The Psychosocial Impact on Facilitators of Working Therapeutically with Sex Offenders: An Experimental Study

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Thesis submitted for the degree of Doctor of Philosophy
University of York
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February 2004

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Abstract

The systematic and widespread implementation of treatment for sex offenders is a recent innovation in the human services field, and the provision of treatment for the perpetrators of sexual abuse is a young profession (Edmunds, 1993). For example, HM Prison Service introduced a comprehensive treatment strategy only in 1991, but since then over 1400 facilitators from a variety of disciplines have been trained in its delivery.

A wide range of studies has indicated that providing treatment for sex offenders may incur significant personal costs. Effects range from mild anxiety to severe psychological morbidity, and have variously been described as burnout, vicarious trauma, secondary traumatic stress and compassion fatigue. The findings have suggested a psychologically bleak future for anywhere between a fifth and a quarter of facilitators. However, owing to methodological and empirical shortcomings, the existing findings did little more than list the range and prevalence of symptoms, and failed to offer insights into causes or solutions for the problem.

The aim of this thesis was to address these shortcomings. In the first stage of the project, a measure of the psychological impact specific to sex offender treatment providers was constructed and validated. The role of individual differences in moderating the impact of treatment provision was then explored, particularly in the context of emotional reactivity and emotional 'style'. Both cross-sectional and longitudinal designs were then introduced, allowing a more rigorous investigation of the causal factors involved in maladaptive responses to treatment provision, and the impact of organisational support on the well-being of treatment providers was also investigated. The use of objective physiological responses and their relationship to self-reported measures of adaptation were then explored, and the empirical work for the thesis concluded with a series of case studies of individual adaptation to treatment provision based on Personal Construct methodology.

Overall, the findings offered a considerably more optimistic view than was apparent from previous research. Sex offender treatment providers experience an ongoing

process of psychological adaptation in response to their work, and the extent to which this was experienced as positive or negative was largely a function of individual differences in psychosocial variables rather than being inherent in the treatment role itself. Components of emotional response style (Roger, Guarino and Olason, 2000), including rumination, detached coping and empathy were identified as salient factors, and there is empirical evidence that these behaviours can be modified by appropriate training. Socio-demographic features including age, gender, levels of experience, previous experience of sexual abuse as an adult and recent trauma were also highlighted as significant. Reliable measurement of psychological well-being was demonstrated by the newly developed Assessment of Dynamic Adaptation (ADA), and the predictive value of objective observation in identifying facilitator well-being was established. Personal construction of experience of sex offender treatment provision was identified as a potential source of the satisfaction/distress interaction so often reported in the sex offender therapist literature.

Recommendations for further research included further development of the ADA to incorporate positive elements of the work, continued development of objective measures of well-being, and further investigation into the role of empathy, both as a potential cause of distress and an essential therapist skill. Operational considerations were also discussed in the context of interventions aimed at developing individual psychological self-maintenance skills and improving organisational support mechanisms.

Acknowledgements

I owe the completion of the thesis to numerous individuals and groups of people, all of whose contributions have made the undertaking of this research one of the most enjoyable and fulfilling periods of my career.

Firstly to my supervisor Dr Derek Roger, who not only took on the onerous task of honing my research skills, but whose patience, enthusiasm, insights and wisdom have taught me far more than he can know.

To the literally hundreds of sex offender treatment providers, both in HM Prison Service and beyond, who have tirelessly responded to yet more requests for questionnaire completion and who have shared their experiences of their work with integrity and bravery. This thesis is dedicated to them.

To my research committee members Dr Nick Hammond, Professor Cynthia McDougall and Professor Maggie Snowling, whose advice and guidance have been invaluable.

To Dr Yvonne Birks, Dr Jane Clarbour, and Dr Jeremy Miles whose friendship and professional skills have variously kept me focused, motivated and sane!

To the Sex Offender Treatment Team at HM Prison Service Headquarters, especially Francis Mair and Ruth Mann, whose practical support of this research has enabled its undertaking.

To Helen Jones and all the members of the Northern Personal Construct Psychology Research Group. Chapter Six would not have been possible without them.

To Dr Claudine Crane, a very dear friend and respected colleague who has not only shared with me the roller coaster ride of motherhood but who has also provided unending practical and emotional support.

To Anne Burton, whose precision, endurance, patience and equanimity ensured a final product of which we can both be proud.

To my mum, who has somehow remained remarkably sane through endless phone calls involving my reading excerpts of chapters, and a myriad of emotional states; and visits home where I did little more than sleep, secure in the knowledge that the world with her is safe.

And finally to my daughter Madi, who will probably decide, as a result of my absentmindedness and distracted state over the past three years, not to become a "psychogolist". You taught me the meaning of unconditional love. Have it always.

Authors Declaration

I hereby certify that the work presented in this thesis is the result of my original work and has not been submitted in any form for the award of another degree at this or any other university. To the best of my knowledge this thesis contains no material previously published or written by another person unless otherwise credited. Parts of this thesis have been presented at a number of national and international conferences.

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Chapter One

Literature Review

1.1 Introduction

Within the immeasurable variety of possible occupations, some are unique with respect to which members risk exposure to traumatic events. Paton (1996) described these as 'critical occupations', a term coined to encapsulate the critical role played by such individuals in protecting communities, as well as the fact that "in the course of acting in this capacity, these professionals can encounter traumatic events which may, under certain circumstances, exert critical impact on their psychological well-being" (Paton and Violanti, 1996; p vii).

The systematic and widespread treatment of sex offenders is a recent innovation in the human services field and provision of treatment to sex-abuse perpetrators is a young profession (Edmunds, 1997). However, in the comparatively short period of time that therapeutic interventions with such clients have become a specialized endeavour, it has been recognized that therapists are presented with many challenges, not least of which is the repeated exposure to vivid descriptions of sexual violence and trauma (Ennis and Horne, 2003). As such, those providing treatment to sex offenders might well be considered members of a 'critical occupation'.

Perhaps because of the invidious nature of sexual violence against children and adults and the consequent exposure of therapists to potentially traumatic material, there appears to have been a pervasive acceptance of detrimental effects to therapists (Ryan and Lane, 1991). Most research in the area has focused almost exclusively on establishing the nature and extent of psychological distress, but in the past decade, empirical evidence has been emerging to contradict traditional assumptions. It would appear that whilst

studies consistently show that between one fifth and one quarter of participants report detrimental psychological changes they attribute directly to their involvement in the provision of treatment to sex offenders (e.g. Edmunds, 1997; Farrenkopf, 1992; Myers, 1995; Turner, 1992), a vast majority of treatment providers (between 75% and 96%) experience their work as immensely satisfying and rewarding (Edmunds, 1997; Ellerby, 1998; Kadambi, 2001, Kadambi and Truscott, 2003; Myers, 1995; Rich, 1997; Turner, 1992).

Since the inception of a centrally administered Sex Offender Treatment Programme (SOTP) in Her Majesty's Prison Service in 1991 (Mann and Thornton, 1998), over 1400 prison staff have been trained in its delivery. In that time, some anecdotal information and limited empirical evidence (Myers, 1995; Turner, 1992) have been shown to support these general findings. Therapists report experiencing fundamental changes in their own worldview, often described as distressing and life altering, which have led to resignation, to some staff taking legal action for compensation, and in one known case to a suicide attempt. Despite this, it remains apparent that therapists continue to be committed to the provision of services to sex offenders and consistently find personal and professional rewards in doing so (Kadambi, 2000; Kadambi and Truscott, 2003; Myers, 1995; Turner, 1992).

Findings such as those described above support the assertions of practitioners and researchers such as Paton (1996) and Stamm (1995), that exposure to traumatic events does not inevitably lead to dysfunctional or pathological outcomes, and that positive outcomes are often reported by members of critical occupations (Anderson, Christensen and Peterson, 1991; Raphael, 1986). It remains unclear which factors, particularly at an individual level, but also at a social and organizational level, might interact to contribute to differences in psychological reactivity.

The aim of the current research is to identify the possible psychosocial factors implicated in either the functional or dysfunctional psychological adaptation of HM Prison Service staff to working therapeutically with sex offenders.

In this chapter the sex offender treatment programme, as it runs in HM Prison Service, is described, together with the importance of particular therapist attributes and qualities. The literature regarding the psychological impact on therapists of working with sex offenders is then reviewed, with particular attention to 1) the features of the work that have been identified as stressful, 2) the nature and prevalence of the psychological symptoms described by therapists, 3) the ways in which these symptoms have been conceptualised, 4) the intellectual and practical objections to such concepts and 5) the methodological shortcomings of the existing research.

An outline will then be given of the format for the current research. This will include the introduction of an integrated model used to provide a structure for incorporating the range factors identified in the literature as influencing therapist psychological well-being, as well as considering ways in which these factors might interact. The final section of the chapter will include explicit research aims and hypotheses.

1.2 The Prison Service Sex Offender Treatment Programme (SOTP)

HM Prison Service's SOTP is the largest multi-site, cognitive-behavioural sex offender treatment programme in the world. In the 12 years since its introduction, it has developed into an internationally renowned intervention for sex offenders. Results from research into the effectiveness of the programme are only just emerging, but they indicate a positive impact on the reconviction of medium-low and medium-high risk offenders over a two-year follow-up period (Friendship, Mann and Beech, submitted). This is broadly in line with meta-analytic reviews that indicate positive treatment effects for similar interventions (e.g. Gallagher, Wilson, Hirschfield, Coggeshall and Mackenzie, 1999).

The SOTP is a family of cognitive-behavioural programmes, comprising:

- the Core Programme, which aims to meet the needs of medium/high risk, low deviance sex offenders;
- the Extended Programme, for men who have completed the Core Programme, are high risk and have outstanding treatment needs in areas other than those targeted by the Core Programme;
- the Rolling Programme, for low risk offenders, or higher risk offenders who have completed the Core Programme, but need additional work to meet offence related targets to a satisfactory level;
- the Adapted Programme, designed for those who may have difficulty keeping up with the language and literacy skills required by the Core Programme;
- the Booster Programme, for those who have successfully completed the Core Programme and are within 18 months of release.

Staff who deliver these programmes are referred to as facilitators, therapists and treatment providers. Facilitator is the formal designation in the Prison Service, though the terms are used interchangeably throughout this thesis.

The Core Programme is a first-stage treatment programme designed to address the majority of criminogenic factors experienced by a majority of sex offenders (OBPU 2000). It is the most long-established of all the programmes, and it is for the delivery of this programme that a majority of staff have been trained. However, as the family of programmes has developed, many facilitators have been trained to deliver a combination of interventions, though all are required to have trained on the Core Programme before diversifying (see Section 1.2.3).

1.2.1 The Core Programme (CP)

The CP consists of between 75 and 95, two-hour group therapy sessions. Generally, eight men convicted of a sexual offence (or in the case of life

sentence prisoners, a current or previous conviction for a sexual offence), and two to three facilitators make up a group. It is a criterion of the accreditation process (see Section 7.1.4) that both male and female facilitators are represented on each group, and preferably at each session. Facilitators may come from any of the disciplines represented in the Prison Service, and are generally prison officers, psychologists, probation staff, teachers, chaplains, and administrators. Treatment teams are multi-disciplinary, and efforts are made to ensure that at least two disciplines are represented. It is noteworthy that community based and overseas sex offender treatment programmes are generally delivered by specialist staff who have trained as psychologists, therapists, and social workers, and the innovative multi disciplinary team approach is considered unique to HM Prison Service.

The major treatment targets of the Sex Offender Core Programme comprise: group cohesion, increased awareness of risk factors and personal attributes related to offending, re-evaluation of cognitive distortions and pro-offending attitudes, increased understanding of victim harm, and skills practice for more effective interpersonal functioning and offence avoidance (Mann 2001). The process of achieving these targets involves the facilitators motivating group members to recognize their behaviour as a problem, to acknowledge the need for change, to learn and practice alternative ways of thinking and behaving, and to apply alternative thinking and behaviours outside the therapeutic context. The difficulties of working with mandated clients or those who do not enter treatment entirely voluntarily are discussed later, but in terms of the above, it is necessary to appreciate the resistance with which many sex offenders enter treatment, and the particular challenge this presents to facilitators.

Research has confirmed that certain specific treatment methods are the most effective in affecting change in criminal behaviour and attitudes. These methods include modelling, graduated practice, role-playing, reinforcement, concrete verbal suggestion, cognitive questioning, restructuring, self-instructional training, problem solving training and moral reasoning

(Blackburn 1993; Andrews and Bonta 1994). In the Core Programme, different methods are applied at different stages in the treatment process, but three methods are used consistently throughout: cognitive restructuring; reinforcement; and modelling.

