sex offender treatment managers. *Journal of Managerial Psychology, 14, 108-120.*

Carmel, S. J.M. & Friedlander, M.L. (2009). Brief Reports: The relation of secondary traumatisation to therapist's perceptions of the working alliance with clients who commit sexual abuse. *Journal of Counselling Psychology, 56, 461-467.*

Clarke, J. & Roger, D. (2002). Working Therapeutically with sex offenders: The potential impact on the psychological well-being of treatment providers. *Issues in Forensic Psychology, 3, 82-96.*

Collins, S. & Long, A. (2003). Working with the psychological effects of trauma: consequences for mental health-care workers- a literature review. *Journal of Psychiatric and Mental Health Nursing,10, 417-424.*

Conrad, D. & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect, 20, 1071-1080.*

Denscombe, M. (1998). *The Good Research Guide for Small Social Research Projects.* USA. Open University Press.

Downs, S.H. & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiol Community Health, 52, 377-384.*

Ennis, L & Horne, S. (2003). Predicting Psychological Distress in Sex Offenders Therapist. *Sexual Abuse: A Journal of Research and Treatment, 15, 149-157.*

Farrenkopf, T. (1992). What happens to facilitators who work with sex offenders. *Journal of Offender rehabilitation, 16, 217-223.*

Figley, C.R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In *Coping with secondary traumatic stress in those who treat the traumatised (pp1-20).* New York. Brunner/Mazel Publishers.

Figley, C. R. (2002). *Treating Compassion Fatigue.* New York. Brunner-Routledge.

Goldberg, D. P. & Williams, P. (1988). *A User's guide to the General Health Questionnaire.* NFER-Nelson. Windsor.

Hatcher, R. & Noakes, S. (2010). Working with sex offenders: the impact on Australian treatment providers. *Psychology, Crime and Law, 16, 145-167.*

Henry, O. & Evans, A. J. (2008). Occupational Stress in Organisations. Journal of *Management Research, 8, 123-135.*

Horowitz, M., Wilner, N. & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine, 41, 209-218.*

Jenkins, A. R. & Baird, S. (2002). Secondary Traumatic Stress and Vicarious G. Trauma: A Validation Study. *Journal of Traumatic Stress, 15, 423-432.*

Jackson, C. (2007). The General Health Questionnaire. *Occupational Medicine, 1, 57.*

Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22,116-122.*

Kadambi, M.A. & Truscott, D. (2003). Vicarious Truamatisation and Burnout amongst Therapists Working with Sex Offenders. *Traumatology, 9, 216-229.*

King, L., A., King, D. W., Leskin, G. & Foy, D. W. (1995). The Los Angeles Symptom Checklist: A self-report measure of posttraumatic stress disorder. *Assessment, 2, 1-7.*

Maslach, C. (1982). *Burnout: the cost of caring.* Englewood Cliffs. NJ: Prentice Hall.

Maslach, C., Jackson, S.E. & Leiter. (1996). *Maslach Burnout Inventory Manual (Third Edition).* Consulting Psychologists Press. USA.

McCann, I, L. & Pearlman, L. A. (1990). Vicarious Traumatisation: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3, 131-149.*

Moulden, H.M. & Firestone, P. (2007). Vicarious Traumatization: The Impact on Therapists who work with Sexual Offenders. *Trauma, Violence and Abuse, 8, 67-83.*

Newell, J & MacNell, G. A. (2010). Professional Burnou, Vicarious Trauma, Secondary Traumatic Stress and Compassion Fatigue: A review of theoretical terms, risk factors and preventative methods for clinicians and researchers. *Best Practices In Mental Health, 6, 57-68.*

Pearlman, L. A. (1996). Psychometric review of TSI Belief Scale, Revision-L. In B.H. Stamm (Ed). *Measurement of stress, trauma and adaptation.* Luterville, MD: Sidran Press.

Pines, A. M. & Keinan. (2005). Stress and burnout: The significant difference. *Personality and Individual Differences, 39, 625-635*.

Robson, C. (2002). *Real World Research. Second Edition.* Oxford. Blackwell Publishing.

Sabin-Farrell, R. & Turpin, G. (2003). Vicarious traumatization: implications for the mental health of health workers? *Clinical Psychology Review, 449-480.*

Sale, J. E.M. & Brazil, K. (2004). A strategy to identify critical appraisal criteria for primary mixed-method studies. *Quality & Quantity, 38, 351-365.*

Scheela, R.A. (1999). A Nurse's Experiences: Working with Sex Offenders. *Journal of Psychosocial Nursing, 3, 25-31.*

Scheela, R. A. (2011). Sex Offender Treatment: Therapists' Experiences and Perception. *Issues in Mental Health Nursing, 22, 749-767.*

Sexton, L. (1999). Vicarious traumatisation of counsellors and effects on their workplaces. *British Journal of Guidance and Counselling, 3, 393-403.*

Shelby, R.A., Stoddart, R.M. & Taylor, L. K. (2001). Factors Contributing to Levels of Burnout Among Sex offender Treatment Providers. *Journal of Interpersonal Violence, 16, 1205-1217.*

Stamm, B.H. (1997). Work-related secondary traumatic stress. *PTSD Research Quarterly. 8, 2.*

Stamm, B. H. (1998). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion satisfaction and fatigue test. *In C. R.*

Figley (Ed). Treating Compassion fatigue (pp 107-119). New York: Brunner-Routledge.

Stamm, B. H. (2005). *The ProQOL manual: The professional quality of life scale: Compassion stat faction, burnout and compassion fatigue/secondary trauma scales.* Retrieved December 12, 2010 from http://www.isu.ed/~bhstamm/documents/proqol/ProQOL_Manaula_oct05.pdf.

Steed, L. & Bicknell, J. (2001). Trauma and the Therapists working with the perpetrators of sexual abuse. *The Australasian Journal of Disaster and Trauma Studies, 1-10.*

Thorpe, G., Righthand, S. & Kubike, K. E. (2001). Brief Report: Dimension of Burnout in Professionals Working with Sex Offenders. *Sexual Abuse: A Journal of Research and Treatment, 13, 197-203.*

Way, I., Vandeusen, K.M., Martin, G., Applegate, B. & Jandle, D. (2004). A Comparison of Clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence, 19, 49-71.*

Weiss, D. S. & Marmar, C. R. (1995). The Impact of Events Scale-Revised. In J.P.Wilson & T. M. Keane. *Assessing psychological trauma and PTSD: A Practitioner's Handbook.* New York. Guildford.

White, B., Driver,S. & Warren, A. (2008). Considering Resilience in the Rehabilitation of People with Traumatic Disabilities. *Rehabilitation Psychology, 53, 9-17.*

EMPIRICAL PAPER

EXPLORING STAFF ATTITUDES TO WORKING WITH SEX OFFENDERS WHO HAVE A LEARNING DISABILITY: WHAT FACTORS MATTER?

Amanda L Walker

University of Birmingham

ABSTRACT

Background: Research has suggested that staff attitudes to clients who are sex offenders and have a learning disability are often negative. This holds implications for care and service provision. Professional status, experience, emotions and burnout are considered important in the development of these. This study explored these factors in relation to staff working with individuals who had a learning disability but were also sex offenders. The study aimed to modify the Attitudes Towards Sex Offenders Scale (Hogue, 1993) for use with this staff group.

Method: A cross-sectional survey was used, with information relating to demographic variables, attitudes, emotions and burnout, collected via self-report questionnaires. A total of 71 questionnaires were returned.

Results: The modified ATS maintained its psychometric properties and could be used with this staff group. Overall staff reported positive attitudes, but held greater negative emotional reactions. Burnout was significantly associated with greater negative attitudes and emotions. Regression analysis revealed the variables of qualification, depersonalisation and personal accomplishment to be important in predicting staff attitudes.

Conclusions: This study illustrated the role of demographic variables, emotions and burnout in relation to staff attitudes to sex offenders with a learning disability. Methodological limitations, clinical recommendations and future studies are emphasised.

Key words: sex offender, learning disability, staff attitudes, emotions, burnout

INTRODUCTION

The concept of attitudes

There is no universal accepted definition of what constitutes an attitude, it is generally accepted that the term is used when responding to someone or something in a specific way (Manstead, 1996). A well established definition is that provided by Ajzen and Fishbein (1980), who consider an attitude as;

> *"an accumulation of information about an object, person, situation or experience… a predisposition to act in a positive or negative way"*

Research has emphasised the importance of attitudes (Baron & Byrne, 2003), accentuating their potential to influence an individuals judgements and behaviour regarding specific subjects (Hogue & Pebbles, 1997). In relation to the criminal system, negative attitudes to sex offenders often exist with these individuals being excluded and considered a sub group by other prisoners and staff (Hogue, 1993). This draws some connections with social categorisation theory (Turner, 1987), which considers negative attitudes to be created when the behaviour of others do not match the appropriate social norms of a well established group. It is possible, therefore that sex offenders are seen as the "out-group" in comparison to other prisoners, staff and the public whom are considered as the "in-group". Negative attitudes may be developed as sex offenders actions and behaviours do not follow the social norms of the more dominant "in-group".

Attitudes of staff towards their clients influences their working practices (Craig, 2005; Lea, Auburn & Kibblewhite, 1999). Research exploring attitudes to sex offenders is limited (Hogue,1995) with people generally viewing these individuals as dangerous

and evil (Brown, 1999; Payne, Tewsksbury & Mustaine, 2010; Weekes, Pelleter & Beaudette,1995) whilst experiencing extreme negative emotional reactions to them including, disgust, fear and moral outrage (Olver & Barlow, 2010).

Staff attitudes to sex offenders

The attitudes of staff who work with sex offenders are often predominately negative (Craig, 2005; Hogue, 1995; Lea, Auburn & Kibblewhite, 1999; Weekes, Pelleter & Beaudette, 1995). Negative attitudes have been associated with feelings of anger, frustration, hatred (Lea, Auburn & Kibblewhite, 1999), disgust, dislike, fear and disappointment (McKenize et al., 2001). Positive attitudes towards sex offenders are less frequent, but often encompass staff holding empathy and understanding towards the individual (Lea, Auburn & Kibblewhite, 1999; McKenize et al., 2001). Staff attitudes to sex offenders vary and appear to be influenced by a selection of factors (Lea, Auburn & Kibblewhite, 1999).