1.2.1.1 Cognitive Restructuring

Blackburn (1993) defines cognitive restructuring as the detection of pro-offending beliefs and attitudes through questioning, challenging and debating statements made by offenders, with a view to discriminating wants from needs and redefining overgeneralizations. In the context of the Core Programme, this method is applied to statements possibly used by the individual at the time of his offending to justify his behaviour, those he employed afterwards to defend his actions, and to the underlying attitudes from which these statements are likely to have arisen. Beliefs are then challenged using the principals of Socratic dialogue (Overholser 1993), whereby facilitators are taught to frame their questions in ways that encourage the offender to analyse his responses before answering, working out for himself alternative ways of thinking. Facilitator skill at Socratic questioning is one of the main assessment criteria during training and in supervision. While some facilitators demonstrate a natural ability in this area, for many it requires continued practice and review.

One of the tasks through which cognitive re-structuring takes place requires group members to give an account of their offences, so that they may begin to examine their thinking and behaviour. In preparation for this, facilitators are required to read victim and witness statements which contain considerable detail about the nature of the abuse perpetrated. Statements from children, the elderly and other vulnerable groups, from parents, teachers, carers of abused children, witnesses of violent sexual attacks, all need to be examined to ensure that each group member gives an accurate and honest description of his behaviour. This method also enables facilitators to identify when an offender may be minimizing or denying aspects of the victim's experience. The offender

later explores the victim's experience in more detail when he is required to re-enact his offence from his victim's perspective. Facilitators are then required to "direct" role-plays of an offence, focusing on the details of the abuse and working with the offender to develop a perspective from his victim's point of view and experience empathy as a result. These processes are repeated for all group members, whose offence behaviour and victims will cross a broad range. It is this aspect of treatment provision in particular that exposes treatment providers to the detail of potentially traumatic material.

1.2.1.2 Reinforcement

The use of reinforcement in the Core Programme refers to verbal and non-verbal reward in response to anti-criminal attitudes, honesty in disclosure and progress in skill development. Andrews and Bonta (1994) argue that there must be three elements present for a therapeutic response to constitute reinforcement. These are 1) an immediate statement of approval, 2) an elaboration of why the approval is being offered, and 3) a sufficiently intense expression of approval in order that it can be distinguished from a baseline level of support and interest.

The extent to which therapists practise reward and reinforcement has been significantly related to at least five indices of clinical change in offenders, including a reduction in victim blaming, less denial of harm, responsibility and premeditation, and a reduction in minimization (Marshall, Serran, Moulden, Mulloy, Fernandez, Mann and Thornton, in press). These researchers also found that therapists' reward of group members was strongly predictive of beneficial change in victim blame, minimization and denial of responsibility.

As with Socratic questioning, the ability to give appropriate praise and reward to group members is not a skill that comes naturally to all facilitators. Prison environments are often described and experienced as harsh and unforgiving, where expressions of emotion or caring, perhaps as indicated by positive

reinforcement, may be interpreted as weakness (Coyle 1994). Prison officers, perhaps more than others, describe finding the concept of praise at odds with other aspects of their professional role, which often requires them to be authoritarian and disciplinarian (Pogrebin 1978). Additionally, the concept of praising an individual for admitting previously undisclosed offence detail, for example, might cause facilitators considerable personal conflict.

1.2.1.3 Modelling

The use of modelling as a method of change relates to facilitators' demonstration of anti-criminal attitudes and behaviours. In order for modelling to be meaningful it must be concrete and vivid, verbal and behavioural, accompanied by verbal reference to the rewards of such anti-criminal behaviour, and done in a way that models coping and not mastery (Andrews and Bonta, 1994). Although in essence it should not present a significant challenge for non-offending facilitators, the practice requires them to exhibit substantial attention and vigilance. This is not necessarily a reflection of individual attitudes, but also a consideration of prevalent socio-cultural factors that impact on everyone.

Because sexual aggression is not a prominent feature of all societies, it has been possible to identify features of those societies where the incidence of sexual assault is higher. Such features include the perpetuation of male dominance (Herman, 1991; Otterbein, 1979), lower status afforded to women (Sanday 1981), and the acceptance of violence as a way of solving problems (Marshall and Barbaree, 1990).

One does not have to look far in most western cultures to find examples of these features, and sex offender facilitators cannot be immune to their influence, so it should be expected that among facilitators there will be a range of beliefs and attitudes that to a greater or lesser degree reflect those held by offenders. It is widely accepted that attitude change is one of the hardest to

effect, particularly if the individual has a strong personal investment in the attitude, but it is one that is routinely demanded of facilitators if they are to model the anti-criminal values of respect for others, genuineness, and taking full responsibility for personal behaviour.

1.2.2 *Therapeutic style and group cohesiveness*

Further to the methods outlined above, increasing emphasis has been placed on therapeutic style and group cohesiveness. As early as 1951, the general psychotherapeutic literature sited core characteristics required of successful facilitators, including congruence, unconditional acceptance and empathy (Rogers 1951; Rogers 1961), and continued research indicated group cohesiveness as the single most important factor for successful group psychotherapy (Yalom 1975). It was not until the late 1990's, however, that the therapeutic style of sex offender facilitators became an empirical question (Beech and Mann, 2002).

Beech and Fordham (1997) undertook one of the first empirical studies of therapeutic style in sex offender treatment, looking at community-based programmes. By taking a measure of group climate (Moos, 1986) and examining the clinical change among group members, as evidenced by psychometric assessment, they were able to identify a range of factors associated with successful intervention, which included high levels of cohesion, leader support, independence and order/organization, and low levels of leader control. The converse was true of the least successful group. These results were replicated in a follow-up study of prison based programmes, when cohesion was identified as the most important attribute of the group for successful treatment effects (Beech, Beckett and Fisher, 1998).

Using ratings of video-taped group sessions, and pre and post-treatment psychometric assessment scores of group members, Fernandez (1999) identified a range of facilitator techniques associated with successful

treatment. For example, responsibility-taking by clients was associated with warm, empathic and genuine behaviours on the part of facilitators. Improvements in perspective-taking were related to the facilitators' sincerity and encouragement to participate, and acceptance of future risk was related to non-confrontational challenge and warmth/empathy/ genuineness. Group participation increased when facilitators actively encouraged it, using open-ended questions and challenging in a non-confrontational way. In this instance, successful treatment related to improvement on clinical measures. These findings were replicated in later studies (Marshall et al (a) in press; Marshall et al (b) in press). The enduring nature of these changes and their impact on recidivism still remains unclear.

Mann (2000, 2001) concludes from this range of research and from extensive experience of training and supervising sex offender treatment providers, that facilitator style should be characterized by positive attitudes to clients, a self-evaluating approach to the provision of therapy, an inquiring mind and a warm interpersonal style.

The implications of these findings are significant to this research. The fundamental pre-requisite of empathy, respect and care towards individuals who have caused untold harm to often vulnerable members of society, in order to reflect meaningful change, may require facilitators to manage a range of their own conflicting emotions. Add to this the skills and competencies described earlier, and it becomes easier to recognize why the role of sex offender facilitator exacts very particular therapeutic demands. The significance of empathy is returned to in Chapter Three, Section 3.1.2.

1.2.3 Facilitator selection and training

HM Prison Services' SOTP was, from the outset, designed to be delivered by lay therapists or paraprofessionals (Mann and Thornton, 1998). Whilst this decision was made partly for economic reasons, previous experience of

implementing group work in prisons indicated that professional background was less important than personal qualities in relation to a person's ability to deliver group work. Further, as Mann and Thornton (1998) highlight, the use of prison officers in particular in programme delivery has the added advantage of offenders interacting on a regular basis with non-offending role models.

In order to ensure appropriate selection of both specialists and non-specialists, a comprehensive competency based assessment method was developed (Sacre 1995). These competencies included the following skills: an understanding of cognitive behavioural theory and concepts; application of cognitive behavioural techniques; warmth and empathy; impartiality; clear use of language; flexibility of style; discussion leading and presentation; team working; agenda; giving feedback; questioning; maintenance of boundaries; tenacity; professionalism; preparation; participation and open-coping style; and openness to feedback (Beech and Mann, 2002). Staff assessed as successfully meeting these criteria then attend two weeks (approximately 55 hours) of intensive residential training covering the key skills and methods used in the treatment process. Specialisation in specific programmes could follow this initial course.

Training is assessed with the expectation that some staff would either not achieve the necessary standard to progress to facilitating a programme, or would de-select themselves having gained a greater insight into the treatment process. Throughout the selection and training process, facilitators are encouraged to consider ways in which the content of the work may impact on their personal lives. Any available information, is made freely accessible and a training session is devoted to dissemination and discussion of that information. Update and refresher training is provided throughout the career of the facilitator.

However, as is often the case with simulated training exercises, the reality of working with groups of sex offenders cannot become apparent until actual

treatment is delivered. This highlights the position that often appears to be the case for people working in critical occupations, that emphasis in training is on the provision of technical skills required to meet the demands of the role, and not on the self maintenance skills required to readily comprehend and effectively deal with potential psychological reactions to the reality of that role.

1.2.4 Summary and conclusions

The systematic treatment of sex abuse perpetrators has only been established as a distinct therapeutic service in the past ten to fifteen years, although in that time a number of procedures have been established in HM Prison Service with the aim of maximizing the effectiveness of such interventions. These have included the identification of therapist features that appear to influence successful therapy in terms of clinical outcome and the introduction of systems to improve therapist selection and training.

HM Prison Service's SOTP has treated in excess of 4000 prisoners since its inception, and as it continues to develop and grow, could be treating more than 1000 men per year at 27 sites across the prison system. When these figures are considered in the context of the number of staff who have been trained, a startling trend is indicated. In the past ten years, for approximately every four prisoners treated, one member of staff has been trained. The causes of such a high turnover need to be established, for pragmatic as well as humanitarian reasons. Although it has not been possible to access data regarding cost per person for training SOTP facilitators, there is little doubt that considerable financial investment has been made. Such a high therapist turnover suggests limited return with respect to the number of therapists who remain in the field long enough to develop experience and expertise in an area where such factors are likely to increase efficacy.

Furthermore, if therapist longevity in the field is influenced by traumatic reactivity to the work, then an understanding of the psychological processes

involved would assist not only in protecting and supporting staff in appropriate ways, but also in reducing the potential for organizational contamination through the distress and dysfunction of some staff members.

1.3 The Impact of Working with Sex Offenders: A Review of the Literature

1.3.1 Introduction

Scott (1989) contends that therapeutic intervention with criminals "is the most demanding task in the entire arena of mental health", but while substantial investigation has been undertaken into the impact on mental health facilitators in general (Bermak, 1977; Farber and Heifetz, 1981; Boice and Meyers, 1987), little similar exploration has been done in the forensic field, and even less in the very specific area of sex offender treatment. In fact, in the context of research into the treatment of sex offenders as a whole, the impact on facilitators is generally agreed to be a neglected area (Ellerby, 1998). In the past five to ten years a growing body of international research has evolved which begins to redress the balance, a critical shift if it is accepted that the future of effective sex offender treatment is contingent on the psychological well-being of the treatment providers (Abel, 1983).

1.3.2 Stressors of the client population

As highlighted in the introduction to this chapter, there appears to have been a pervasive acceptance that working with sex offenders has a detrimental effect on therapists (Ryan and Lane, 1991), possibly attributable in part, to the nature of the individuals with whom therapists work. Certain features of difficult populations to whom therapeutic services are provided have been consistently identified as significant sources of therapist stress. In broad terms, they include working with apathetic or unmotivated clients (Farber and Heifetz, 1981;

Deutsch, 1984), mandated clients (Strasburger, 1986; Steenson, 1987), and clients with personality disorders (Deutsch, 1984; Hellman, Morrison and Abramowitz, 1987). Types of client behaviour that therapists have identified as most stressful include expressions of aggression and hostility, lying, extreme client dependency, suicidal gestures and passive-aggressive behaviour, all of which are often the norm rather than the exception among incarcerated populations. Client features perceived to be beyond the capacity of the service provider, specifically chronicity, acuity and complexity, are considered to be strongly associated with the symptoms of burnout (Figley, 1995).

It is generally agreed that sex offenders present with a unique set of features which distinguish them not only from the larger mental health population, but also from the criminal population of which they are a part (Ellerby, Gutkin, Smith and Atkinson, 1993; Edmunds, 1997). For example, sex offenders engage in sexually deviant behaviours that are stimulating and pleasurable to them. Some are blocked from acceptable sexual outlets and choose a deviant outlet over no outlet at all. Nearly all are secretive about and protective of those behaviours, and are resistant to exploration, discussion or change, preferring to deny, minimise, rationalize and justify their behaviour (O'Connell, Leberg and Donaldson, 1990). Client resistance and denial are often cited as sources of stress for facilitators (Ellerby, 1993; Turner, 1992).

Added to this, sex offenders rarely enter treatment programmes voluntarily (Ellerby, 1997). Incarcerated sex offenders may perceive their involvement in treatment as a means to early release, rather than as a way to effect personal change, and consequently present as unmotivated, resistant, deceptive, manipulative, angry, hostile and controlling.

In this context, treatment efficacy has been identified as an area of continued concern for many facilitators. With research suggesting that sex offenders may be at risk of recidivating for between 10 to 31 years after release (Hanson, Steffy and Gauthier, 1992), no definitive conclusion about offender recovery is possible. Pithers, Marques, Gibat and Marlatt (1983), emphasise treatment is

not "cure" and that sex offenders need to embark on a life-long process of self-monitoring and self management if they are to avoid re-offending.

A client population presenting features such as these, gives rise to particular challenges, and it perhaps becomes more obvious why the skills and qualities of facilitators, described earlier in this chapter, are central to effective intervention. It also emphasizes the need for comprehensive supervision and training, lack of which serve as another potential source of stress (Ellerby, 1998).

1.3.3 Organisational stressors

Of facilitators surveyed by Ellerby (1993), over two-thirds described themselves as poorly prepared to work with sex offenders, and only 18% received appropriate supervision from a mental health professional with forensic experience. Plyer, Woolley and Anderson (1990) reported similar findings with three-quarters of respondent clinicians who provided treatment to incest offenders having no offender-specific training. In a recent case brought against HM Prison Service by two prison officer facilitators, lack of supervision was cited as one of the causes for the onset of Post Traumatic Stress Disorder (PTSD).

Further organisational issues thought to moderate facilitators' experience of delivering treatment include organizational politics, support of colleagues and financial matters (Ellerby, 1998). Ellerby found that organizational issues such as internal politics, administrative and collegial support were the best predictors of personal depletion, characterised by emotional exhaustion (Maslach and Jackson, 1981) and compassion fatigue (Figley, 1995), and depersonalisation as measured by the Maslach Burnout Inventory (MBI - Maslach and Jackson, 1981). The concept of burnout is discussed more fully in Section 1.4.2.

Further examination of collegial support found it to be the single most important predictor across all variables (practice, facilitator and offender variables) for the experience of high levels of personal accomplishment, again as highlighted by the MBI (Ellerby, 1998). This result recurs in both general therapy and trauma therapy literature (Farber 1983; Pearlman and Saakvitne 1995a; Pearlman and Saakvitne 1995b; Rich 1997), indicating that the support of colleagues is strongly connected to job satisfaction and reduction in personal distress. However, the need for social support among prison officers might also be considered admittance of incompetence, and thus far from ameliorating stress, may in fact exacerbate it (Schaufeli and Peeters,2000). The issue of collegial and social support is returned to in Chapter Seven.

Ellerby (1998) found that facilitators practising in institutional settings reported higher levels of MBI measured depersonalisation, while community providers experienced a significantly greater sense of personal accomplishment. This finding supports similar results in the mental health system (Farber and Heifetz, 1981), where clinicians working in the community experienced lower levels of distress than their counterparts in institutions.

The increased distress and depersonalisation experienced by facilitators in institutions is perhaps not surprising, given the characteristics of the setting and the work. For example, there is likely to be more regular contact with clients who have a greater degree of psychopathology, in a context where there is little organizational or personal support, and a milieu that is often punitive and anti-therapeutic (Ellerby, 1998).

Community reaction to sex offender treatment has also been highlighted as a cause of dissonance for facilitators, often resulting in increased defensiveness (Freeman Longo, 1997; Jackson, Holzman and Barnard, 1997). Accusations have been levelled at facilitators that too little is done for *victims* of sexual offences and that working with sex offenders equates to acting as protective advocates. The paradox for sex offender workers is that they are typically motivated in their work by facilitating a reduction in sexual abuse and

preventing future victimization, in an attempt to protect the very community that has often vilified them.

This may be further compounded by facilitators' reluctance to discuss their work with those other than colleagues, perhaps believing they would not understand, concerns about confidentiality, through tiredness (Jackson et al, 1997), or for fear of alienating or contaminating them in some way. The likely result is a sense of alienation that gives rise to defensiveness, further isolating the sex offender facilitator.

1.3.4 Stressors related to work content

It would be unlikely, given the range of features identified as potential stressors, for facilitators to remain unchanged by their experience of treatment provision, and unsurprisingly, there has been consistent identification of a range of psychological symptoms among facilitators that have been directly attributed to the content of their work.

For example, continual exposure to sexually explicit and deviant material and a detailed knowledge of the incidence and prevalence of sexual abuse, combined with an understanding of the logic, rationale and modus operandi of offenders, would be likely to exacerbate facilitators' fears about personal vulnerability. As Ryan and Lane (1991) contended, in this case fear of the known may be greater than fear of the unknown. Awareness of the risks sex offenders pose to society may over-sensitise facilitators to violence and explicitly sexually exploitative influences in the culture (Ryan and Lane, 1991). Given the previous observations about the characteristic features of societies with a prevalence of sexual abuse, such awareness may be overwhelming.

1.3.5 Symptomatology

One of the earliest systematic studies of the effects on facilitators of working therapeutically with sex offenders was conducted by Farrenkopf (1992). Following pilot interviews with prison based facilitators, he generated a survey covering personal impact of working with sex offenders, perceived phases of impact, gender differences, personal coping strategies and demographic information. This was then sent to mental health workers known to work with sex offenders. Over half the total respondents (n=24) reported a shift in their perspective, diminished hopes and expectations in their work, and greater cynicism. Many disclosed a hardening or dulling of emotions and almost one-third felt more hyper vigilant and suspicious of others. Generalised stress, exhaustion, depression or "burnout" were reported by a quarter of respondents.

Farrenkopf (1992), proposed a "Phases of Impact" model, identifying stages of adjustment experienced by facilitators encountering sex offenders on such a personal level. Phase One, he argued, was characterized by feelings of fear and vulnerability. Phase Two he called the "Mission" phase, characterized by the facilitators' adaption, desire to help clients and a professional zeal for treatment effectiveness. Repressed emotions, feelings of anger, a confrontative attitude and intolerance surfaced at Phase Three (Yochelson and Samenow 1976), as facilitators' idealism became challenged by inevitable re-offence incidents, offender denial, victim-stancing and abusiveness. These emotions became amplified in Phase Four, "Erosion", where anger and intolerance mounted to a sense of resentment, futility, exhaustion and depression, perhaps leading to depersonalisation.

One-fifth of Farrenkopf's (1992) sample stopped working with sex offenders at this point. One participant described her phase progression as: "First 'save the world' then 'save a few', then 'save yourself'". Farrenkopf proposed that the alternative to "Erosion" was "Adaption", where facilitators began to regain their motivation and therapeutic compassion by adopting a more detached

attitude and lowering their expectations. He did not hypothesize about the processes or factors involved in this shift, or suggest why some facilitators, and not others, may have adopted a more detached style. However, the clear implication was that a detached style of coping allowed facilitators to continue in their work with reduced negative impact. This may be critical to the future of facilitator well being and will be considered in more detail in Section 1.3.7 of this chapter.

Turner (1992) undertook the first substantial piece of research in the Prison Service, just two years after the introduction of SOTP. Based on the outcome of a focus group involving seven experienced staff, he devised a questionnaire that included open and closed questions referring to the individual's experience of running the Core Programme. The questionnaire was distributed to all trained facilitators (197 in 1992), with a response rate of 42%. Following analysis of the returned data, Turner conducted 10 in-depth interviews that were recorded and transcribed. The transcripts were content analysed and systematically coded with reference to themes identified in the questionnaire.

The results indicated that an overwhelming majority of the sample (96%) reported that facilitating on the Core Programme was a positive experience, resulting in a sense of achievement in their work. However, this was set against a backdrop of disturbing psychological symptoms.

Some therapists reported finding group work difficult and progress slow, resulting in loss of confidence in their own effectiveness as therapists. Some found they were distancing themselves from certain offenders and feeling angry with group members, whilst not knowing how to manage that emotion. Mann (1998) suggested this reflected the difficulty of striking a balance between being supportive but not collusive. Unresolved aspects of therapists' own abuse also appeared to come to the fore as a result of facilitating treatment. Interestingly, adverse effects did not appear to be related to professional background.

A third of respondents with partners felt their relationships had been affected, to the extent that in two cases, relationship breakdowns were directly attributed to involvement in SOTP. Forty percent of those with children felt that being involved with the programme had affected their relationship or behaviour with their own children in some way, such as becoming over-protective or limiting their children's activities outside the home. Some facilitators reported feeling self-conscious about their own behaviour with their children and felt concerned about whether this had hidden meaning. Some felt no longer able to engage in physical play with their children, and some found themselves thinking about sexual abuse of children to such an extent that they worried that it might suggest they were turning into abusers themselves.

Of respondents who felt they did not receive adequate support in their SOTP work (40%), most worked in establishments where there was little or no formal support. There was a general feeling that managers had very limited understanding of the impact on staff, with one respondent describing middle and senior managers as "bystanders". Respondents had little or no time for debriefing after therapy sessions and over two-thirds of facilitators received only half an hour or less supervision per week.

Around a quarter of the sample found reading about or listening to details of the offences to be traumatic. Managing offenders' denial was particularly difficult. Some reported ruminating on the details of offences to the point that they became the subject of dreams/nightmares. Turner (1992) concluded that individual life experience and psychological make-up would influence the extent of psychological impact on facilitators, but did not expand on this area or hypothesise about the processes involved.

Jackson et al (1997), using a method similar to that employed by Farrenkopf (1992), sampled 98 facilitators drawn from membership of ATSA (The Association for the Treatment of Sexual Abusers), a North American organization for sex offender treatment providers, and reported observing a

wide range of burnout reactions.

They found many respondents (67%) experienced visual imagery about sexual violence, which they found either: "painful and disturbing", (21%); "repulsive" (19%); and/or "arousing" (1%). Twenty eight per cent reported a combination of these reactions. Facilitators also reported changes in their own sexual behaviour (48%), and changes in their behaviour around children (57%), which they attributed directly to their experience of working with sexual abusers. Over half the respondents (54%) expressed fear for their own safety.

Edmund's (1997) study of 176 facilitators also identified symptoms associated with burnout. She found that 29% of respondents reported an overall increase in emotional, physical, and psychological symptoms, including fatigue and frustration, cynicism, sleep disturbances, general irritability, difficulty making decisions, depression and/or depressive episodes.

Ellerby (1998) conducted possibly the largest study in the field to date, when he sampled 686 ATSA members. Responding to the shortcomings of previous research in terms of the lack of use of standardized measures, Ellerby employed the MBI, the Compassion Fatigue Self-Test (Figley, 1993), the Personal Resources Questionnaire (Osipow and Spokane, 1981), and demographic information, in an attempt at a more reliable assessment of the breadth and depth of impact on facilitators. Interestingly, he failed to find conclusive support for the presence of "burnout". Although he reported high depersonalisation scores (the dimension measuring indifferent, cynical and impersonal attitudes towards clients) he also noted high levels of personal accomplishment, a factor inversely related to burnout.

Kadambi (2000), like Ellerby (1998), noted higher than expected scores on the depersonalisation subscale of the MBI, compared with other mental health professionals. She argued that this may have been indicative of a coping style, suggesting that the development of attitudes and beliefs that depersonalised the client may have served to neutralize the toxicity of the graphic and violent

material presented in therapy. She also supported Ellerby's findings with respect to a substantial elevation on the personal accomplishment scale of the MBI, indicating that acceptance of burnout as a consequence of therapeutic intervention with sex offenders could be misleading.

Other researchers, such as Hill (1995), attributed the experience of depersonalisation to the interaction between the offender, society and institutional mandates that produced a unique pattern of engagement and disengagement between the facilitator and the offender throughout therapy. This, in turn, disrupted the process of empathic engagement, resulting in a sense of disconnection between facilitator and offender, which then depersonalised the facilitator's experience of the offender. Such a psychodynamic approach to understanding the process of depersonalisation had some advantages in that it considered the interaction between a range of factors highlighted by a number of researchers (e.g. Ellerby, 1998).