Females are often thought to express more negative attitudes than males (Craig, 2005; Radley, 2001) however; some studies have found females to be positive and empathic in their views to sex offenders (Higgins & Ireland, 2009; Johnson, Hughes & Ireland, 2007). The role of age is thought to hold some association with attitude formation. Through delivering a training program, Craig (2005) found those participants aged 35 and above held more positive attitudes pre training, these became more negative post training. In comparison participants under the age of 35 held more negative attitudes pre training and these became more positive following the training. Kjelsbery and Loos (2008) found that older prison officers held more

positive attitudes to sex offenders; however they do not state what age bracket they used to define age differences.

Professionals who have more experience working with sex offenders often report more positive attitudes than those with the least experience (Nelson, Herlihy & Oscher, 2002; Sanghara & Wilson, 2006) furthermore those with the least experience tend to hold more stereotyped views (Lea, Auburn & Kibblewhite, 1999). Level of experience has been defined differently amongst the studies.

Attitudes to sex offenders appear to vary amongst different professional groups. Kjelsbery and Loos (2008) discovered that prison officers held more negative attitudes than other prison employees such as teachers. Hogue and Pebbles' (1997) found that police officers had more negative attitudes than other professional groups including social workers and probation officers, however their sample size was small hence their findings are limited. Higgins and Ireland (2009) explored the attitudes of forensic staff (psychologists and probation officers), prison officers and members of the public. Their findings illustrated that forensic staff held more positive attitudes compared to prison officers who had more negative attitudes. Hogue (1993) found a significant difference in attitudes towards sex offenders with psychologists, probation officers and prison officers who were directly involved in sex offender treatment programs holding more positive attitudes than those prison officers who were not involved. Johnson, Hughes and Ireland (2007) found that police officers held significantly more positive attitudes towards sex offenders than the general public. The studies attribute their findings to the differences in job role and the amount of direct contact professionals have with sex offenders.

The impact of training on shaping attitudes has produced several different results. Craig (2005) implemented a brief introductory training to professionals and paraprofessionals working with sex offenders. The staff in his study reported more favourable attitudes to prisoners than sex offenders with no significant attitude changes after training, however participants felt more confident in their work after training. Hogue (1995) delivered a 3 week training programme designed to provide psychologists, prison and probation officers with knowledge, skills and experience to facilitate structured sex offender treatment groups. Measuring their attitudes pre and post training he concluded these became significantly more positive, with participants holding greater beliefs in their own skills, these changes were maintained at six month follow-up. In contrast, Kjelsbergy and Loos (2008) found no significant change in prison employees attitudes following a two day compulsory educational based training program. Final measures were, however not taken until a year after the training. Furthermore Johnson, Hughes and Ireland (2007) found that police demonstrated more negative attitudes to sex offenders following attendance at a educational training course. The content of the training and the lack of direct police experience may have accounted for these findings.

Staff attitudes to sex offenders with a learning disability

Little is known about the attitudes of staff working with sex offenders who have a learning disability (Clare & Murphy, 1998; Day, 1997; McKenzie et al., 2001; Yool et al., 2003). Staff working with these individuals often minimise the offending behaviour (Brown, Stein & Turk, 1995) and are reluctant to involve the police (Lyall, Holland & Collins, 1995; Rees, 2001). Various reasons for this have been proposed, including staff viewing these individuals as lacking appropriate relationship skills and

having poor impulse control, whilst considering them as sexually naïve and vulnerable individuals (Day, 1993), who do not understand abstract concepts such as laws, societal norms and values (Price-Jones & Barrowcliff, 2010). Nevertheless, despite a learning disability being present negative attitudes to these individuals predominately remain (Lyall et al., 2001; McBrein & Candy, 1998; McKenzie et al., 2001; Taylor, Keddie & Lee, 2003; Yool et al., 2003).

Factors including gender, professional status, experience and the provision of training are important in determining the attitudes of staff working with this client group. Despite a small sample size, Yool et al., (2003) conducted semi-structured interviews with staff; she found that females held more negative attitudes than males, attributing this to concerns associated with their own safety. McKenzie et al., (2001) conducted a questionnaire based study that explored the attitudes of social care and health care staff working with sex offenders who had a learning disability. Differences in attitudes based on an individual's profession emerged. Social care staff held significantly more negative attitudes towards a client's behaviour. Health care staff also demonstrated negative attitudes however, these were directed towards the actual person rather than the person's behaviour. These findings were reached through the authors own self-designed open ended questionnaire, of the 63 questionnaires, 20 were analysed by two raters. The authors fail to indicate the raters skill level or how accurate their levels of inter-rater reliability were, thus limiting their findings. Taylor, Keddie and Lee (2003) explored staff attitudes to sex offenders with a learning disability during a two and a half day training workshop. Findings showed that staff held more positive attitudes after completing the training. In particular those

staff with less experience showed more positive attitudes post training than those staff with more experience. Using the outcomes of a self-report workshop evaluation the authors speculate that the knowledge and understanding of less experienced staff were improved whilst the skill level of those experienced staff were reinforced; which may have accounted for this difference.

Exploring staff attitudes towards sex offenders (with or without a learning disability) has been investigated through both qualitative and quantitative methodologies. Quantitative studies have used a selection of different self-report measures which have varied in their psychometric properties (Brown, Deakin & Spencer, 2008; Brown, 1999; Craig, 2005; Hogue, 1995; McKenzie et al., 2001; Nelson, Herlihy & Oescher, 2002; Olver & Barlow, 2010; Sanghara & Wilson, 2006; Taylor, Keddie & Lee; 2003; Weekes, Pelleter & Beaudette,1995). The Attitudes Towards Sex Offenders Scale (ATS) developed by Hogue, (1993) appears to be the most frequently and successfully used measure in this area (Craig, 2005; Nelson, Herlihy & Oescher, 2002; Sanghara & Wilson, 2006). Staff attitudes to working with sex offenders (with or without a learning disability) overall appear to be negative, thus holding implications for the quality of care which they may provide to this group. Research focusing on staff attitudes to those offenders who have a learning disability is limited, with a review of the literature revealing only four studies (Lyall et al., 2001; Taylor, Keddie and Lee, 2003; McKenzie et al., 2001; Yool et al., 2003). Further research into the nature of these attitudes and the potential influence of a selection factors in their formation could assist in the creation of future therapeutic interventions, including staff training, psycho education or supportive programs.

Role of Emotions

Associated closely with the concept of attitudes is emotions; rational emotive behaviour therapy (REBT) pioneered by Ellis (1962), proposes that a person's thoughts, feelings and actions often intertwine (Dryden, 1998). Therefore when an individual thinks about working with a sex offender who has a learning disability they will experience an emotional reaction (either positive or negative), consequently a person's attitudes should be consistent with their emotions.

Gill, Kroese and Rose (2002) used this theory to explore general practitioners (GPs) attitudes and emotions when working with patients who had a learning disability. Outcomes implied a robust association between GPs attitudes towards learning disabled clients and their emotional response. Building on this research, Lewis and Kroese (2009) investigated the attitudes and emotional reactions of nursing staff towards caring for patients with a learning disability in a hospital environment. Findings revealed a strong relationship between nurse attitudes and emotional response, with those nurses who held significantly less positive attitudes, experiencing greater negative emotions. Rose (2009) explored the emotional responses of staff working with clients who had an intellectual disability and a mental illness. She found that staff emotional responses to this client group were positive.

It is plausible that staff attitudes to working with sex offenders who have a learning disability will be related to their emotional responses. If staff do not possess positive attitudes and feelings about their work this is likely to impact upon the quality of care they deliver. Day (1997) proposes that responses to this client group vary from

sympathy and understanding to more extreme emotions including fear and rejection. Literature exploring the emotional impact on practitioners working with this client group is limited (Clare & Murphy, 1998), therefore, given this and the possible implications for patient care and service provision further research into this area is warranted.

Role of Detrimental effects

Good quality working lives for staff is paramount in ensuring that high quality care is delivered to their patients (Department of Health, 2009). Individuals working in caring professionals are considered at high risk of work stress (Figley, 1995). Stress is commonly thought to be the result of a transactional process between factors within the environment and the individual (Thomas & Rose, 2009). Continual experiences of ongoing stressors can result in the development of burnout (Pines & Keinan, 2005), a concept first introduced by Freudenberger in 1974. A more well known and widely accepted definition is that provided by Maslach (1982). She claimed that burnout encompassed three different domains. Emotional exhaustion (EE) which is a sense of being emotional overextended and exhausted by ones work, depersonalisation (DP) which consists of an individuals' impersonal response towards recipients in their care or treatment and personal accomplishment (PA) which relates to ones feelings of competence and successful achievements in ones work with people. Maslach (1982) proposed that emotional exhaustion can lead to the depersonalisation of clients, thus reducing ones sense of personal accomplishment.

The detrimental effects of stress and burnout have been linked to staff working with clients who are sex offenders (Carmel & Friedlander, 2009; Kadambi & Truscott, 2003; Lea, Auburn & Kibblewhite, 1999; Shelby, Stoddart & Taylor, 2001; Steed & Bicknell, 2001; Thorpe, Righthand & Kubik, 2001) or have a learning disability (Skirrow & Hatton, 2007). A number of factors are thought to impact upon staff stress and burnout (Hatton, 1999). Findings from the sex offender literature suggest that staff who lack support from colleagues (Brown & Blount, 1999), organisations (Farrenkopft, 1992), and have a greater amount of direct contact with sex offenders (Thorpe, Righthand & Kubik, 2001) are more vulnerable to experiencing burnout. Outcomes from the learning disability literature imply that staff who are unqualified (Alexander & Hegarty, 2000) have greater experience (Chung, Corbett & Cumella, 1996), employ a maladaptive coping style (Rose, David & Jones, 2003), feel unsupportive by colleagues, (Howard, Rose & Levenson, 2009) and devalued by their work organisation (Blumenthal, Lavender & Hewson, 1998; Van Yperen, 1995) report high rates of burnout. Thomas and Rose (2009) also reported that staff levels of EE and DP were associated with increased negative emotions. Overall it is apparent that staff stress and burnout can be influenced by various demographic, individual and organisational factors.

Staff are considered as an essential factor in enabling national policies to be translated into practical action. High workplace stress can led to situations becoming overwhelming for staff, subsequently this can hold implications for the quality of their work performance (Hatton et al., 2004; Hatton, 1999) and the provision of care which they provide (Duquette, Sandhu and Beaudet, 1994). Research, investigating stress

and burnout in staff working with sex offenders who have a learning disability is extremely sparse. The complexity of this client group holds challenges for the staff working with them. It is likely that staff may question their own attitudes and feelings about working with this client group whilst high work demands may create feelings of burnout which can influence staff work performance. Exploring the presence of burnout in association with staff attitudes and emotions could potentially aid the development of future preventative and reactive interventions. In order to redress this lack of research, the study has a number of aims and hypotheses.