1.3.6 Personality variables associated with the process of adaptation

It is evident from the research presented so far, that considerable effort has been made to identify sources of stress, and that attention has generally been focused on external variables with immediate face validity in terms of explaining facilitators' complex emotional reactions to their work. It is also apparent that current research has extended only to describing these emotional responses, without investigating alternative aspects of their aetiology. Specifically, the area that has been largely neglected is the influence of facilitators' own psychology in the interaction between the client, the treatment process, the practice setting and the community.

The only research to have focused on the role of personality variables in the experience of facilitators was undertaken by Myers (1995). Although limited in scope by its being part of undergraduate qualification, it has contributed significantly to the ways in which the Prison Service has responded to greater

understanding of the potential damage to facilitators experienced in the course of their work.

Myers (1995) developed Turner's (1992) work by utilizing the Emotion Control Questionnaire (Roger and Najarian, 1989) as a method of considering individual differences among facilitators. She also incorporated the Coping Styles Questionnaire (CSQ) as a measure of coping, (Roger et al, 1993), and assessed the impact of facilitating on physiological health through use of the General Health Questionnaire (GHQ -Goldberg 1978). These measures were used in addition to Turner's (1992) original survey, and in-depth interviews with six participants. A further improvement was the introduction of a control group of non-SOTP staff.

Myer's (1995) results generally supported and elaborated upon Turner's from 1992. For example, a majority of staff (87%) reported finding undertaking treatment work with sex offenders a positive and rewarding experience. But again, the psychological impact of the work was also highlighted and in this research, substantiated by independent measures.

Of particular interest was the extent to which facilitators replayed details of offences (ruminated) and experienced intrusive thoughts. These occurrences feature prominently in facilitator accounts across the literature (e.g. Turner, 1992; Edmunds, 1997; Bengis, 1997). Myer's research provided the first empirical evidence that sex offender treatment providers experienced these phenomena to an extent which was of greater statistical significance than non-treatment providers. A number of authors have suggested that inhibiting or continuing to ruminate over emotional distress might contribute to delayed recovery [from stressful events] (Cameron and Meichenbaum, 1982). It is, therefore, imperative that further consideration is given to this in the context coping with the impact of the work (see section 1.3.7).

The methodological shortcomings of Myer's (1995) research negate the otherwise innovative approach. The sample of 45, only 22 of whom facilitated

the SOTP, means that statistical inferences may be unreliable. This is exacerbated by participants' scores being assessed against student norms, and the results from the psychometric measures being poorly utilized e.g. pooling data to compare scale scores, with insufficient emphasis on group differences. Further, as Myers highlights, the sample was drawn from the same establishment, preventing meaningful generalization of the results.

Despite this, as a survey of the impact on staff, Myer's (1995) research both supported the findings of the previous investigation, and provided some additional evidence about the nature of the impact on facilitators.

1.3.7 *Factors implicated in the process of adaptation to therapeutic work with sex offenders*

Bengis (1997) suggested that eventually most facilitators would find themselves having to cope with distressing, repetitive imagery containing feeling and meaning for them. He proposed that although it was not necessarily frightening or negative, the mere presence of such imagery could be disturbing, because it appeared to come from nowhere. It was also clear that the risk of increased time thinking about work (e.g. Ellerby, 1997) intrusive visual imagery (e.g. Jackson et al, 1997; Rich, 1997), increased vulnerability (Ellerby et al, 1993) changes in sexual behaviour (e.g. Farrenkopf, 1992) and rumination (Myers, 1995) was ubiquitous among sex offender treatment providers. Bengis proposed that finding healthy, creative and integrative methods of dealing with such effects was one of the challenges that facilitators faced.

The existing literature lacks systematic investigation into how individual differences may ameliorate or exacerbate these experiences, both in terms of the likelihood of their occurrence, and methods adopted for coping with them. So far, any analysis of the influence of personal characteristics on differences in impact and coping among sex offender treatment facilitators has stressed the importance of demographic details such as age, qualifications, years of

experience, marital status, profession, personal experience of sexual abuse and so on.

For example, Ellerby (1998) reported that younger therapists were at greater risk of emotional exhaustion, depersonalisation and compassion fatigue than older, more experienced colleagues, a finding replicated in the trauma field (Boice and Meyers, 1987; Arvay and Uhlemann, 1996). He also noted that clinicians with higher educational levels experienced a greater sense of personal accomplishment. Although contrary to the findings of other researchers such as Pearlman and MacIan (1995), he did not find educational level to be associated with burnout.

Some researchers have indicated that time spent working directly with sex offenders has a significant impact on levels of job-related distress (e.g. Edmunds, 1997), while others have failed to support this finding (e.g. Ennis and Horne, 2003). Experience in the field has also been identified as relating to distress, with those very new to the field apparently most at risk from symptoms such as secondary traumatic stress (STS), and those with between two and five years least at risk (Steed and Bicknell, 2001).

Professional status has been identified as associated with stress (e.g. Arvay and Uhlemann, 1996), with lower status professionals experiencing higher levels (Farber and Heifetz, 1981). Ellerby's (1998) findings suggested that facilitators who did not identify themselves as mental health professionals, but rather criminal justice workers, experienced higher levels of emotional exhaustion and depersonalisation, were at greater risk from burnout, and experienced lower levels of personal accomplishment. Ellerby argued that this might be a reflection of insufficient training, working within an unfamiliar theoretical framework, or the perception that therapists, psychologists and psychiatrists held a higher professional status. Somewhat surprisingly, gender and parenthood did not prove to be significant factors in experience of distress in this study.

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The somewhat equivocal nature of the findings regarding factors implicated in adaptation to the work, suggests the interplay of another, so far neglected factor, the individual therapist's psychological constitution; and in terms of coping with these effects, consideration seems only to have extended as far as use of behavioural strategies, tied into the social context, such as increased supervision, entering therapy, and pursuing recreational activities, with a very few researchers (e.g. Farrenkopf, 1992; Jackson et al, 1997) citing the role of individual psychological resources, such as a detached coping style.

Lazarus and Folkman (1984) defined coping as an individual's evaluation of whether they possessed the physical and/or psychological resources to enable them to deal with harm, threat or challenge posed by an event. In the context of sex offender treatment, the event may be defined as prolonged exposure to sexually deviant material, presented by frequently resistant individuals in a punitive environment. The atypical nature of such exposure meant that facilitators may not always have been able to draw on previous learning, training or experience, even when they were involved in the work for some time (as supported by Turner's (1992) research), in order to understand elements of their work, or their reaction to them.

While it would not be appropriate to suggest that one coping strategy would be effective for all individuals in all circumstances, the role of emotional detachment is the one recurring psychological strategy in the sex offender impact literature likely to affect functional adaptation to the work. Roger et al, (1993) defined detachment as the feeling of being independent of a stressful event and the associated emotion. This construct was inversely correlated with emotional coping (Roger et al, 1993), which was previously been identified as problematic in the management of occupational stress (Hart et al, 1995). Furthermore, it has been positively correlated with rational, or problem-focused coping styles, considered indicative of psychological well being (Cohen and Hoeberman, 1983; Diener and Emmons, 1985; Headey and Wearing, 1992).

Some personality characteristics, such as those related to coping resources, have been found to help people resist the deleterious effects of stress, but efforts to ascertain the moderating role of personality between stress and illness have been equivocal (Steptoe, 1983). Roger and colleagues (Roger, 1988; Roger and Jamieson, 1988) suggested that individual differences in emotion control patterns, particularly the degree to which individuals mentally rehearse or ruminate, might serve to either prolong or attenuate physiological recovery from stress.

The lack of adequate measures of emotional style led Roger and colleagues (Roger and Najarian, 1989; Roger, 1995) to construct a new scale entitled the Emotion Control Questionnaire (ECQ). Developed specifically in the context of stress research, it comprised four empirically discriminable factors labelled rehearsal, emotional inhibition, aggression control and benign control. The rehearsal scale considered the tendency to ruminate about emotional upset, and has been shown to have highly significant relationships with scores on a variety of physiological indices of adaption, including: heart-rate recovery and prolonged elevations in urinary-free cortisol secretion following exposure to stress (Roger, 1988; Roger and Jamieson, 1988); differences in analgesic demand in peri-natal women (Nieland and Roger, 1993); and anger management among prisoners (McDougall, Venables and Roger, 1991).

The aggression control and benign control scales of the ECQ do not appear to be implicated in the stress process. Emotional inhibition, however, while not making a significant independent contribution to the dependent variables in the physiological studies described above, is statistically orthogonal to rehearsal, and high scores on both factors showed the greatest effects in supplementary two-way analysis of variance. This factor describes 'bottling up' or inhibiting the expression of experienced emotion.

Rumination and a reluctance to express personal distress, whilst not elucidated in an emotional style framework in the sex offender therapists' impact literature, have been cited by a number of researchers as implicit in facilitators'

experience of distress as a result of their work, so it is clear that comprehensive measurement of emotional response style is required in addition to consideration of the demographic variables described previously.

1.4 Conceptualisations of the Impact on Therapists

It becomes apparent from reviewing the available literature, that the way in which working therapeutically with sex offenders impacts on therapists' well-being has been conceptualised in a variety of ways. Indeed, Stamm (1997, p.5), after an extensive review of the trauma literature, commented, "The great controversy about helping-induced trauma is not, can it happen, but what shall we call it?". Stress, burnout, vicarious trauma, secondary traumatic stress and compassion fatigue have all been used as over-arching terms to encapsulate the symptoms described by sex offender treatment providers.

The following sections provide a brief explanation of each of these concepts, together with a critique of their applicability to sex offender treatment providers.

1.4.1 Stress

The concept of stress has become the dominant term for uniting a range of related concepts that reflect the adaptional problems imposed by the pressures of daily living (Lazarus,1999). For example, emotional distress, conflict, anomie, frustration, depression and trauma, all appear to have been brought together under the rubric of stress. In the work setting, psychological stress is a phenomenon that has captured the imagination and interest of a diverse range of professionals in recent decades. Lazarus (1999) contends that a major reason for this is the abundant evidence, provided by stress research and theory, that it is important for our social, physical and psychological health.

It is beyond the scope of this thesis to provide a comprehensive review of the literature on stress. For example, a computer-based search of the literature using PsychInfo alone yielded over 4,800 references to occupational stress, published between 1991 and 2001. However, consideration of specific aspects of the occupational stress research is clearly necessary. The definition of stress widely used in the occupational field and accepted as pertinent for the purposes of this thesis, is a relational one proposed by researchers such as Cox (1978; 1985; 1990), Levi (1987) and Weiner (1989) and adopted by the Health and Safety Executive, as an adverse reaction to excessive pressure or other types of demand placed on an individual. This definition considers the relationship between the demands, either environmental (external) or psychological (internal), and the resources that an individual possesses to cope with them, either psychologically or environmentally. Stress is the psychological state that occurs when there is an imbalance between demands and resources in any sphere. More precisely, Roger (2002) defines stress as the preoccupation with emotional upset in response to events or situations. The applicability of these definitions to the current research is the incorporation of individual differences as central to stressful responding.

In the occupational setting, stress has been researched in groups as diverse as offshore oil installation workers (Chen et al, 2001) teachers (Pithers and Fogarty 1995; Guglielmi et al, 1998), retail workers (e.g. Broadbridge et al, 2000), medical workers (Swanson et al, 1998; Clegg 2001), mental health service providers (Hiscott and Connop 1989), correctional officers (Digman, Barrera and West, 1986) trauma workers (McCann and Pearlman 1990), and members of the police force (Hart et al, 1995; Brown et al, 1996). For the purposes of the current review, stress in relation to prison and police officers will be considered.

1.4.1.1 Prison Officer Stress

The prevailing opinion among professionals and lay persons is that working in

prisons, particularly as a prison officer, is stressful (Schaufeli and Peters 2000), an opinion supported by empirical evidence regarding behaviours considered indicative of stress in the occupational setting. For example, the turnover rates among prison officers is alarmingly high, with a rate of between 16.2% and 38% across American states (Corrections Compendium, 1996), and up to 50% in the first 18 months in Israel (Shamir and Drory, 1982). Although such high rates may be indicative of ineffective selection criteria, this would not necessarily explain the rate of absenteeism among prison officers that, in some places, is 300% higher than the average rate of similar occupations (Cheek and Miller, 1983). Verhagen (1986), in a study of Dutch prison officer absenteeism, established that about one-third was stress related. The incidence of psychosomatic disease has also been found to be more common among prison officers when compared with other occupations, including police officers - a comparable profession (Cheek and Miller, 1983). For example 17% of prison officers had visited their physician for hypertension in the six months leading up to a United States survey, compared with 10% of police officers and 9% of other professions. Similar results were found in a Swedish study (Harenstam, 1989), which indicated that prison officers not only had higher blood pressure than comparison groups, including physicians, engineers, traffic controllers and musicians, but also higher levels of the stress hormone cortisol.

The causes of such stress related reactions have been attributed to such factors as, among others, high workload (Digman et al, 1986; Koomer, 1990), lack of autonomy (Karasek and Theorell, 1990; Schaufeli et al, 1994), lack of variety (Hughes and Zamble, 1993), role problems (Philliber, 1987); Koomer, 1990; Shamir and Drory, 1982; Digman et al, 1986), demanding social contacts (Harenstam et al, 1988); Digman, et al, 1986) and health and safety risks (e.g. Shamir and Drory, 1982; Philliber, 1987).

In relation to the current research, the significance of variety, role problems and demanding social contacts are of particular interest, especially as over half of HM Prison Service's sex offender treatment facilitators are prison officers. For example Schaufeli and Peeters (2000) noted that task variety for prison

officers had been reduced in recent years by the influx of new treatment professionals taking over part of the traditional role of officers. Whilst this is unlikely to be an issue for officers involved in treatment programme delivery, there is some evidence that employment in a therapeutic role might exacerbate the experience of role ambiguity and conflict. This feature was identified in a number of studies (Digman et al, 1986; Lindquist and Whitehead, 1986; Lombardo, 1989; Myers, 1995) and was obviously an issue for officer therapists. Schaufeli and Peeters (2000) contended that role problems were aggravated not only because of the conflicting demands of guarding prisoners while simultaneously facilitating their rehabilitation, but also because description of the objectives of rehabilitation was often vague. Contrary to this was the finding that when social contact with prisoners was perceived as positive, arguably a central feature of rehabilitative interactions, feelings of personal accomplishment increased.

Beyond contact with prisoners, social contact has also been investigated in relation to peers and superiors. Poole and Regoli (1981) argued that development of group loyalty and collegiality among prison officers was weak, because of the emphasis on individual rather than team responsibility, leading to the formation of an individualistic culture in which asking for social support was considered to be an expression of incompetence (Schaufeli and Peters, 2000). This assertion was supported, at least anecdotally, by reports from officer therapists that they became increasingly distanced from their non-therapeutic colleagues and perceived in them a lack of understanding of their role (Turner, 1993).

Results concerning social support and stress reduction in prison officers have been equivocal. As in many occupations (for overviews see Warr 1987; Buunk, de Jong, Ybema, de Wolff, 1998), social support of colleagues and supervisors has been found to reduce prison officer stress (Dollard and Winefield, 1985). However, Peeters et al (1995) found that social support did not lead unconditionally to a positive affect among a group of Dutch prison officers, a finding supported by other studies (Grossi and Berg, 1991; Morrison, Dunne,

Fitzgerald and Cloghan, 1992). This may be explained in part by Forbes and Roger (1999), who in an examination of individual differences in the capacity to self-disclose, found that individuals reported less satisfaction with perceived emotional support if they had a greater fear of disclosing emotionally upsetting information. Individual differences in ability to self-disclose will be returned to in later parts of this thesis.

Across the literature examining prison officer stress, lack of consideration of individual differences has been a fundamental shortcoming. A comprehensive review of over 40 studies in this area, provided by Schaufeli and Peeters (2000), highlights a range of strains and stressors experienced by officers, but there is no appraisal of the role of individual differences in moderating those factors. For example, pertinent to this research is the response of prison officers to the introduction of therapeutic interventions for prisoners. Though there is empirical evidence that some may find it a stressful invasion on their professional role (as highlighted above), there is also anecdotal evidence, specifically in the British system, that many staff respond positively to opportunities to diversify their role (Turner, 1992). The variables distinguishing these two groups remain unresearched.

Furthermore, whilst prison officers constitute the biggest group of staff in prisons, and indeed among sex offender facilitators, no research was identified that considered the stresses on other disciplines of staff working in the prison environment. So the extent to which the role is stressful, versus the environment in which that role is performed, remains unclear.

1.4.1.2 Police Officer Stress

The issue of individual differences in the context of stress responses has been more thoroughly researched among police officers. It is generally believed that policing is inherently stressful because of the dangerous and unsavoury tasks that are part of everyday police work (Sigler and Wilson, 1988). However,

Terry (1981) contended for that to be the case, police officers should report less favourable levels of psychological well being in comparison with other occupational groups. Results of the few comparative studies that have been conducted in this area have been equivocal (Anson and Bloom, 1988; Hart et al, 1993).

Hart et al (1995), investigated the psychological well being of police officers within a Perceived Quality of Life (PQL) framework, drawing on the dynamic equilibrium theory of stress proposed by Hart et al (1993). The authors argued that conceptual and methodological problems in previous research left a paucity of information about the extent to which policing is stressful, or about the factors that determine perceived quality of life among police officers.

By integrating the dynamic equilibrium theory with Lazarus and Folkman's (1984) transactional model of stress, they sought to examine the continual interplay between coping strategies and daily work experiences (Lazarus and Folkman, 1984). Their contention was that this addressed the deficits of previous research, by predicting that enduring personality characteristics such as neuroticism and extraversion, would determine, to a large extent, police officers' patterns of daily work experiences, use of coping strategies and levels of psychological well being.

Indication that personality characteristics were the strongest determinants of distress and well-being were provided by Hart et al's (1995) results. In particular, these supported a growing body of evidence suggesting that neuroticism, emotion focused coping, adverse life events and psychological distress tended to correlate with each other, and that these correlations were independent of those typically found between extraversion, problem-focused coping, beneficial life events and well-being (Costa and McCrae, 1980; Warr et al, 1983; Costa and McCrae, 1985; Hart et al, 1993; Hart 1994; Hart et al, 1994).

The finding that beneficial and adverse experiences operated orthogonally, Hart et al argued, supported the need for consideration of both positive and

negative experiences when trying to determine the causes of psychological well-being. This aspect of occupational stress research has also been emphasised in the trauma literature, by researchers such as (Stamm, 2002), who argued that it is not possible to understand the negative aspects of work involving caring, without also knowing about the positive.

A second important finding from Hart et al's research was that organisational rather than operational experiences appeared more important in determining distress and well-being, a finding replicated in teacher stress research, suggesting that the organizational context of teaching is more distressing than the actual job itself (Borg, 1990; Hart, 1994; Hart et al, 1995). However, what has not been elucidated from such research is the role of individual differences in the attribution of distress to organizational or operational factors, a significant omission if it is accepted that individual differences are central to predicting individual responses to operational and organizational events.

Hart et al (1995) provided a clear and comprehensive framework for investigating distress and well-being in workers required to operate in potentially stressful and demanding situations. But as with the research into prison officer stress, their work lacked a longitudinal component, creating difficulty in making causal inferences about the aetiology of the distress they identify, and so making the recognition of individual differences a less reliable predictor of stress responses.

Although the concept of stress provides a broad account of negative effects resulting from an imbalance between demands on the individual and resources to manage these demands, it is argued that to conceptualise sex offender therapists' experiences in this way oversimplifies the issues, particularly if it is accepted that treatment provision constitutes a critical occupation, given the extent of the demands placed on the individual.

1.4.2 Burnout

Perhaps because of Farrenkopf's (1992) early conclusions regarding the prevalence of burnout symptoms among sex offender therapists, the concept appears to have become the predominant focus for researchers in the field. This is evident not only in the regular adoption of the term in the SOTP impact literature (e.g. Kadambi, 2000; Edmunds, 1997;), but also in the widespread employment of the MBI (Maslach and Jackson, 1981) to assess the level of the occupation's impact. Given what is understood about the nature of such work, and the emphasis that the burnout concept places on the characteristics of the stressor, i.e. that distress is a result of the nature of the external event (McCann and Pearlman, 1990), it is perhaps easier to see why it has such intuitive appeal for researchers in the field of sex offender facilitator well-being. Ryan and Lane (1991) noted with interest that the risk of "burnout" was recognized much more readily than the pervasive and insidious effects of the work that changed the individual's life in less obvious but more permanent ways.

Over the past 25 years, the concept of "burnout" has emerged as a distinct theory in the occupational stress literature, generating an entire field of research dedicated to its explication and measurement, receiving considerable attention in the general mental health literature in particular. For example, Figley (1995) highlighted a 1993 literature search of *Psychological Abstracts,* which located 1,100 relevant articles and over 100 books written since the term was first coined by Freudenberger (1974).

According to Maslach and Schaufeli (1993), burnout could be considered as prolonged job stress. Demands in the workplace tax or exceed an individual's resources. Brill (1984), in distinguishing between stress and burnout, defined the former as a temporary adaption process accompanied by mental and physical symptoms, and the latter as a breakdown in adaption, accompanied by chronic malfunctioning.

Burnout was defined by Maslach and Jackson (1986) as "a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that could occur among individuals doing 'people work' of some kind" (p.1). This definition was derived partially from the development of a measure of burnout called the Maslach Burnout Inventory (MBI; Maslach and Jackson, 1981), a three-dimensional scale comprising *emotional exhaustion*, referring to feelings of being emotionally overextended and depleted of one's emotional resources, *depersonalisation*, referring to a negative, callous, or excessively detached response to others (usually the service recipients) and a *reduced sense of personal accomplishment*, referring to a decline in feelings of competence and successful achievement in one's work.

The incorporation of the latter two dimensions, Maslach (1993) argued, differentiated burnout from stress. She posited that a reduced sense of personal accomplishment reflected a critical element of self-evaluation in the stressful context, and depersonalisation focused on interpersonal relationships, consequently placing the exhaustion element in a relational context. On this basis, it is clear why researchers in the field of sex offender treatment provision have focused, almost exclusively, on the prevalence of burnout symptoms among treatment providers.

Furthermore, in describing the operational and personal costs of burnout, Maslach and Jackson (1986) identified high job turnover, absenteeism and low morale as key indices, together with self-reported personal dysfunction, including insomnia, physical exhaustion, marital and family problems and increased use of alcohol and drugs, all of which have featured prominently in accounts of sex offender treatment providers who have felt damaged by their work.

A consistent finding in the more recent research into sex offender therapist well-being is that facilitators experience high levels of job satisfaction and personal accomplishment, despite the existence of a range of other distressing symptoms (Edmunds, 1997; Ellerby, 1999; Kadambi, 2000; Kadambi and

Truscott, 2003; Myers, 1997; Rich, 1997; Turner, 1992;), clearly contrary to a diagnosis of burnout.

Kadambi and Truscott (2003) identified seven key areas in which sex offender treatment providers found reward and meaning in their work. These included what the authors termed protection of the public, socially meaningful curiosity, enjoyment of counselling, professional benefits, connection to colleagues, offender wellness and change, and offending specific change. Of these, protection of the public was the theme rated most highly in therapists' perceived benefits of the role, followed by offender change and wellness and connection to colleagues. Kadambi and Truscott concluded that focusing more attention on the rewards and satisfaction of work with sex offenders would serve to create a more balanced perspective of impact and contribute to an understanding of how, far from burning out, the majority of professionals treating sex offenders remain emotionally well. They also proposed that attention should be paid to how individual differences in perceptions of the rewards of the work evolved over time, suggesting that by shifting the emphasis from a belief in individual change by clients (perhaps more common among less experienced therapists) to an overriding belief in the ultimate effectiveness of treatment, therapists might well be demonstrating an adaptive response to the work, concomitant with Farenkopf's (1992) 'phases of impact'.

Aligned with this, Maslach (1993) argued that while social factors were in most critical need of addressing in explaining the burnout concept, the development of a better conceptual model in order to rethink the relevance of individual factors in the burnout process was essential. She suggested the current finding (that situational factors were more predictive of burnout than individual ones) was possibly a reflection of research bias, rather than a true indication of the factors involved.

Acceptance of a concept in which distress was attributed to external factors also assumed the inevitability of the experience of distress. It has inhibited exploration of a range of other variables that may have ameliorated the

experience of working in potentially distressing situations or with potentially distressing material and also prohibited the possibility of treatment methodologies (Pearlman and Saakvitne, 1995a).

The apparently inherent paradox among sex offender facilitators regarding distress and reward, together with Ryan and Lane's (1991) observation about the acceptance of burnout as a consequence of therapeutic provision, and the concerns regarding the restrictions the concept places on understanding the impact on therapists, demanded a new approach to understanding the psychological impact their work had on therapists.