Aims

This research involved developing a modified version of the ATS that was psychometrically robust. The study also aimed to use the modified questionnaire to explore the specific relationships between staff attitudes, emotions and burnout in relation to working with clients who had a learning disability, some of whom had committed a sexual offence. The research further aimed to examine the relative contribution of these factors to the attitudes reported by staff towards sex offenders who have a learning disability.

Hypotheses

1) Females, qualified and more experienced staff will report more positive attitudes and emotions but less burnout.
2) Staff will report more negative emotional responses to clients who are sex offenders.

3) Staff with more positive attitudes will express more positive emotional responses to people with learning disabilities and people with learning disability who sexually offend.
4) Higher staff burnout will be associated with more negative attitudes and emotional responses.
5) Staff who are currently working with clients who have a learning disability and are sex offenders will have more positive attitudes and emotions and report higher levels of burnout.

METHOD

Design and Procedure

A cross-sectional questionnaire based survey design was employed, this enabled a large amount of standardised data to be collected from staff in the U.K. National Health Service (NHS). Once ethical approval had been granted (see Appendix B), service co-ordinators, professional leads and unit managers from a hospital and a community service providing treatment and services to adults with a learning disability who may have committed a sexual or violent offence were approached and the purpose of the study was explained. They were offered the opportunity for the main researcher to visit each unit to explain the study to staff, all opted to relay the study's background information and questionnaires directly to unit staff.

Staff were provided with a questionnaire pack, this contained an information sheet (See Appendix C), consent form (See Appendix D) and four questionnaires (See Appendix E). Staff were asked to return completed questionnaires in an provided envelope to the psychology department of the hospital via internal mail. Staff were asked to indicate on the consent form if they wished to complete an extra questionnaire at a later date: this would allow the test- retest reliability of the modified ATS to be established. Those who agreed were provided with a second questionnaire approximately 2-3 weeks later, this contained the same identification number as their original questionnaires, thus allowing comparisons of responses to be established. Once transferred to the computerised database each questionnaire was given a new identification number to increase confidentiality.

Measures

Demographic Information

Participants were asked to indicate their sex, age, designation, whether they held a professional qualification, employment status, direct weekly client contact and specify their length of time in employment. Staff were asked about their experiences of working with clients with learning disabilities who may have committed a sexual or violent offence.

Attitudes to Sex Offenders with a Learning Disability

Staff attitudes to sex offenders with a learning disability were determined through using a modified version of the ATS (Hogue, 1993). This scale was originally adapted from the Attitudes to Prisoners Scale (Melvin, Gramling & Gardner, 1985) in which all references to "prisoners" were replaced with "sex offenders". The scale consists of 36 items, in which participants rate their degree of agreement to attitudinal statements through a 5-point Likert scale with responses of 1 (strongly disagree) through to 5 (strongly agree). Of the 36 items, 19 are worded negatively and 17 positively, on scoring those negative items are reversed and a constant of 36 is subtracted from the total sum. Scores can range from 0-144, with higher scores indicating more positive attitudes. The scale has been frequently used and has demonstrated sound psychometric properties with Cronbach alphas' of .96 (Higgins & Ireland, 2009), .94 (Kjelsberg & Loos, 2008), .86 (Craig, 2005), test retest of r = .82 (Nelson, Herlihy & Oescher, 2002) and discriminate validity (Hogue, 1993). As no specific measure exists for assessing the attitudes of those staff working with sex offenders who have a learning disability, this scale was modified by asking

participants to consider each item in relation to this client group. It could be argued, that this modification is minor, however, by changing a construct of the scale this can potentially change the meaning which participants attach to each item.

Emotional Scale

This scale assessed the experience of 12 emotions (sad, hopeless, confident, nervous, relaxed, sympathetic, frustrated, optimistic, disgusted, awkward, incompetent and frightened) thought to be relevant to the experience of working with clients who have a learning disability and clients who are sex offenders. Participants indicated the frequency which they experienced these emotions by placing a mark on a 5 cm visual analogue scale ranging from “always” to “never”. The scale consists of 4 items relating to positive emotions and 8 items corresponding to negative emotions. Responses for each item range from 0.25-5, with total scores for the positive items spanning from 1-20 and total scores for the negative items ranging from 2-40. High scores indicated a high presence of the emotion, whilst low scores demonstrated a low presence of the emotion.

The scale was developed from empirical studies which explored staff emotional responses to working with clients who have a learning disability (Dagnan, Trower & Smith, 1998; Mitchell & Hastings, 1998) these studies have shown the scale to have acceptable psychometric properties with a Cronbach alpha of .80 and test-retest of pearsons r = .70. In this study participants were asked to consider their emotional reactions encompassing both negative and positive emotions to working with two separate client groups; those individuals who have a learning disability and

individuals who had a learning disability but were also sex offenders, thus allowing comparison between the groups to occur.

Maslach Burnout Inventory

Staff levels of burnout was assessed by this 22 item measure which has been widely used in various countries and consists of three subscales measuring emotional exhaustion (EE), depersonalistaion (DP) and personal accomplishment (PA) (Maslach, Jackson & Leiter, 1996). Participants respond to each item through a 6-point Likert response mode ranging from 0 (never) to 6 (every day). Subscale scores are computed through summing the responses of each relative item, high scores of EE and DP and low scores of PA indicate levels of high burnout. The measure holds robust psychometric properties with internal reliability figures of .90 (EE), .79 (DP) and .71 (PA) (Maslach & Jackson, 1986). The measure has been successfully used to assess levels of burnout in staff working with sex offenders (Shelby, Stoddart & Taylor, 2001) and staff working with individuals with learning disabilities (Skirrow & Hatton, 2007).

Participants

Service co-ordinators, professional leads and unit managers involved in four secure forensic units and one admissions unit (non-forensic) were approached and 153 questionnaires were provided for their staff. A further 15 questionnaires were sent to members of the multidisciplinary team covering these units, whilst a final 10 questionnaires were sent to staff working in a community learning disability service. All staff were in direct contact with clients who had a learning disability, some of whom may have committed a sexual or violent offence.

Seventy one questionnaires were returned (40%), 49 of these staff said they would complete a second ATS of these, 26 were returned (53%). The majority of the main sample consisted of females (70%) with ages ranging from 22 years to 62 years with a mean age of 38 years. The sample consisted of 19 support staff, 24 qualified nurses, 12 psychologists, 4 psychiatrics, 2 occupational therapists and 9 classified as "other" which encompassed speech and language therapists and day care co-ordinators. Full time employment was held by 80.3% of the sample, direct weekly client contact ranged from 10 hours (11.3%) to 40 or more (36.6%), the length of employment varied from 5 to 432 months with a mean of 124 months. Participants frequently worked across different units within the hospital and often had experience of working with clients with a learning disability some of whom had committed both a sexual and violent offence. The sample of 26 participants who completed a second modified ATS consisted mainly of qualified staff (92%), who were predominantly female (69%), with ages ranging from 24 to 62 years with the mean age being 35 years. Full time employment status was held by 92 % of the sample and their length of employment varied from 5 to 432 months with a mean of 108 months.

RESULTS

Data analysis was undertaken in several parts to coincide with the study's hypotheses. All data was analysed using SPSS (version 17) statistical package.

Assessing Normality

The distribution of scores for the main variables were explored using One-sample Kolmogorovo-Smirnov tests. The test results suggested that all variables were normally distributed with the exception of the MBI subscale of depersonalisation. In line with Tabachnick and Fidell's (1996) recommendations this data was transformed via a square root methodology, which resulted in the variable becoming normally distributed. Parametric tests were then used on all of the variables.

Preliminary Analysis

The mean and standard deviations for the attitudes, emotions and burnout measures, and comparison data from previous studies are presented in Table 1. The modified ATS measure achieved similar means at both time points to those recorded in previous studies by Hogue (1993, 1995) who considered a score of this magnitude to represent positive attitudes. The means for the emotional scale was considered in relation to negative and positive emotions for the two client groups. Higher means were found for the negative emotions scale relating to clients who had a learning disability and had committed a sexual offence; whilst higher means for the positive emotions scale was found for those clients who had a learning disability but had not offended. The mean of the positive emotion scale was similar to that found in Rose's (2009) study. Although Lewis and Kroese (2009) used a similar emotion scale in their study, this was slightly modified, therefore direct comparison of means was not

appropriate. With regards to burnout, the means from the three sub scales of the MBI suggested similar levels of emotional exhaustion, low levels of depersonalisation and high levels of personal accomplishment when compared to other studies.

Table 1: Descriptive statistics for measures and comparison studies

Measure	Mean	Standard Deviation	Study	Comparison Samples	Mean
ATSM time 1	80.3	19.8	Hogue, 1993	Psychologists	90.7
				Police Officers	80.0
ATSM time 2	90.2	16.8	Hogue, 1995	Prison staff pre training	81.98
				Prison staff post training	86.12
			Hogue Pebbles, 1995	Police officers	72.54
				Social workers	81.15
			Johnson, Hughes Ireland, 2007	Police officers pre training	100.3
				Police officers post training	89.5
NegLD	12.47	5.85	Gill, Kroese Rose, 2002	GP's negative emotion scale to clients with a learning disability	17.02
			Rose, 2009	Staff negative emotion scale to clients with a learning disability and mental illness	10.81
NegLDSO	14.39	6.17			
Post LD	14.50	3.73	Rose, 2009	Staff positive emotion scale to clients with a learning disability and mental illness	14.53
Post LDSO	12.14	3.60			
EE	23.66	10.54	Shelby, Stoddart Taylor, 2001	Sex offender workers	19.62
			Maslach, Jackson Leiter, 1996	Mental health workers	16.89
			Howard, Rose Levenson, 2009	Learning disability care staff	21.77
DP	6.24	6.03	Shelby, Stoddart Taylor, 2001	Sex offender workers	8.21

Table 1: continued

			Maslach, Jackson Leiter, 1996	Mental health workers	5.72
			Howard, Rose Levenson, 2009	Learning disability care staff	5.66
PA	32.45	9.09	Shelby, Stoddart Taylor, 2001	Sex offender workers	38.92
			Maslach, Jackson Leiter, 1996	Mental health workers	30.87
			Howard, Rose Levenson, 2009	Learning disability care staff	28.16

Key

Abbreviation	Scale
ATSM	Modified Attitudes Towards Sex Offenders Scale
NegLD	Negative emotion scale relating to clients with a learning disability
NegLDSO	Negative emotion scale relating to clients with a learning disability and who are sex offenders
Post LD	Positive emotion scale relating to clients with a learning disability
Post LDSO	Positive emotion scale relating to clients with a learning disability and who are sex offenders
EE	Emotional exhaustion
DP	Depersonalisation
PA	Personal accomplishment

Aim One: To develop a modified version of the ATS that will retain its psychometric properties.