1.4.3 Secondary Traumatic Stress (STS)

Secondary traumatic stress (STS) was defined by Figley (1995: p.7) as "the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other - the stress resulting from helping or wanting to help a traumatized or suffering person". Figley asserted that there was a fundamental difference between the sequelae or pattern of response during and following a traumatic event, for people exposed to the primary stressors and for those exposed to the secondary stressors. So STS is a syndrome of symptoms nearly identical to Post Traumatic Stress Disorder (for a full description see DSM IV), except in terms of the original stressor.

In contrast to burnout, which emerges gradually, Figley (1995) pointed out that STS could emerge suddenly and with little warning, and might also have a faster recovery rate. He asserted that STS was often accompanied by a sense of helplessness and confusion, and of isolation from supporters, with symptoms often disconnected from their real causes.

In the context of sex offender treatment, STS has at least superficial face validity. The symptoms encompassed by such a diagnosis appear to mirror

those described in the sex offender facilitator literature, including re-experiencing (e.g. intrusive images), avoidance (e.g. depersonalisation) and persistent arousal (e.g. hyper vigilance for ones own safety). However, contention arises over the source of stress. Though it is undoubtedly true that some sex offenders present their own trauma in the process of treatment, this is not the focus of the intervention, and sex offender facilitators are specifically required to work with the trauma their clients have caused others. It is argued that this introduces a dynamic not accounted for in the STS definition, in that the facilitator is a further step removed from the source of the trauma, making the applicability of STS tenuous at best.

1.4.4 Compassion Fatigue (CF)

The expression Compassion Fatigue (CF) was first coined by Joinson (1992) in the context of burnout among nurses and was favoured by researchers such as Figley (1995), as lacking the derogatory connotations often associated with terms such as stress. Joinson argued that CF and STS could be used interchangeably, although it seems that the concept of STS has been predicated strongly on the manifestation of symptoms, and only in the context of CF has consideration been given to individual differences, albeit generically.

Figley (1995) proposed the concepts of empathy and exposure were at the heart of the theory of CF, and those with "enormous capacity for feeling and expressing empathy" were more at risk from the condition. As previously highlighted, the paradox of empathic concern being central to effective treatment of sex offenders, whilst at the same time being a potential cause of increased distress, requires careful and extended consideration.

Despite the appeal of STS or CF as models on which to centre research into the way in which facilitators are impacted by their work, shortcomings are evident. As Kessler, Sonnega, Bromet, Hughes and Nelson, (1995) pointed out, being exposed to a traumatic stressor did not guarantee that one would

develop a diagnosable pathology. The STS and CF models as they stand do not attempt to identify moderating variables, other than to highlight empathy and exposure as central.

1.4.5 Vicarious Trauma (VT)

Vicarious Trauma (VT) was first introduced by McCann and Pearlman (1990) as an alternative concept to explain the unique effects on therapists of working with survivors of sexual violence. Therapists' experience of themselves and others was affected negatively as a direct result of an empathic connection with clients' traumatic material (McCann and Pearlman, 1990; Pearlman and Saakvitne, 1995b).

McCann et al (1988), in an attempt to understand psychological responses to victimization, developed a theory of personality they called constructivist self-development theory (CSDT). The underlying principle of CSDT understands individuals' responses to trauma as an adaptation determined by an interaction between the characteristics of the individual, the nature and dynamics of the traumatic stressor and the socio-cultural environment in which the stressor is experienced (McCann and Pearl man, 1990). Individuals construe themselves and their world through cognitive schemas that help interpret experience. These mental frameworks include beliefs, assumptions and expectations of the world and others and enable individuals to make sense of their experiences. It is suggested that certain areas of psychological need (safety, trust, power, control and intimacy) and the corresponding schemas may be considerably disrupted by the provision of therapeutic services to trauma clients, leading, in turn, to the symptomatology of VT.

It has also been advocated that the model generalizes effectively to sex offender treatment providers, on the basis that their fundamental belief system, self-identity and cognitive schema associated with, for example, safety and trust, might be challenged by the work they undertake with sex abuse

perpetrators (Rich, 1997). For example, facilitators reporting increased fear for the safety of themselves and their children would be likely to have experienced disruption in their core belief that the world is safe.

Systematic and validated assessment of the prevalence of vicarious trauma amongst trauma workers has yet to be established (Pearlman and Saakvitne, 1995a). The first published study applying the VT concept to sex offender therapists (Rich, 1997), found up to 62% of respondents identified themselves as vicariously traumatized, reporting symptoms such as difficulty coping with work related stress, doubts about ability to manage the stress of their jobs and distressing images of traumatic material However, Kadambi and Truscott (in press) argued that asking study participants to self-diagnose limits conclusions about the prevalence and validity of the phenomena among this population. In their own study of the prevalence of VT among sex offender treatment providers, Kadambi and Truscott employed the Traumatic Stress Institute of Belief Scale - Revision L (TSI - Pearlman, 1996), and found no significant differences between participants' scores and those of a criterion reference group of mental health professionals. They also failed to find a relationship between variables previously shown to be predictive font, such as length of time working in the field and perceived exposure to traumatic material, and levels of VT in their sample. They also found the TSI to be more highly correlated with a measure of burnout than with symptoms of post traumatic stress, even though VT and burnout are considered distinct constructs (Schauben and Frazier, 1995; Pearlman and Saaknitne, 1995b).

More generally, Kadambi and Ennis (submitted), in a critical review of the concept of VT, concluded that the evidence to support the notion that those working with traumatized clients were significantly and adversely affected by their clinical work, had been largely inconclusive, and that support for the pervasiveness of the construct among trauma professionals was inconsistent. This was the possible result of insufficient consideration of individual differences in terms of susceptibility to the syndrome - a factor which should

be incorporated into the re-evaluation of the construct recommended by Kadambi and Ennis.

1.4.6 Summary and conclusions

The systematic and widespread treatment of sex offenders has enabled the generation of a body of research investigating the impact on providers of such a service. It is an area still in its infancy, considered by many to have been neglected (e.g. Ellerby, 1998) in the broader arena of sex offender treatment.

To date, the research has focused primarily on the identification of stressors specific to working with sex offenders, including organizational and work content related issues. Particular attention has also been paid to the range of negative symptomatology reported by therapists, but as will be discussed in the next section, the descriptive and intuitive basis of the existing research provides little more than this.

Attempts have been made to conceptualise the identified symptoms within existing frameworks from related fields, but a number of objections are raised concerning the applicability of these concepts, either because of methodological shortcomings, or because of failure to encapsulate the unique aspects of sex offender provision identified in the research.

The following sections consider the shortcomings of the existing literature, introduce a model generated as a framework for guiding current research, and describe the aims of current research with this as a basis.

1.5 Shortcomings of the Existing Literature

As is evident from the literature reviewed in this chapter, most empirical research undertaken with sex offender therapists to date has focused primarily

on the manifestation of symptoms. Although this has provided a crucial foundation upon which further research can be based, there are a number of acknowledged shortcomings:

- *all the available evidence is retrospective*

Without exception, all the published research into the impact of their work on sex offender treatment providers has been retrospective and based on "snap-shot" methodology. Consequently, it is not possible to make reliable causal inferences regarding the nature of the reported symptoms, nothing can be ascertained regarding the psychological processes implicated in the development of those symptoms, and the lack of baseline data through measurement of pre-therapeutic well-being means little is known about the level of symptomatology resulting directly from therapy provision. Furthermore, such an approach fails to facilitate intervention evaluation or theory development and testing.

- *studies have been based on poorly constructed and ad-hoc surveys*

Many of the instruments used in the assessment of impact on treatment providers have been generated by individual researchers working on clinical intuition. Surveys contain items that have been driven by loose theory or face validity, and if evidence is available concerning construct validity, it is rarely reported. Consequently, results are confounded by researcher bias and studies are not replicable.

- *when psychometric measures have been used, they have only been generally applicable*

To date, there is no specific psychometric measure available to assess the impact of their work on sex offender therapists. The existing research has relied on scales drawn from conceptually similar fields such as the MBI (Maslach and Jackson, 1981) and the Impact of Events Scale - R (IES-R; Weiss and Marmar, 1995), neither of which is orientated to the specific concerns of

sex offender treatment facilitators. As a result, where normative data for the scale do exist, they do not incorporate data from similar groups, rendering comparisons impossible. The psychometric validity of these scales has also been questioned.

- *the existing studies only provide* a *description of symptoms*

The available research to date has extended only as far as the identification of symptoms and the measurement of their prevalence. Across most studies, a fifth to a quarter of the sample have reported negative effects (e.g. Edmunds, 1997; Kadambi, 2000; Ellerby, 1998), but there has been a distinct lack of attention to the psychological processes involved in the aetiology of the effects described.

- *there is a lack of control groups*

Only one study of those reviewed incorporated a control group of non-therapist participants (Myers, 1995). When comparisons of norms between occupational group scores have been recorded it has usually been with a criterion reference group (e.g. Kadambi and Truscott, 2003), which precludes drawing reliable conclusions about differences between occupational groups.

- *there is an over-reliance on self-report measures*

The shortcomings of self-reporting are well documented and include difficulties with response distortions, lack of objectivity and verification problems. These are compounded by the retrospective nature of the data, resulting in further response distortion because of over-reliance on memory. So far, there has been no objective assessment of the impact of the work, such as the use of measures of physiological reactivity or behavioural ratings.

- *there appears to be an implicit assumption that negative effects should be attributed to the nature of the material or organizational deficits, such as lack of support/training*

This has resulted in the neglect of a third set of variables embedded in individual differences among therapists. Although some research has concluded that individual differences in areas such as coping and pre-therapeutic personality should be investigated, very little attention has been given to the explication of personality variables that might potentially exacerbate or reduce the risk of psychological distress induced by the provision of therapy to sex offenders.

- *too little attention has been given to the positive aspects of working therapeutically with sex offenders*

Only one study to date has focused exclusively on the rewards of working therapeutically with sex offenders (Kadambi and Truscott, submitted), despite a consistent finding across a vast majority of studies, that sex offender treatment providers find high levels of satisfaction in their therapeutic work. Several researchers argue that in order to understand the processes involved in occupationally related psychological distress, an understanding must also be sought of what maintains people in their work (Paton, 1996; Stamm, 2002).

- *in attempting to label the negative aspects of sex offender treatment provision, there has been an over-reliance on existing conceptualisations*

Even though researchers have attempted to distinguish sex offender treatment providers as a unique group among mental health professionals, the impact of the work has been invariably conceptualised within existing frameworks derived from hypothetically similar fields such as trauma and victim research. This, it is argued, negates attempts to identify and explicate the issues specific to sex offender treatment providers, and presents a number of additional problems. Firstly, the conceptualisations that have been applied, such as burnout and vicarious trauma, are presented as fixed outcomes that are almost inevitable consequences of working with traumatized clients or potentially traumatizing material. Secondly, it is argued that such models pathologise the

impact of the work, precluding exploration of the impact as a potentially normal response by normal people to abnormal situations that may actually reflect a process of adaptation rather than a final outcome.

Ellerby (1998) concluded in his own review of the available literature, "it has yet to detail objective measures of distress, discuss distress on a continuum in terms of levels of impairment or to highlight factors which might moderate the experience of distress".

1.6 An Alternative Conceptualisation: The Process of Dynamic Adaptation

The empirical evidence supporting the prevalence of a range of distressing psychological symptoms amongst sex offender treatment facilitators is comprehensive, and the current research does not seek to replicate previous studies in relation to ascertaining the extent of the problem. Indeed it is notable that consistently across studies, both North American and British, between one-fifth and one-quarter of samples studied report deleterious psychological effects that they attribute to providing sex offender therapy. However, as highlighted above, little is understood about the psychological processes that might result in therapists experiencing such effects, the variables implicated in moderating, exacerbating or minimizing the effects, or the extent to which the effects are permanent consequences of sex offender therapy provision or indicative of a dynamic psychological process through which therapists adjust to their experience.

In an effort to try and address these issues, a new model is proposed to provide a framework into which the multitude of factors implicated in the psychological well-being of therapists can be incorporated. It is hypothesised that by integrating these factors into a coherent framework, it will be possible to gain a clearer understanding of the relative significance of each of the variables, changes in their comparative importance over time and the ways in which they might interact to moderate or exacerbate effects, thereby enabling

the identification of areas in which particular strategies for alleviating distress may be targeted.