The internal consistency of the modified ATS was examined and a Cronbach's alpha of .93 was found on both administrations, this is comparable to previous findings of .92 (Nelson, Herlihy & Oescher, 2002), .96 (Higgins & Ireland, 2009), .91 and .94 (Kjelsberg & Loos, 2008), .91 and .93 (Johnson, Hughes & Ireland, 2007). The test-retest reliability for the modified ATS was r =.85 (n=26, p,.< 0.01) which was analogous to Nelson, Herlihy and Oescher (2002) who reported r =.82. This suggests that the ATS maintained its psychometric properties and can be reliably used with this staff group, therefore hypothesis one is supported.

The internal consistency of the emotion scale was explored; this produced a Cronbach's alpha of .82 for negative emotions and .83 for positive emotions relating to working with those people who had a learning disability. A Cronbach's alpha of .77 for negative emotions and a slightly low .63 for positive emotions relating to working with those individuals who had a learning disability and were sex offenders was found. A study by (Rose, 2009) reported similar Cronbach's alpha of .78 for the negative emotion scale and .73 for the positive emotion scale in relation to working with clients who had an intellectual disability and a mental illness. Debate still remains over an adequate value for Cronbach's alpha, however figures of 0.7 and above are regularly considered acceptable (Field, 2000). It may have proved advantageous to have explored the test-retest for the emotions scale however, this would have placed extra demands on staff time and was not the prime objective of the study.

Using recommendations provided in McGraw and Wong (1996) paper, the intra class correlation of the ATS was assessed. A two-way random model with absolute agreement was selected. This produced a significant single measures intra class correlation of .858 with a 95% confidence of .709 (lower bound) to .934 (upper bound). However an F value of .218, $p<.644$, indicated that there was no significant difference between the ATS mean scores on the first or second administration.

Hypothesis One: Females, qualified and more experienced staff will report more positive attitudes and emotions but less burnout.

The measures were explored for differences relating to gender using an independent t-test (see table 2). This revealed no significant differences between men and women on the attitudes, emotions or burnout scales.

Table 2: An independent samples T –Test examining differences in gender between measures

Measure	Female mean scores	Male mean scores	t- value	Significance (Two-tailed)
ATSM	81.60 (n = 50) (SD = 15.5)	77.90 (n =21) (SD = 27.6)	.588	.562
Neg LD	12.45 (n =50) (SD = 4.7)	12.51 (n = 21) (SD = 7.9)	.-037	.970
Neg LDSO	15.10 (n = 50) (SD = 5.9)	12.69 (n =21) (SD =6.4)	1.15	.134
Post LD	14.41 (n= 50) (SD = 3.4)	14.72 (n = 21) (SD = 4.5)	.-318	.751
Post LDSO	12.0 (n = 50) (SD = 3.5)	12.35 (n = 21) (SD = 3.8)	.-319	.751
EE	23.54 (n = 50) (SD = 10.5)	23.95 (n = 21) (SD = 10.7)	.-149	.882
DP	2.14 (n = 50) (SD = 1.1)	2.38 (n = 21) (SD = 1.2)	.-779	.438
PA	32.42 (n =50) (SD = 9.0)	32.52 (n = 21) (SD = 9.35)	.-044	.965

Key

Abbreviation	Scale
ATSM	Modified Attitudes Towards Sex Offenders Scale
NegLD	Negative emotion scale relating to clients with a learning disability
NegLDSO	Negative emotion scale relating to clients with a learning disability and who are sex offenders
Post LD	Positive emotion scale relating to clients with a learning disability
Post LDSO	Positive emotion scale relating to clients with a learning disability and who are sex offenders
EE	Emotional exhaustion
DP	Depersonalisation
PA	Personal accomplishment

Using an independent t-test (see table 3) the measures were examined for differences between qualified and unqualified staff. For the purpose of analysis, qualified staff were classified as those individuals who held a professional

qualification (e.g. degree (BSc, MSc, RMN), doctorate (DClinPsy) relevant to their work, whilst unqualified staff were considered as those individuals who may hold some qualifications (e.g., NVQ) that although desirable were not essential for their employment. Outcomes revealed a significant difference (t(68)-5.38) , P =.001) with qualified staff (M = 87.50, SD = 15.54) holding more positive attitudes than unqualified staff (M= 63.73, SD = 18.61). Another significant difference (t (68) 3.25, P=.01) emerged with unqualified staff (M= 2.85, SD= 1.25) reporting higher levels of depersonalisation than qualified staff (M= 1.93, SD= .96). This provides some support for hypothesis one.

Table 3: An independent samples T –Test exploring differences in those qualified and unqualified staff

Measure	Qualified mean scores	Unqualified mean scores	t- value	Significance (Two-tailed)
ATSM	87.50 (n = 51) (SD =15.54)	63.73 (n =19) (SD= 18.61)	-5.38	.000
Neg LD	12.33 (n =51) (SD = 4.75)	13.22 (n = 19) (SD = 8.17)	.566	.574
Neg LDSO	15.23 (n = 51) (SD = 6.16)	12.27 (n =19) (SD = 5.96)	-1.79	.077
Post LD	14.73 (n= 51) (SD = 3.41)	13.61 (n = 19) (SD = 4.40)	-1.11	.267
Pos LDSO	12.30 (n = 51) (SD =3.29)	12.06 (n = 19) (SD = 4.26)	.-243	.808
EE	22.84 (n = 51) (SD = 9.49)	25.26 (n = 19) (SD= 13.0)	.854	.396
DP	1.93 (n = 51) (SD = .96)	2.85 (n = 19) (SD =1.25)	3.25	.002
PA	32.41 (n =51) (SD = 8.92)	32.68 (n = 19) (SD = 9.98)	.110	.091

Key

Abbreviation	Scale
ATSM	Modified Attitudes Towards Sex Offenders Scale
NegLD	Negative emotion scale relating to clients with a learning disability
NegLDSO	Negative emotion scale relating to clients with a learning disability and who are sex offenders
Post LD	Positive emotion scale relating to clients with a learning disability
Post LDSO	Positive emotion scale relating to clients with a learning disability and who are sex offenders
EE	Emotional exhaustion
DP	Depersonalisation
PA	Personal accomplishment

One third of staff had less than 78 months experience, another third had 130 months or more whilst the reminding third fell between these. In order to investigate the impact of length of experience on staff attitudes, emotions and burnout, the group were split into three groups of an equal size. An independent t-test was used to compare the third with the most experience and the bottom with the least experience (see table 4). This revealed no significant differences; therefore the hypothesis relating to this is not supported.

Table 4: An independent samples T –Test examining differences in level of experience

Measure	Less experience (78 months or less) mean scores	More experience (130 months or more) mean scores	t-value	Significance (Two-tailed)
ATSM	86.8 (n =24) (SD =21.9)	82.54 (n =24) (SD=16.4)	.773	.443
Neg LD	14.2 (n =24) (SD =6.96)	12.1 (n = 24) (SD =4.93)	1.26	.213
Neg LDSO	13.7 (n = 24) (SD =6.77)	15.7 (n =24) (SD =5.74)	-1.13	.264
Post LD	13.9 (n= 24) (SD =4.21)	15.3 (n = 24) (SD =3.14)	-1.27	.210
Post LDSO	12.8 (n = 24) (SD =4.12)	12.1 (n = 24) (SD =2.83)	.614	.542
EE	23.54 (n = 24) (SD =11.5)	25.25 (n = 24) (SD= 10.3)	-.548	.586
DP	1.85 (n = 24) (SD =1.29)	2.24 (n = 24) (SD =1.10)	-1.12	.268
PA	33.05 (n =24) (SD = 8.82)	33.3 (n = 24) (SD =9.01)	.-097	.923

Key

Abbreviation	Scale
ATSM	Modified Attitudes Towards Sex Offenders Scale
NegLD	Negative emotion scale relating to clients with a learning disability
NegLDSO	Negative emotion scale relating to clients with a learning disability and who are sex offenders
Post LD	Positive emotion scale relating to clients with a learning disability
Post LDSO	Positive emotion scale relating to clients with a learning disability and who are sex offenders
EE	Emotional exhaustion
DP	Depersonalisation
PA	Personal accomplishment

Hypothesis Two: Staff will report more negative emotional responses to clients who are sex offenders.

Paired sample t-tests were used to examine any differences in staff emotional responses to clients who had a learning disability in comparison to clients who had a learning disability and were also sex offenders. This revealed a significant difference in that staff experienced more positive emotional responses towards those clients who had a learning disability ($M = 14.5$, $SD = 3.75$) compared to those clients who had a learning disability and were sex offenders ($M = 12.1$, $SD = 3.60$), ($t(70) = 4.31$, $p<.05$). A significant difference in the negative emotions scale was also found $t(70) = -2.49$, $P<0.05$) with staff showing more negative emotional responses to clients who had a learning disability and were sex offenders ($M = 14.39$, $SD = 6.17$) compared to those clients who had a learning disability but were not sex offenders ($M = 12.47$, $SD = 5.88$). This provides practical support for hypothesise two.

Hypothesis Three: Staff with more positive attitudes will express more positive emotional responses to people with learning disabilities and people with learning disability who sexually offend.

Pearson correlations were used to explore the relationship of attitudes, emotions and burnout see table 5. Significant positive correlations were found between the ATSM and the positive emotion scale relating to clients with learning disabilities ($r = .24$, $P<0.05$) and the positive emotion scale relating to clients who had a learning disability and were also sex offenders ($r = .31$, $P<0.01$), thus providing partial support

for hypotheses four. This means that those staff who were more positive in their attitudes often showed more positive emotions. No significant relationships were found with the negative emotions scale for either client group.