The premise for the model comes from the risk prediction field (Grove and Meehl, 1996), where a view is emerging from a number of different authors (e.g. Hanson and Bussiere, 1998; Thornton, 2001) that there are categories into which factors can be divided that contribute to the prediction of risk. It should be emphasized that the model presented in this research is not intended for use as a prediction tool. However, organization of the variables in the way described and refinement of those included as a result of the current research might well mean that in future a valid and reliable risk prediction tool could emerge.

The categories referred to include:

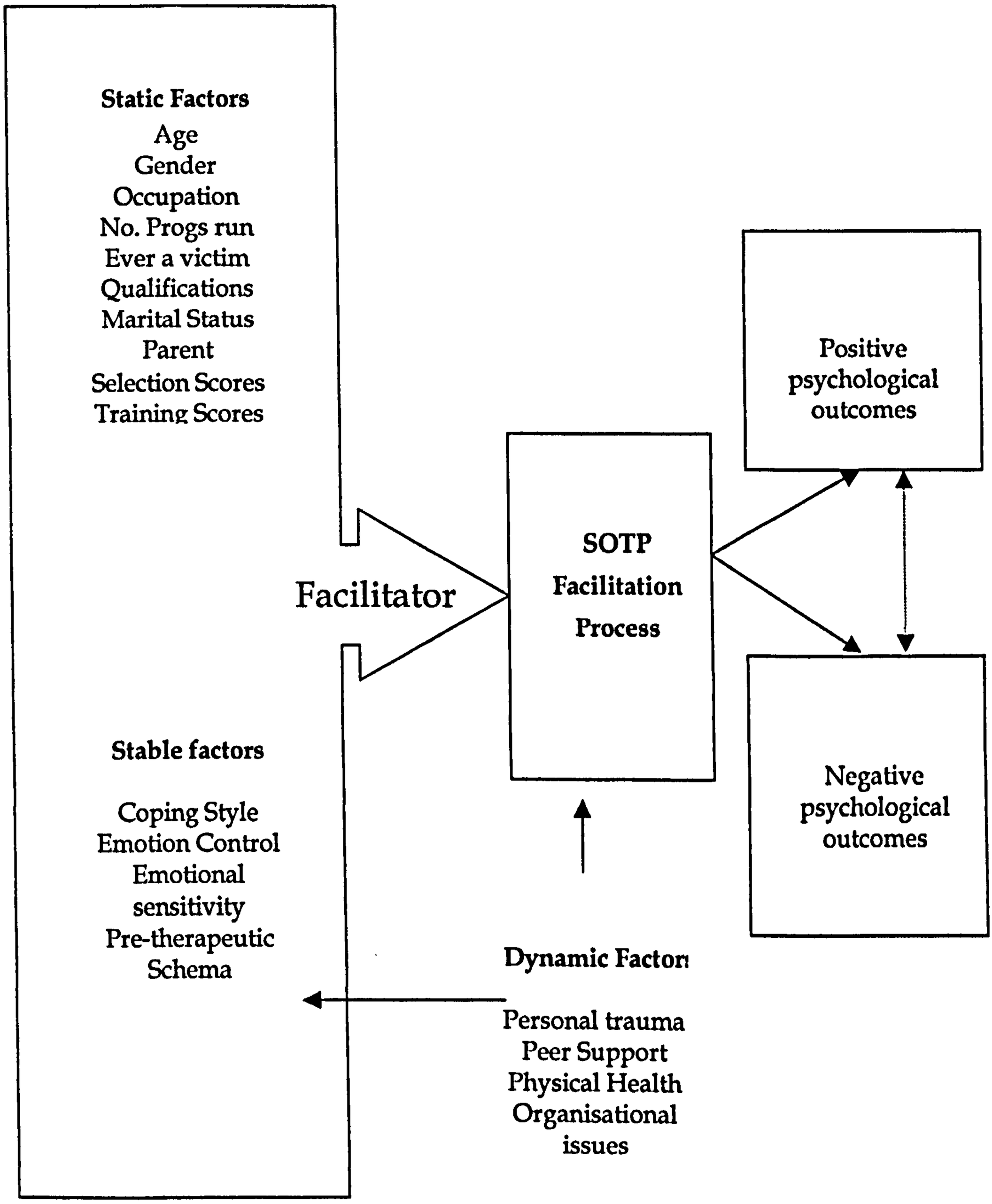
- the Static category, incorporating factors from an individual's history that are fixed and unchanging;
- the Stable category, including factors that are potentially changeable but relatively stable; factors that under normal circumstances only change slowly;
- the Dynamic category, incorporating factors that change rapidly, from one month to another, or even week by week.

All of the above are normally thought of as features of the individual but situational/environmental factors can also be classified in much the same way i.e. according to how fixed they are (Thornton,2001).

The model illustrated below incorporates a range of factors, categorized according to the definitions suggested above. In this model static and stable variables are considered intrinsic to the individual, with the stable factors potentially amenable to change. The Dynamic category includes factors thought to impact potentially on the process of facilitating, if and when they arise. The lack of detail in the outcome boxes represents the deficiencies in the

existing literature concerning appropriate measures of effect, and it is this area that is addressed in Chapters Two and Three of this thesis. The two way arrow between the outcome boxes indicates that these are not mutually exclusive groups, and that facilitators are likely to experience both positive and negative effects of their work, as evidenced by the literature.

Figure 1.1 An integrated model of factors implicated in the psychological adaptation of sex offender therapists



1.7 Methodological Refinements

In response to the shortcomings of the previous research, described in section 1.5, and in order to test the significance of the variables incorporated in the model, a number of refinements to previous research methodologies are proposed. These include:

- the construction of a scale designed to assess symptoms resulting specifically from working with sex offenders;
- the prospective examination of the impact on facilitators of working therapeutically with sex offenders, through longitudinal study over the duration of training and initial practice;
- the comparison of sex offender treatment providers with other groups of staff with varying degrees of involvement with sex offenders, allowing for valid comparisons between groups and the opportunity to accurately attribute factors associated with well-being to sex offender treatment facilitators;
- the use of objective measures of impact on facilitators, including physiological assessment and behavioural ratings. The opportunity to correlate self-reported distress with physiological measures and behavioural ratings will enable more comprehensive and potentially more accurate measurement of the likely causes of distress.

1.8 Research Aims

On the basis of the model and methodologies described above, this research project sets out a number of aims:

1. to construct and validate a scale designed specifically for the assessment of the psychological well-being of sex offender treatment providers (Chapters Two and Three);
2. to identify the static factors associated with psychological well-being (Chapters Two, Three, Four, Five and Six);
3. to identify the stable factors associated with psychological well-being, with particular emphasis on emotional response style (Chapters Two, Three, Four, Five, Six and Seven);

4. to identify the dynamic factors associated with psychological well-being (Chapters Two, Three, Four, Five and Six);
5. to test a physiological assessment of reactivity (blood pressure monitoring) of sex offender treatment providers to enable objective assessment of effect
6. to consider differences between therapists and non-therapists in terms of their psychological and physiological reactivity to sex offender treatment provision (Chapter Four);
7. to identify objectively monitored behavioural ratings that may be indicative of psychological well-being (Chapter Five);
8. to consider the extent to which the symptoms identified in the literature are indicative of a fixed outcome or a process of psychological adaptation (Chapter Five);
9. to consider assessment of stable factors that might not be measurable through use of psychometric assessment (Chapter Seven);
10. based on the findings from 1- 9 above provide a testable model of factors that may be used to assess individual therapist's risk status, within a new conceptualisation of the psychological consequences of providing therapeutic services to sex offenders (Chapter Eight).

The following chapters explicate these research aims in detail, with a view to providing the first detailed account of the processes underlying the effects on sex offender therapists of their work that have been so consistently reported in the existing literature.

Chapter Two

The Construction of a Scale to Assess the Personal and Professional Effects of Working Therapeutically with Sex Offenders

2.1 Introduction

It was highlighted in the previous chapter that assessments of the impact on therapists of working therapeutically with sex offenders have so far relied on either existing measures of psychological symptomatology, e.g. the Maslach Burnout Inventory (MBI-Maslach, 1981) or the Compassion Fatigue Self-Test (CFST - Figley, 1995), or poorly constructed questionnaires of unknown quality. In a review of 15 published studies that focus directly on sex offender therapists, 14 of them reported conclusions concerning the impact of the work based primarily on surveys constructed by the authors (e.g. Rich, 1997; Jackson et al, 1997). Only five studies provided any supporting evidence from validated psychometric assessments such as the MBI (Ellerby, 1998; Kadambi, 2000; Shelby, Stoddart and Taylor, 2001), the CFST (Steed and Bicknell, 2001), the Impact of Events Scale (IES-R; Weiss and Marmar, 1995; Steed and Bicknell, 2001) and the Los Angeles Symptom Checklist (LASC - King et al, 1995; Ennis and Horne, 2003). Only one unpublished dissertation (Myers, 1995) considered measures of individual differences in addition to assessment of symptomatology.

It is argued that conclusions based on retrospective data drawn from intuitively constructed surveys, or general psychometric measures, are at best spurious and at worst, misleading. For example, the retrospective nature of the data means causal attributions cannot be made. By definition, the surveys can only produce descriptive data that a) are likely to reflect the bias of the researcher, and b) do not provide any meaningful information regarding psychological processes underlying the described symptoms or the role of individual

differences in the experience of these. Further, the use of general measures of psychological symptoms developed outside the context of sex offender treatment, such as the MBI, neglect to take into account the very specific effects described by treatment providers, and so fail to provide a comprehensive assessment.

This chapter describes the construction of a scale designed to make a specific assessment of the impact on facilitators of undertaking therapeutic work with sex offenders, the rationale for which is given in a critique of three of the most commonly applied conceptualisations and their measurement.

2.1.1 Burnout

Burnout is the term most usually applied in the literature to describe the impact on facilitators of working with sex offenders. Its frequent adoption is likely to reflect the conclusions of one of the earliest published studies in the field, by Farrenkopf (1992), who concluded that one quarter of his sample experienced burnout as a result of their sex offender intervention work.

The term 'burnout', first introduced by Freudenberger (1974), described a process rather than a fixed condition, involving a gradual exposure to job strain (Courage and Williams, 1986), erosion of idealism (Freudenberger, 1986; Pines et al, 1981) and a void of achievement (Pines and Maslach, 1980), which begins gradually and becomes progressively worse (Cherniss, 1980; Maslach, 1976, 1982). Aligned with this, Farrenkopf described four phases of impact that essentially parallel the burnout process. Labelled "Shock", "Mission", "Repressed Emotions" and either "Erosion" or "Adaptation" respectively, he commented that a fifth of his sample stopped working with sex offenders altogether at phase four.

A range of associated symptoms has been identified as a consequence of exposure to job strain. Kahill (1988) divided these into five categories, including physical symptoms (e.g., fatigue, physical depletion, increased illness), emotional symptoms (e.g., anxiety, guilt, depression), behavioural symptoms (e.g., cynicism, aggression, substance abuse), work-related symptoms (e.g., poor work performance, lateness, resigning), and interpersonal symptoms (e.g., withdrawal from clients/colleagues).

Farber (1983) noted that as a consequence of their symptomatology, "burned out professionals are more frequently absent or late for work than their non-burned out colleagues; they become noticeably less idealistic, and more rigid; their performance at work deteriorates markedly, and they may fantasize or actually plan on leaving the profession" (p.3), resulting in the concept of burnout moving from a "hot topic" to a serious issue which affects millions of workers (Farber, 1983).

2.1.2 *The measurement of burnout*

It is not surprising then that considerable effort has been put into constructing methods of assessing a syndrome that is both psychologically and economically costly. Perhaps the best-known measure of burnout is the MBI. Developed by Maslach and Jackson (1981), it is a three dimensional inventory incorporating:

- *emotional exhaustion* (e.g., "I feel emotionally drained by my work");
- *depersonalisation* (e.g., "I worry that the job is hardening me emotionally); and
- *reduced personal accomplishment* (e.g., "I feel I'm positively influencing other peoples lives through my work").

More recently, Pines and Aronson (1988) constructed the Burnout Measure

(BM), another three factor scale measuring physical exhaustion (e.g., tiredness), emotional exhaustion (e.g., depressed) and mental exhaustion (e.g., disillusionment). The emergence of emotional exhaustion as a factor in both scales reflects a strong theme throughout the literature, that burnout is considered a collection of symptoms associated with emotional exhaustion (Figley, 1995).