Table 5: Correlation Analysis between attitudes, emotions and burnout

Measure	1	2	3	4	5	6	7
1) ATSM							
2) Post LD	.240*						
3) Neg LD	-.106	.-542**					
4) Post LDSO	.312**	.211	.-121				
5) Neg LDSO	.-002	.-140	.418**	.-568**			
6) EE	-.266*	.019	.107	.-281*	.235*		
7) DP	-578**	.-033	.106	.-386**	.106	.597**	
8) PA	.369**	.262*	.-176	.240*	.-090	.035	.-219

N=71

*Correlation is significant at the 0.05 level (two-tailed)

**Correlation is significant at the 0.01 (two-tailed)

Key

Abbreviation	Scale
ATSM	Modified Attitudes Towards Sex Offenders Scale
NegLD	Negative emotion scale relating to clients with a learning disability
NegLDSO	Negative emotion scale relating to clients with a learning disability and who are sex offenders
Post LD	Positive emotion scale relating to clients with a learning disability
Post LDSO	Positive emotion scale relating to clients with a learning disability and who are sex offenders
EE	Emotional exhaustion
DP	Depersonalisation
PA	Personal accomplishment

Hypothesis Four: Higher staff burnout will be associated with more negative attitudes and emotional responses.

Pearson correlations were used to explore the relationship of attitudes, emotions and burnout see table 5. A significant positive correlation was found between the ATSM

and the MBI personal accomplishment scale (r = .36, P< 0.01). Significant negative correlations were found between the ATSM and the MBI emotional exhaustion scale (r = -.26, P< 0.05) and depersonalisation scale (r = -.56, P<0.01). This means that those staff who were more positive in their attitudes to individuals with a learning disability who were sex offenders may experience less burnout.

The MBI personal accomplishment scale was significantly positively correlated with the positive emotion scale related to working with individuals who had a learning disability (r = .26, P<0.05). The MBI personal accomplishment scale also positively correlated with the positive emotion scale relating to those individuals who had a learning disability but were sex offenders (r = .24, P<0.05). This means that overall, staff felt a sense of achievement in their work, regardless of whether clients were sex offenders.

A significant positive correlation was found between the MBI emotional exhaustion scale and the negative emotion scale for those clients with a learning disability and who were sex offenders (r = .23, P<0.05). A significant negative correlation was found between the MBI emotional exhaustion scale and the positive emotion scale for clients who had a learning disability and were sex offenders (r = -.28, P<0.05). This means that staff could often feel exhausted by their work with this client group and this was often associated with more negative emotional responses.

A significant negative correlation between MBI depersonalisation scale and the positive emotions scale relating to people with a learning disability who were sex offenders (r = .38, P< 0.01) was found. This means that those staff who had more

impersonal responses to these individuals may also experience less positive emotional reactions to them.

Hypothesis Five: Staff who are currently working with clients who have a learning disability and are sex offenders will have more positive attitudes and emotions and report higher levels of burnout.

Staff in the study often had varying experience of working with individuals who had a learning disability and were sex offenders. At the time of data collection 55 staff were currently working with this client group. To see if they had more positive attitudes and emotions and higher levels of burnout than those staff who were not currently working with this client group an Independent t-test was used. See table 6.

A significant difference was found between staff (t (68) 2.09,P=.05) currently working with individuals who had a learning disability and were sex offenders having more negative attitudes (M= 77.9, SD = 19.3) than staff who were not currently working with this client group (M= 89.8, SD =19.6).

A significant difference was found with those staff who were not currently working with individuals who had a learning disability and were sexual offenders (t(68)3.02,P=.01) showing more negative emotional responses to this client group (M= 18.1, SD =5.08) than staff who currently work with this client group (M=13.1, SD = 5.8).

A significant difference arose with staff currently working with individuals who had a learning disability and were sex offenders (t(47)-2,24, P=.05) showing higher levels of

emotional exhaustion (M=24.5, SD =11.2) than those staff not working with this client group (M= 19.5, SD = 5.55).

A final significant difference was found with those staff currently working with individuals who had a learning disability and were sex offenders (t(68)-2.52, P=.05) having higher levels of depersonalisation (M= 2.38, SD = 1.17) than those staff not working with this client group (M= 1.56, SD = 11.0). This generates some support for the hypothesis.

Table 6: An independent samples t-test exploring differences in staff currently working with sex offenders who have a learning disability and staff not currently working with this client group

Measure	Currently working Mean scores	Not currently working mean score	t- value	Significance (Two-tailed)
ATSM	77.9 (n =55) (SD =19.3)	89.8 (n =15) (SD=19.6)	2.09	.040
Neg LDSO	13.1 (n =55) (SD =5.8)	18.1 (n = 55) (SD =5.08)	3.02	.003
Post LDSO	12.4 (n= 55) (SD =3.76)	11.4 (n = 55) (SD =2.58)	-1.00	.317
EE	24.5 (n = 55) (SD =11.2)	19.4 (n = 15) (SD= 5.55)	-2.42	.019
DP	2.38 (n = 55) (SD =1.17)	1.56 (n = 15) (SD =11.0)	.-2.52	.014
PA	32.04 (n =55) (SD = 8.55)	33.33 (n =15) (SD =11.0)	.488	.627

Key

Abbreviation	Scale
ATSM	Modified Attitudes Towards Sex Offenders Scale
NegLDSO	Negative emotion scale relating to clients with a learning disability and who are sex offenders
Post LDSO	Positive emotion scale relating to clients with a learning disability and who are sex offenders
EE	Emotional exhaustion
DP	Depersonalisation
PA	Personal accomplishment

Aim Two: To examine the relative contribution of specific factors to the attitudes reported by staff towards sex offenders who have a learning disability.

The preceding analysis showed several variables including qualifications, emotions, burnout and currently working were significantly associated with attitudes. To explore the relative contribution of these variables in predicting staff attitudes regarding clients who had a learning disability and were sex offenders an enter regression model was used (see table 7).

The multiple regression model was significant and produced an R 2 of .559, F (7,62) =11.23, P<.001, with the predictor variables of qualifications (unqualified was entered as 0 and qualified as 1), currently working (not currently working entered as 0 and currently working entered as 1), emotions and burnout explaining 55.9% of the variance in staff attitudes to those clients who have a learning disability and were sex offenders. Of these predictor variables, three reached a significant level with qualification making the largest contribution to explaining staff attitudes (beta =.423, p<.000) followed by depersonalisation (beta =.-.288, P< 0.05) and personal accomplishment (beta =.282, P<.005).

Table 7: Liner regression analyses of the associations between qualification, currently working, emotions and burnout to attitudes

R squared = .559

Predictor variable	Standardised B	T	Significance
Qualification	.423	4.42	.000
Currently working	-.040	-.432	.667
Neg LDSO	.038	.338	.737
Post LDSO	.138	1.21	.228
EE	-.020	-.179	.859
DP	-.288	-2.27	.026
PA	.282	3.11	.003

Key

Abbreviation	Scale
ATSM	Modified Attitudes Towards Sex Offenders Scale
NegLDSO	Negative emotion scale relating to clients with a learning disability and who are sex offenders
Post LDSO	Positive emotion scale relating to clients with a learning disability and who are sex offenders
EE	Emotional exhaustion
DP	Depersonalisation
PA	Personal accomplishment

DISCUSSION

The modified ATS was successfully adapted and its findings comparable to previous studies (Hogue, 1993; Hogue, 1995; Hogue & Pebbles, 1995) which represented positive attitudes. This suggests that despite the concept of a learning disability being present, staff rated these individuals in a similar way to sex offenders without a learning disability. The score on this measure was considerably higher on its second administration; this may reflect that 92% of the second sample were qualified staff who were more liberal in their views. The emotion scale scores implied that staff were more negative in their emotional reactions to individuals with a learning disability who were sex offenders. This suggests that staff may emotionally react more directly to the concept of a sex offender rather than that of a learning disability. With regards to burnout, scale scores suggested that the sample contained relevantly high levels of emotional exhaustion; and comparable levels of depersonalisation and personal accomplishment in relation to previous studies (Maslach, Jackson & Leiter, 1996; Shelby, Stoddart & Taylor, 2001). At the time of data collection there were several service organisational issues that were taking place in the organisation; these may have held some bearing on staffs feelings and ratings.

It was predicted that the ATS could be successfully adapted for staff working with individuals who had a learning disability and were sex offenders. Findings showed that the measure demonstrated sound internal consistency and achieved high test-retest; thus supporting this hypothesis. The adapted version could potentially be used as a way of assessing the nature of attitudes of staff working with this client group. If a staff group showed negative attitudes as indicated by this measure, then this could prompt the implementation of appropriate interventions. Perini (2004)

proposes that care services often look for staff with positive qualities, including an empathic, positive and non-judgemental manner. The modified ATS may be a useful screening tool for potential new staff members.

A second hypothesis proposed that females, qualified staff and staff with greater levels of experience would show more positive attitudes and emotions. Unexpectedly no relationship between gender and these variables arose; thus opposing pervious research (Higgins & Ireland, 2009; Johnson, Hughes & Ireland, 2007). This may have been due to the fact that the sample was unbalanced as it consisted of 70% females and as a result made comparing gender differences difficult. No relationship was found between staff level of experience and these variables. The mean length of employment was 10 years and 4 months which is a relatively long period of time in an area of work which often reports a rapid turnover of approximately 20% of its staff (Hatton et al., 1995). The stability of the staff in the sample may have influenced the significant findings. Exploring reasons for this stability may have offered insight into staff perceptions of organisational factors which assisted them in their work.

Qualified staff had more positive attitudes than unqualified staff; hence supporting past studies (Higgins & Ireland, 2009; Hogue, 1993; Hogue & Pebbles, 1997; Johnson, Highes & Ireland, 2007; Kjelsbery & Loo, 2008). One possible reason for this is that the time which qualified staff spend with clients is generally less and often has a different focus to unqualified staff. Unqualified staff, often spend greater periods of time with clients in a selection of different contexts. As a result they are

exposed to different aspects of a client's presentation and personality which can be challenging and may hold the potential to influence their attitudes in a negative way. Additionally, unqualified staff may have received less training or education about working with this client group; hence their level of knowledge and skills may be less in this area. This may hold implications for their behaviour and level of care which they provide.

Unqualified staff reported higher levels of burnout in the form of depersonalisation than qualified staff. If staff hold an impersonal response to the clients they work with, this will ultimately impact upon their ability to form therapeutic relationships and deliver care. This finding offers support for past research (Thrope, Righthand & Kubik, 2001). It seems logical that unqualified staff, who often have less training and spend greater periods of time with clients would be more vulnerable to the development of burnout.

Results showed that staff elicited greater negative emotional responses to clients who were classified as sex offenders in comparison to those clients who just had a learning disability. It is suggested that staff interactions and experiences with these clients and external factors such as dominant public views (Levenson & Ward, 2010) and the media (Church II et al., 2008) may have been influential; however future exploration is required.

It was hypothesised that the nature of staff attitudes would be consistent with their emotional responses. This was however, only confirmed in relation to positive attitudes and emotions. It is plausible that staff may have responded to the measures in a socially desirable way. In regards to the emotion scales staff may not

have wanted to view themselves as hopeless, disgusted or incompetent as these deviate from their caring professional role or be portrayed as holding negative attitudes which may have placed them in a position of being viewed as uncaring and unprofessional. As a result this may have influenced their response sets on these scales and thus reduced the possibility of associations with these scales.

Overall higher levels of burnout were associated with staff having greater negative attitudes and more negative emotional responses to those individuals who had a learning disability and were sex offenders. This generates support for the original hypothesis and previous research (Thomas & Rose, 2009). These findings however, are based on correlation analysis; consequently determining the causality of variables is impossible.

It was hypothesised that those staff currently working with individuals who had a learning disability and were sex offenders would show more positive attitudes and emotions to these individuals but display higher levels of burnout than those staff not currently working with these clients. Findings showed that these staff held more positive emotions and experienced greater levels of burnout, however their attitudes were more negative than staff not currently working with this client group. This finding was not anticipated and it is does not support previous research (Hogue, 1993; Johnson, Hughes & Ireland, 2007). Taking into account previous findings of this review and past research (Thomas & Rose, 2009), it is possible that those staff who felt more emotionally exhausted and extended by their work may begin to react in an maladaptive way to individuals who they may associate with the source of this discomfort. Alternatively the nature of the questions which were used to assess staff experience were limited by their design. Most staff in the study had experience of

working with both individuals who had a learning disability and individuals who had a learning disability and were sex offenders, consequently the findings are limited.

Findings showed that qualification proved the most robust predictor of staff attitudes. This supports previous research which suggests that professional status is important in the shaping of attitudes (Kjelsbery & Loos, 2008; Hogue & Pebbles, 1997; Higgins & Ireland, 2009). Results demonstrated that depersonalisation was the next strongest predictor of staff attitudes. This supports past research which has shown burnout to be present in staff who work with sex offenders (Carmel & Friedlander, 2009; Kadambi & Truscott, 2003; Lea, Auburn & Kibblewhite, 1999) and individuals with learning disabilities (Skirrow & Hatton, 2007). This implies that if staff begin to feel burnout in their work then this will contribute to the development of their attitudes. Personal accomplishment was the next strongest predictor, which suggests that staff sense of achievement in their work predicts their attitudinal response to the clients they are working with.

Methodology Issues and Future Research

As with the majority of research which has explored staff attitudes a retrospective cross sectional survey questionnaire design was used, consequently determining causality is impossible. To determine causality a longitudinal design would be required; this would be an important area for future research.

The measures used within the study relied on self-report data, which is subject to social bias and may be unreliable. Biases in the outcomes may have occurred as only staff that chose to complete the questionnaires were included, therefore they

may have been more interested and motivated in the study. In this study the majority of the sample consisted of qualified female staff, which poses limitations for generalisation. Furthermore the sample size was relatively small, which was a reflection of the low response rate; ultimately this would have impacted on the findings. Future studies should seek to address ways of improving response rates and should include participants from varying backgrounds.

Previous research has emphasised the importance of effective coping strategies in managing burnout when working with sex offenders (Hatcher & Noakes, 2010) and individuals with a learning disability (Hatton & Emerson, 1995). It may have been advantageous to have included a coping scale to evaluate how coping strategies may have influenced staff attitudes, emotions and burnout. It has been emphasised that staff in this study may have responded in a socially desirable manner, consequently, including a social desirability scale would have assisted in formally accounting for this.

The study has acknowledged on several occasions that the nature of staff attitudes, emotions and level of burnout may hold implications for the delivery of client care and service provision. Future research might look at investigating a possible link between staff psychological variables and the role of attributions, this would help to establish if staff attitudes determined staff behaviours with these individuals.

A further study may consider administering the ATS in its original and adapted form to the same staff group. This would allow staff attitudes to be compared for both client groups and could pave some interesting findings for interventions. Finally

qualitative studies may allow a greater awareness into the formation and maintenance of staff attitudes which has not been captured by this study.

Clinical Implications

A main conclusion from this research is that staff attitudes to individuals with a learning disability who are sex offenders can be influenced by whether staff hold a professional qualification and their level of burnout. These findings have important implications for the effective delivery of client care and service provision. Past research has shown that training can be useful in positively shaping staff attitudes. Taylor, Keddie & Lee (2003) delivered a brief training program to staff working with individuals who had a learning disability and were sex offenders. Their outcomes showed that following the training, staff held more positive attitudes and their knowledge, understanding and skill level in working with this client group had improved. Taking into account the outcomes of this study one possible intervention point may be the delivery of staff training and education. This should contain some orientation to the key issues of working with sex offenders with learning disabilities, provide factual information, describe the treatment process and emphasis the importance of staff in this progress. Allowing staff the opportunity to consider how this type of work personally impacts them may enable them to begin to consider their own emotional reactions and address possible coping strategies.

Findings showed that staff in the study were experiencing burnout, which is likely to have an impact upon their work performance (Department of Health, 2009). The delivery of psychosocial interventions, which focus on encouraging staff to cognitively reappraise situations and behaviours has been successful in reducing burnout in

qualified and unqualified staff working in mental health secure units (Ewers et al., 2002; Redhead et al., 2010). Gardner et al., (2005) found that an intervention, using aspects of cognitive therapy was effective at assisting staff in managing their work related stress. Whilst Rose, Jones & Fletcher (1998) concluded that staff training which focused on problem-solving and personal stress management was successful in reducing staff anxiety and depression levels when working with those individuals who had a learning disability. Consequently integrating aspects of these into a training component may prove an appropriate intervention point for this study. Alternatively, to ensure that staff feel supported in their work the organisation may wish to consider the use or development of individual or peer supervision/support groups. The importance of these when working with complex clients have been emphasised by previous research (Sexton, 1999).

Conclusions

In conclusion, this study has showed that staff attitudes towards those clients who have a learning disability and are sex offenders were overall positive; nevertheless unqualified staff displayed more negative attitudes. Collectively the sample displayed greater negative emotional reactions to this client group. Whilst burnout was closely associated with negative attitudes and negative emotions, with unqualified staff holding higher levels of depersonalisation. In summary these findings implies that the association between demographic variables, emotions and burnout with staff attitudes are important factors to consider in the context of providing services to this client group and in ensuring this is to the highest possible quality.

REFERENCES

Alexander, M. & Hegarty, J. R. (2000). Occupational stress and burnout amongst staff working with people with an intellectual disability. *Behavioural Interventions, 9, 225-234.*

Ajzen, I & Fishbein, M. (1980). *Understanding Attitudes and Predicting Social Behaviour.* Englewood Cliffs. NJ, USA. Prentice-Hall.

Baron, R. A. & Byrne, D. (2003). *Social Psychology. Tenth Edition*. USA. Pearson education.

Blumenthal, S., Lavender, T. & Hewson, S. (1998). Role Clarity, perception of the organisation and burnout amongst support workers in residential homes for people wit intellectual disabilities: a comparison between a national health service trust and a charitable company. *Journal of Intellectual Disability Research 42, 409-417.*

Brown, J & Blount, C. (1999). Occupational Stress among sex offender treatment managers. *Journal of Managerial Psychology, 14, 108-120.*

Brown, H., Stein, J. & Turk, V. (1995). Report of a second two year incidence survey on the reported sexual abuse of adults with learning disabilities: 1991 and 1992. *Mental Handicap Research, 8, 1-22.*

Carmel, S. J.M. & Friedlander, M.L. (2009). Brief Reports: The relation of secondary traumatisation to therapist's perceptions of the working alliance with clients who commit sexual abuse. *Journal of Counselling Psychology, 56, 461-467*

Chung, M. C., Corbett, J. & Cumella, S. (1996). Relating staff burnout to clients with challenging behaviour in people with a learning disability: Pilot study 2. *European Journal of Psychiatry, 10, 155-165.*

Church II, W.T. (2008). The Community Attitudes Towards Sex Offenders Scale: The Development of a Psychometric Assessment Instrument. *Research on Social Work Practice, 18, 251-259.*

Clare, C.H.I. & Murrphy, G.H. (1998). Working with Offenders or Alleged Offenders with Intellectual Disabilities. In Emerson, E., Hatton, C., Brimely, J. & Caine, A. (1998). *Clinical Psychology and People with Intellectual Disabilities.* Chichester. (pp.154-176). John Wiley and Sons.

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

Church, W. T., Wakeman, E.E., Miller, S.L., Clements, C.B. & Sun, F. (2008). The Community Attitudes Towards Sex Offenders Scale: The Development of a Psychometric Assessment Instrument. *Research on Social Work Practice, 18, 251-259.*

Dagnan, D., Trower, P. & Smith, R. (1998). Care staff responses to people with learning disabilities and challenging behaviour: A cognitive-emotional analysis. *The British Journal of Clinical Psychology, 37, 59-68.*

Day, K. (1993). Crime and Mental Retardation: A Review. In Howells, K. & Hollin, C.R. *Clinical Approaches to the Mentally Disordered Offender. (pp111-144).* Chichester. John Wiley and Sons Ltd.

Day, K. (1997). Sex Offenders with Learning Disabilities. In Read, S.G. (1997). *Psychiatry in Learning Disabilities.* London. Saunders Company Ltd.

Department of Health. (2009). *NHS health and Well-Being.* Leeds. DH Publications

Dryden, W. (1990). *Rational- Emotive Counselling in Action*. London. Sage Publications.

Duquette, A., Sandhu, B.K. & Beaudet, L. (1994). Factors related to nursing burnout: a review of empirical knowledge. *Issues in Mental Health Nursing, 15, 337-358.*

Ewers, P., Bradshaw, T., McGovern, J. & Ewers, B. (2002) Does training in psychosocial interventions reduce burnout rates in forensic nurses? *Journal of Advanced Nursing, 37, 470-476.*

Eliis, A. (1962). *Reason and Emotion in Psychotherapy.* Cutadeal Press. Secaucus.

Farrenkopf, T. (1992). What happens to facilitators who work with sex offenders. *Journal of Offender rehabilitation, 16, 217-223.*

Freudenberger, H.J. (1974). Staff burnout. *Journal of Social Issues, 30, 159-165.*

Field, A. (2000). *Discovering Statistics using SPSS for Windows.* London. Sage publications.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: an overview. In Figley, C. R. *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized.* New York. Brunner/Mazel.

Gardner, B., Rose, J., Mason, O., Tyler. & Cushway, D. (2005). Cognitive therapy and behavioural coping in management of work-related stress: An intervention study. *Work & Stress, 19, 137-152.*

Gill, F., Kroese, S. & Rose, J. (2002). General Practitioners' attitudes to patients who have learning disabilities. *Psychological Medicine, 32, 1445-1455.*

Hatcher, R. & Noakes, S. (2010). Working with sex offenders: the impact on Australian treatment providers. *Psychology, Crime and Law, 16 (1-2), 145-167.*

Hatton, C., Brown, R., Caine, A. & Emerson, E. (1995). Stressors, Coping Strategies and Stress-Related Outcomes Among Direct Care Staff in Staffed Houses for People with Learning Disabilities. *Mental Handicap Research, 8, 252-271.*

Hatton, C. & Emerson, E. (1995). Organisational predictors of staff stress, satisfaction and intended turnover in a service for people with multiple disabilities. *Mental Retardation, 31, 388-395.*

Hatton, C. (1999). Staff Stress. In Bouras, N. (1999). *Psychiatric and Behavioural Disorders in Mental Retardation. (pp 427-438).* Cambridge. University Press.

Hatton,C., Wigham, S., Craig, J. & Gudgeon, E. (2004). Developing job performance measures for staff support in housing services. *Journal of Intellectual Disabilities Research, 44, 499.*

Higgins, C & Ireland, C.A. (2009). Attitudes towards male and female sex offenders: a comparison of forensic staff, prison officers and the general public in Northern Ireland. *British Journal of Forensic Practice, 11,14-19.*

Hogue, T. E. & Pebbles, J. (1997). The influence of remorse, intent and attitudes towards sex offenders on judgements of a rapist. *Psychology, Crime & Law, 3, 249-2599.*

Hogue, T. E. (1995). Training Multi-disciplinary teams to work with sex offenders: Effects on staff Attitudes. *Psychology, Crime and Law, 1, 227-235.*

Hogue, T. E. (1993). Attitudes towards prisoners and sexual offenders. In Clark, C.N & Stephenson, G. *DCLP Occasional Papers: Sexual Offenders.* Leicester: British Psychological Society.

Howard, R., Rose, J. & Levenson, V. (2009). The psychological impact of violence on staff working with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 22, 538-548.*

Johnson, H., Hughes, G. J. & Ireland, J. L. (2007). Attitudes towards sex offenders and the role of empathy, locus of control and training: A comparison between a probationer police and general public sample. *The Police Journal, 80, 28-54.*

Kadambi, M.A. & Truscott, D. (2003). Vicarious Truamatisation and Burnout amongst Therapists Working with Sex Offenders. *Traumatology, 9, 216-229.*

Kjelsberg, E & Loos, H. L. (2008). Conciliation or Condemnation? Prison Employees' and Young Peoples' Attitudes Towards Sexual Offenders. *International Journal of Forensic Mental Health, 7, 93-103.*

Lea, S., Auburn, T. & Kibblewhite, K. (1999). Working with Sex Offenders: The Perceptions and Experiences of Professionals and Paraprofessionals. *International Journal of Offender Therapy and Comparative Criminology, 43,103-119.*

Lewis, S & Kroese, S. B. (2009). An investigation of nursing staff attitudes and emotional reactions towards patients with intellectual disability in a general hospital setting. *Journal of Applied Research In Intellectual Disabilities, 23, 355-365.*

Lyall, I., Holland, A. J. & Collins, S. (1995). Offending by adults with learning disabilities and the attitudes of staff to offending behaviour: implications for service development. *Journal of Intellectual Disability Research, 39, 501-508.*

Manstead, A. S. R. (1996). Attitudes and Behaviour. In Semin, G. R. & Fielder, K. *Applied Social Psychology*. London . Sage Publications.

Maslach, C. (1982). *Burnout: the cost of caring.* Englewood Cliffs. NJ: Prentice Hall.

Maslach, C. & Jackson, E. S. (1986). *Maslach Burnout Inventory Manual: second edition.* Consulting Psychologists Press. Palo Alto, CA.

Maslach, C., Jackson, E. S & Leiter, P. M. (1996). *Maslach Burnout Inventory Manual: Third edition*. Consulting Psychologists Press. USA.

McBrein, J. & Candy, S. (1998). Working with Organisations, or " Why Won't They Follow My advice?". In Emerson, E., Hatton, C., Brimely, J. & Caine, A. (1998). *Clinical Psychology and People with Intellectual Disabilities.(pp, 265-279).* Chichester. John Wiley and Sons.

McGeaw, O.K. & Wong, S.P. (1996). Forming Inferences about some Intraclass Correlation Coefficients. *Psychological Methods, 1, 30-46.*

McKenzie, K., Matheson, E., McKaskie, K., Patrick, S., Paxton, D., Michie, A. & Murray, G.C. (2001). Health and Social care staff responses to working with people with a learning disability who display sexual offending type behaviours. *The Journal of Sexual Aggression, 71, 56-66.*

Melvin, K. B., Gramling, L.K. & Gardner, W. N. (1985). A scale to measure attitudes towards prisoners. *Criminal Justice and Behaviour, 12, 241-252.*

Mitchell, G. & Hastings, R.P. (1998). Learning disability care staff's emotional reactions to aggressive challenging behaviours: Development of a measurement tool. *The British Journal of Clinical Psychology, 37, 441-449.*

Nelson, M., Herlihy, B. & Oescher, J. (2002). A survey of counselor attitudes towards sex offenders. *Journal of Mental Health Counseling, 24, 51-67.*

Olver, M.E. & Barlow, A. (2010). Public Attitudes towards Sex Offenders and their relationship to Personality Traits and Demographic Characteristics. *Behavioural Sciences and the Law, 28, 832-849.*

Payne, B.K., Tewsbury, R. & Mustain, E.E. (2010). Attitudes about rehabilitating sex offenders: Demographic, victimization, and community- level influences. *Journal of Criminal Justice, 38, 580-588.*

Perini, A.F. (2004). Staff Support and Development. In Lindsay, W.R., Taylor, J.L. & Sturmey, P. *Offenders with Developmental Disabilities.* West Sussex. John Wiley & Sons.

Pines, A. M. & Keinan. (2005). Stress and burnout: The significant difference. *Personality and Individual Differences, 39, 625-635*.

Price-Jones, D. W & Barrowcliff, A. (2010). Attitudes towards sex offenders regarding competency, liability, voluntariness of offence, and disposal: the influence of being classified as having a learning disability. *Psychology, Crime & Law, 16. 251-263.*

Radley, L. (2001). Attitudes to Sex Offenders. *Forensic Update, 66, 5-9.*

Redhead, K., Bradshaw, T., Braynion, P. & Doyle, M. (2011). An evaluation of the outcomes of a psychosocial intervention training for qualified and unqualified nursing staff working in a low-secure mental health unit. *Journal of Psychiatric and Mental Health Nursing, 18, 59-66.*

Rees, S. R. (2001). Responding to people with a learning disability who offend. *Nursing Standard, 15, 36-39.*

Robson. C. (2002). *Real World Research. Second Edition.* Oxford. Blackwell Publishing

Rose, J., David, G. & Jones, C. (2003). Staff who work with people who have intellectual disabilities: The importance of personality. *Applied Research in Intellectual Disabilities, 16, 267-277.*

Rose, J., Jones, F. & Fletcher, B. C. (1998). The Impact of a stress management programme on staff well-being and performance at work. *Work & Stress, 12, 112-124.*

Rose, N. (2009). *Health Professionals' attitudes and emotions towards working with Intellectual Disability and Mental Illness.* Unpublished Doctorate Thesis.

Sanghara, K. K. & Wilson, J.C. (2006). Stereotypes and attitudes about child sexual abusers: A comparison of experienced and inexperienced professionals in sex offender treatment. *Legal and Criminology Psychology, 11, 229-244.*

Sexton, L. (1999). Vicarious traumatisation of counsellors and effects on their workplaces. *British Journal of Guidance and Counselling, 3, 393-403.*

Shelby, R.A., Stoddart, R.M. & Taylor, K.L. (2001). Factors Contributing to Levels of Burnout Among Sex Offender Treatment Providers. *Journal of Interpersonal Violence, 16, 1205-1217.*

Skirrow, P. & Hatton, C. (2007). 'Burnout' Amongst direct care workers in service for adults with intellectual disabilities: A Systematic Review of the research findings and initial normative data. *Journal of Applied Research in Intellectual Disabilities, 20, 131-144.*

Steed, L. & Bicknell, J. (2001). Trauma and the Therapists working with the perpetrators of sexual abuse. *The Australian Journal of Disaster and Trauma Studies, 1-10.*

Tabachnick, B. G. & Fidell, L. S. (1996). *Using multivariate statistics (3rd edition).* New York. HaperCollins.

Taylor, J.L., Kediie, T. & Lee, S. (2003). Working with sex offenders with intellectual disability: evaluation of an introductory workshop for direct care staff. *Journal of Intellectual Disability Research, 47, 203-209.*

Thomas, C. & Rose, J. (2009). The Relationship between Reciprocity and the Emotional and Behavioural Response of Staff. *Journal of Applied Research in Intellectual Disabilities, 23, 167-178.*

Thorpe, G.L., Righthand, S. & Kubik, E.K. (2001). Brief Report: Dimensions of Burnout in Professionals Working with Sex Offenders. *Sexual Abuse: A Journal of Research and Treatment, 13, 197-203.*

Turner, J.C., Hogg, M.A., Oakes, P.J., Reicher, S.D. & Wetherall, M.S. (1987). *Rediscovering the Social Group: A self-categorisation theory.* Oxford. Blackwell.

Yool, L., Langdon, P.E. & Garner, K. (2003). The Attitudes of Medium-Secure Unit Staff Toward the Sexuality of Adults with Learning Disabilities. *Sexuality and Disability, 21, 137-150.*

Van Yperen, N. W. (1995). Communal orientation and burnout syndrome among nurses a replication and extension. *Journal of Applied Social Psychology, 26, 338-354.*

Weekes, J.R., Pelletier, G., Beaudette, D. (1995). Correctional Officers: How Do They Perceive Sex Offenders? *International Journal of Offender Therapy and Comparative Criminology, 39, 55-61.*

CLINICAL IMPLICATIONS TO THE DELIVERY OF CARE WHEN WORKING WITH CLIENTS WHO HAVE COMMITTED A SEXUAL OFFENCE AND MAY HAVE A LEARNING DISABILITY

Amanda L Walker

University of Birmingham

OVERVIEW

The research detailed below was submitted as partial fulfilment for the degree of Doctorate in Clinical Psychology. The first part represents a literature review, in which the author questioned what the impact was to those who worked with sex offenders. The second part was a research study which explored staff attitudes to working with individuals who had a learning disability and were sex offenders. The purpose of this paper is to provide the reader with a brief summary and key findings from these areas.

PART ONE: LITERATURE REVIEW

Background

Research suggests that those individuals who work with sex offenders can often experience several harmful effects from this type of work, including vicarious trauma, secondary trauma, compassion fatigue, post traumatic stress disorder (PTSD) and burnout (Moulden & Firestone, 2007). Those individuals who experience these harmful effects may find it difficult to deliver a high quality of care to their clients. Research investigating the impact of these harmful effects to individuals who work with sex offenders is limited. Although two previous reviews have been conducted (Clarke & Rogers, 2002; Moulden & Firestone, 2007) they have several limitations.

Aims

This review aimed to undertake a systematic search of the literature using the concepts defined upon. The literature was re-considered using a more objective and critical stance to question what the psychological impact is on those who work with

sex offenders. The influence of moderating and protective factors associated with these harmful effects were also explored.

Method

A search of the literature using key terms was carried out in June 2010, using electronic databases of PSYCHINFO, EMBASE, OVID MEDLINE and WEB OF SCIENCE.

Results

Through inclusion criteria, 8 papers were obtained, a further 4 were gained through other relevant sources. This produced a total of 12 papers.

Main Findings

The literature documented several harmful effects of working with sex offenders these included vicarious trauma, secondary trauma, compassion fatigue, (PTSD), stress and burnout. The frequency of these varied amongst the studies, whilst the different methods used by the studies made it impossible to establish an overall incidence level. Interestingly the literature revealed some positive effects associated with working with sex offenders these included, increased levels of confidence and compassion satisfaction (satisfaction in ones work).

A selection of moderating factors thought to increase the intensity of these harmful effects were identified. These included an individual's level of experience, their profession, lack of supervision and team work. Various protective factors thought to help prevent or reduce these harmful effects were found. These related to an

individual's coping strategies and the availability of supervision and colleague support within their work organisation.

The main findings from the literature were restricted by various methodological limitations, including differences in the way each study had defined and measured "harmful effects". The use of self-report data is subject to biases, whilst the use of retrospective information prevented the longer term effects of this work being identified.

The findings were used to develop A Model of Awareness. This model could be used as a guide for identifying the potential harmful effects of this type of work, whilst considering the selection of strategies which could be implemented to help reduce these effects.

Conclusions

Those who work with sex offenders are at risk of developing a selection of harmful effects from their work. Awareness of the role of moderating and protective factors are important as these hold the potential to either increase or reduce these harmful effects. These findings have been encapsulated into a Model of Awareness which could potentially be used in clinical practice. Further research is required as the outcomes described are restricted in their reliability by methodological limitations.

PART TWO: RESEARCH STUDY

Background

Attitudes are important in shaping our judgements and views about specific subjects, objects and people whilst, influencing how we react and behave (Hogue & Pebbles, 1997). Sex offenders who have a learning disability are often viewed as sexually naïve and vulnerable (Day, 1993), whilst staff working with them can often hold negative attitudes (Lyall et al., 2001; McBrein & Candy, 1998; McKenzie et al., 2001).

Staff attitudes are thought to be linked to a number of factors including gender (Yool et al., 2003), job role (McKenzie et al., 2003), level of experience and training (Taylor, Keddie & Lee, 2003). The emotional reaction of staff (Gill, Kroese and Rose 2002; Rose, 2009) and their experience of burnout, which is classified as long term emotional exhausted and diminished interest in work (Maslach, 1996) are also thought to have an effect on their attitudes. Research into this area is extremely limited (McKenzie et al., 2001; Yool et al., 2003) and no specific measures exist for assessing these attitudes.

Further research into this area is important as negative staff attitudes may influence how staff work (Hatton et al., 2004; Hatton, 1999) and care for these individuals (Duquette, Sandhu and Beaudet, 1994).

Aims

This study explored the attitudes of staff working with individuals who had a learning disability but were also sex offenders, whilst considering the role of individual factors, emotions and burnout in the development of these attitudes. The study also aimed to modify the Attitudes Towards Sex Offenders Scale (ATS) (Hogue, 1993) for use with this staff group.

Method

Participants

Seventy one members of staff from four secure forensic units, one non secure forensic unit and a community service, all which provided services to adults with a learning disability who may have committed a sexual or violent offence, took part in the study. The majority of the staff (73%) held professional status (psychologist, psychiatrics, nurses). The sample mainly included females (70%), with the mean age of the staff being 38 years and their average length of employment being 124 months. A second questionnaire was completed by 26 of these staff members.

Design and Procedure

The study used a cross-sectional survey design. Ethical approval was obtained from the National Research Ethics Service. The study was explained to service co-ordinators, professional leads, unit managers, the units and community service. Questionnaire packs were then delivered to staff willing to partake. These packs contained an information sheet, consent form and the four questionnaires. Staff who agreed to complete a second ATS indicated this on the consent form. This was

provided 2-3 weeks later and matched to the original questionnaires of staff through identification numbers which were then re coded to ensure anonymity.

Measures

Demographic Information: Questions relating to participants gender, age, designation, employment status, direct weekly client contact and length of employment were obtained.

Attitudes to Sex Offenders with a Learning Disability: A modified version of the ATS (Hogue, 1993), assessed staff attitudes to working with clients who had a learning disability and were sex offenders.

Emotional Scale: Participants were asked to rate their response to twelve emotions (four were positive and eight were negative) in relation to working with clients who had a learning disability and then in relation to clients who had a learning disability and were sex offenders.

Burnout: Staff levels of burnout were assessed by the Maslach Burnout Inventory (Maslach, Jackson & Leiter, 1996).

Main findings

All results were analysed using a computerised statistical program (SPSS, version 17). The main findings showed that the modified ATS could be successfully used for this staff group. Overall staff demonstrated positive attitudes to sex offenders who had a learning disability. Qualified staff were more positive in their attitudes with

unqualified staff showing higher levels of burnout. Emotional responses to this client group were generally negative, with the expectation of those staff who were currently working with this client group. Staff who showed negative attitudes and emotions reported feeling more emotional exhausted by their work.

Clinical implications and future studies

The study was successful in achieving its aims and increasing a limited research area. The findings provided support for the importance of individual factors, emotions and burnout in the development of staff attitudes when working with clients who had a learning disability and were also sex offenders.

The findings hold various clinical implications for the delivery of client care and service provision. Qualified staff were more positive in their attitudes: this may be a reflection of their exposure to greater training and knowledge than unqualified staff. Future studies should focus on exploring this, it may be advantageous that all staff are provided with training related to working with this client group. This training should aim to increase the knowledge and skill base of staff, whilst allowing staff the opportunity to discuss their feelings about working with this client group. Those staff who felt burnout or emotionally exhausted by their work often reported more negative attitudes and experienced more negative emotional reactions to this client group. Training or support groups may help staff think of effective ways to manage their feelings. This information will be shared with both the managers of the services and

the staff who partook in the study. It is hoped that they will find some of the suggestions helpful and use them as necessary to improve their working practices.

REFERENCES

Clarke, J. & Roger, D. (2002). Working Therapeutically with sex offenders: The potential impact on the psychological well-being of treatment providers. *Issues in Forensic Psychology, 3, 82-96.*

Day, K. (1993). Crime and Mental Retardation: A Review. In Howells, K. & Hollin, C.R. *Clinical Approaches to the Mentally Disordered Offender. (pp111-144).* Chichester. John Wiley and Sons Ltd.

Duquette, A., Sandhu, B.K. & Beaudet, L. (1994). Factors related to nursing burnout: a review of empirical knowledge. *Issues in Mental Health Nursing, 15, 337-358.*

Gill, F., Kroese, S. & Rose, J. (2002). General Practitioners' attitudes to patients who have learning disabilities. *Psychological Medicine, 32, 1445-1455.*

Hatton, C. (1999). Staff Stress. In Bouras, N. (1999). *Psychiatric and Behavioural Disorders in Mental Retardation. (pp 427-438).* Cambridge. University Press.

Hatton,C., Wigham, S., Craig, J. & Gudgeon, E. (2004). Developing job performance measures for staff support in housing services. *Journal of Intellectual Disabilities Research, 44, 499.*

Hogue, T. E. (1993). Attitudes towards prisoners and sexual offenders. In Clark, C.N & Stephenson, G. *DCLP Occasional Papers: Sexual Offenders.* Leicester: British Psychological Society.

Hogue, T. E. & Pebbles, J. (1997). The influence of remorse, intent and attitudes towards sex offenders on judgements of a rapist. *Psychology, Crime & Law, 3, 249-2599.*

Lyall, I., Holland, A. J. & Collins, S. (1995). Offending by adults with learning disabilities and the attitudes of staff to offending behaviour: implications for service development. *Journal of Intellectual Disability Research, 39, 501-508.*

Maslach, C., Jackson, E. S & Leiter, P. M. (1996). *Maslach Burnout Inventory Manual: Third edition*. Consulting Psychologists Press. USA.

McBrein, J. & Candy, S. (1998). Working with Organisations, or " Why Won't They Follow My advice?". In Emerson, E., Hatton, C., Brimely, J. & Caine, A. (1998). *Clinical Psychology and People with Intellectual Disabilities. (pp, 265-279).* Chichester. John Wiley and Sons.

McKenzie, K., Matheson, E., McKaskie, K., Patrick, S., Paxton, D., Michie, A. & Murray, G.C. (2001). Health and Social care staff responses to working with people with a learning disability who display sexual offending type behaviours. *The Journal of Sexual Aggression, 71, 56-66.*

Moulden, H.M. & Firestone, P. (2007). Vicarious Traumatization: The Impact on Therapists who work with Sexual Offenders. *Trauma, Violence and Abuse, 8, 67-83.*

Taylor, J.L., Kediie, T. & Lee, S. (2003). Working with sex offenders with intellectual disability: evaluation of an introductory workshop for direct care staff. *Journal of Intellectual Disability Research, 47, 203-209.*

Yool, L., Langdon, P.E. & Garner, K. (2003). The Attitudes of Medium-Secure Unit Staff Toward the Sexuality of Adults with Learning Disabilities. *Sexuality and Disability, 21, 137-150.*