However, Maslach (1993) resisted the description of burnout as a unidimensional phenomenon, arguing that although the variables studied to date were more strongly correlated with emotional exhaustion than the other components, a single-factor approach oversimplified the concept. She posited that "to limit the concept of burnout to just the component of emotional exhaustion is to define it simply as experienced stress and nothing more" (p.27).

The ambiguity in facilitator scores across the three dimensions of the MBI has caused researchers in the sex offender field to question the prevalence of burnout. Specifically, facilitators consistently report high levels of personal accomplishment as a result of their work (e.g., Ellerby 1998; Kadambi, 2000), which would appear contrary to the experience of burnout. This alone supports the need to re-examine the way in which the consequences of sex offender treatment provision are construed.

In addition to fundamental concerns about the appropriateness of the MBI for describing the impact their work has on facilitators, the scale has questionable psychometric robustness. Wallace and Brinkerhoff (1991) identified problems relating to the scale's construct validity and theoretical conceptualisation. Schaufeli et al (1993) noted that the three dimensions of burnout were not deduced theoretically before the proper test construction of the MBI, but were labelled after the original factor analysis was performed.

The description of factor extraction detailed by Maslach and Jackson (1981) also

indicated psychometric anomalies. For example, the authors reported subjecting their data to principal factoring using eigenvalue 1 as the criteria for factor selection. This procedure tends to extract too many factors, often with too few items to represent reliable samples of the behaviour in question (Kline, 1993; Roger et al, 1993). In the case of the MBI this was evidenced by the initial extraction of 10 factors, of which four accounted for three-quarters of the variance. The four-factor structure was further examined by applying a series of criteria to the original 47 items, and not just those identified by the factor analysis. These criteria were: a factor loading greater than 0.40 on only one of the four factors, a large range of subject response, a relatively low percentage of respondents checking the "never" response, and a high item-total correlation. It was the application of these criteria, and not the factor analysis, that reduced the item pool from 47 to 25. It was not until a further sample of 420 subjects had responded to the 25 items that these items were themselves subject to factor analysis, and the four-factor structure described.

Considerable emphasis is placed on the depersonalisation construct in describing therapists' attitudes to clients, but the MBI depersonalisation factor consists of only 5 items, too few to constitute a reliable factor (Kline, 1993). Schaufeli, et al (1993) commented that this may well have accounted for the poor internal consistency coefficients reported for this factor, and also for depersonalisation being consistently the least stable dimension in studies of the test-retest reliability of the MBI (Jackson, Schwab and Schuler, 1986; Wade, Cooley and Savicki, 1986). Digman et al (1986) raised further concerns when they found that on administering the MBI to a group of 166 correctional officers, Emotional Exhaustion and Depersonalisation appeared to be indices of the same construct.

Schaufeli et al (1993) pointed out that no attempt had been made to test the factorial validity of the MBI through confirmatory factor analysis, and that adequate psychometric analyses of the MBI performed outside the United States

were completely lacking. Furthermore, the MBI was a broadly constructed measure, standardised on a sample that incorporated police officers, doctors, nurses, lawyers and teachers. Shapiro, Burkey, Dorman and Welker (2001) contended that the work experience of those groups might differ in important ways from those of mental health and social services professionals, such as practitioners in the sex offender field.

Shortcomings in the clinical application and psychometric standards of the MBI indicate that its continued use is no longer tenable in assessment of the well being or otherwise of facilitators. Advances in the literature clearly indicate a need for alternative measures to be found.

2.1.3 Compassion Fatigue

The Compassion Fatigue Self-Test (CFST-Figley, 1995) is a measure that has been adopted more recently by researchers in the field of sex offender treatment provision. The scale is purported to be generalisable to nearly any group in the Human Services field, including psychotherapists, teachers and public safety personnel, and has been used in numerous studies across a variety of disciplines (Figley and Stamm, 1996).

Evolving from research into secondary traumatic stress, and incorporating features from the burnout literature (Pines, 1993), the instrument is still considered to be under development. Structural analysis has so far yielded at least one stable factor, characterised by depressed mood in relationship to work, accompanied by feelings of fatigue, disillusionment and worthlessness. Figley and Stamm (1996) reported the structural reliability of this factor, as indicated by Tucker's Coefficient of Congruence, as 0.91. However, the nature of a second structure has been difficult to determine.

The test authors were cautious about use of the Compassion Fatigue Self-Test as

a diagnostic tool, stating that it was primarily designed as an educational resource and warning device and, as such, tended to err on the side of over-inclusion. As a result more false-positive responses would be incorporated than is desirous in a diagnostic measure (Figley and Stamm, 1996).

A further reservation about extensive use of the CFST for assessment of sex offender facilitators arises from the context in which the facilitators work. Much of the literature on secondary traumatic stress has been based on individuals providing treatment to victims of trauma. As stated in Chapter One, the focus for sex offender treatment facilitators is the individuals who *cause* trauma (i.e. the offenders) rather than those who suffer its consequences (i.e. the victims). It was argued that this introduced an additional, tertiary, component to the nature of any stress response, not accounted for in the secondary traumatic stress literature, with the consequence that reliance on the CFST may prohibit appropriate assessment.

2.1.4 Vicarious Trauma

Rich (1997) used the framework of Vicarious Traumatisation (VT) to examine the impact on therapists of working with sex offenders. This concept was developed by McCann and Pearlman (1990) in an attempt to describe the effects on therapists of empathically engaging with sexual violence survivors. They argued that exposure to graphic details of abuse left therapists vulnerable to changes in their own cognitive schema, especially regarding issues of trust, safety, power, esteem and intimacy, resulting in adaptation in behavioural, cognitive, emotional and interpersonal domains of the individual.

VT, like' burnout', has an intuitive appeal in terms of its application to sex offender therapists, but unlike burnout, which is considered temporary, work specific and preventable, VT is considered permanent, professionally and personally pervasive and inclusive of emotional and behavioural manifestations

of traumatic stress not described by the burnout concept (McCann and Pearlman, 1990; Pearlman and Saakvitne, 1995a). Consequently, attention has more recently been given to VT as an alternative and potentially more comprehensive conceptualisation of the impact of their work on sex offender therapists.

Rich's (1997) research identified VT symptoms in 62% of the sample, including for example, flashbacks, bad dreams and images relating to the clients traumatic material, increased anxiety, greater cynicism, less trust, increased depression and increased feelings of isolation. Rich was cautious about drawing general conclusions from the data based on sampling and psychometric anomalies, and recommended further research.

Kadambi (2002), in a study of the prevalence of both burnout and VT in the sex offender therapist population, employed the Traumatic Stress Institute Belief Scale (TSI; Pearlman, 1996), an 80-item measure assessing levels of cognitive disruption considered indicative of VT, together with the MBI and IES (Horowitz, Wilner and Alvarez, 1980). She failed to find a significant difference in VT symptoms between sex offender therapists and a criterion reference group of general mental health professionals, but did find higher than expected correlations between the TSI and MBI, raising concern about the psychometric validity of the TSI. She concluded that the sampling bias of the criterion reference group of the TSI, the lack of support for variables theorized to be predictive of VT and the correlational patterns between the TSI and MBI indicated that further work on the construct validity of the TSI was needed.

2.1.5 Conclusions

In the past 10 years a great deal has been learnt about the ways in which facilitators are affected by their intervention work with sex offenders, but little

is yet understood of the reasons. A continuing lack of targeted assessment of sex offender facilitators will do little to redress this balance, and to date, no attempts have been made to develop specific measures of facilitator well-being in the context of individual and organisational factors.

To address the lack of targeted psychometric evaluation, a new instrument was developed aimed specifically at assessing well-being. The aim was to devise a tool that would address as wide a range of critical factors as possible, and the construction of this instrument is reported here.

2.2 Method

2.2.1 Item construction

The item pool for the scale was generated using the "scenario study" technique, developed by Roger and colleagues in the construction of psychometric measures such as the Emotion Control Questionnaire (Roger and Najarian, 1989; Roger and Nesshoever, 1987) and the Interpersonal Trust Questionnaire (Forbes and Roger, 1999).

The method requires subjects to list their typical responses to a series of scenarios related to the field of study. Scenarios were generated based on anecdotal information from experienced SOTP facilitators, literature review, and the author's own experience. Thirty-four original scenarios were edited down to 30 (owing to similarity and repetition), and were broadly categorised into four key areas:

1. Group work related (8)
2. Management related (8)

3. Personally related (9)
4. Prison related (5)

The first category highlighted typical situations facilitators might encounter in the group setting, such as distorted/distressed/resistant group members (e.g., "A group member insists that his victim did not experience long-term damage from his abuse of her, as she is now grown up and has a family of her own"). The second referred to management-based issues such as being asked to run more sessions than originally required or being withdrawn from training (e.g., "After a particularly draining session, your line manager asks you to undertake an urgent task right away"). The third category described situations such as seeing a lost child, or having intrusive thoughts about work, such as "During an intimate moment with your partner, you start getting intrusive thoughts about an offender on your group", and the category four scenarios were based on occurrences in a prison which might impact negatively on facilitators, including colleagues not understanding the role of SOTP facilitators (e.g., "You hear a rumour that the governor is thinking of cutting SOTP from the regime"). A full list of scenarios can be found in Appendix A.

The scenarios were randomly listed (i.e. not in their particular categories), and each was followed by three questions:

- What do you think?
- How do you feel?
- What do you do?

Participants were asked to give their personal, rather than professional, reactions to each scenario. They were also asked to consider what they might think, feel, and do immediately, as well as in the longer term. Additionally, if there was a scenario that they had not encountered before, they were asked to imagine how they *might* respond in that situation.

2.2.2 *Participants: scenario study*

Participants in this stage of the study were 30 "active" SOTP facilitators, i.e. those currently running, or available to run, a Core Programme. Their names were selectively drawn from the OBPU facilitator database on the basis of two key criteria:

A. They had expressed an interest in the research and/or were known to the author to be candid and honest in their experience of facilitating the SOTP.
B. They were representative of the occupation and gender ratios of the national facilitator population.

The breakdown of participants is given below (Table 2.1), with national proportions given in brackets underneath (based on the 1999 OBPU database).

Table 2.1 Breakdown of gender and occupation data for participants in the scenario study.

Gender		Occupation			
Male	Female	Officer	Psychologist/Asst	Probation	Education
15 (50%)	15 (50%)	17 (57%)	7 (23%)	4 (13%)	2 (7%)
(49.5%)	(50.5%)	(57%)	(18%)	(13%)	(6%)

Participants were asked to return their completed scenarios anonymously within three weeks, and all were sent a reminder letter one week before the deadline. At this stage of the research, anonymity was ensured for participants and no demographic information was requested. With the exception of the original list of names, papers were not marked with any form of identification, and no records were kept of who did or did not respond.

Seventeen of the 30 sets of scenarios were returned, all of which were fully completed and usable. The responses yielded over 260 statements, and after rejecting over-generalised and repetitious items (84), a pool of 176 items constituted the preliminary scale (see Appendix B). Subject responses were recorded on a dichotomous scale of "mostly true" and "mostly false".

2.2.3 *Participants: scale construction study*

Participants were the entire "active" SOTP facilitator population (n=289). A total of 188 (65%) returns were received, of which six were not useable, as respondents had not completed facilitation of a full Core Programme. The final scale incorporated data from 182 participants, or 63% of the total active facilitator population in HM Prison Service. Participants were asked to provide a number of demographic details (see Appendix C), the breakdown of which are provided in Sections 2.2.3.1 to 2.2.3.6 below, and did not receive any remuneration for their involvement in the research.

Table 2.2 Breakdown of occupation data for participants in the scale construction study

Occupation	Sample	Total Population
Officers	68 (37.4%)	145 (46.8%)
Probation Officers	28 (15.4%)	53 (52.8%)
Chaplains	2 (1%)	2 (100%)
Psychological Assistants	23 (12.6%)	Not Known*
Education staff	4 (2.2%)	10 (40%)
Psychologists	49 (26.9%)	59 (83%)
Other	8 (4.4%)	Not Known

*NB. Owing to misidentification of some Psychological Assistants as Psychologists, accurate data are not available for this group.

Table 2.2.1 Breakdown of gender data for participants in the scale construction study

Gender	Sample	Total Population
Male	75 (41.2%)	143 (52.4%)
Female	107 (58.8%)	146 (73%)

2.2.3.1 *Age*

The modal age range age of participants was 25-29 years (21.1%), with over half the sample (52.8%) aged under 40 years.

2.2.3.2 *Work history*

Over a third of the sample (n=61) had joined the Prison Service in the previous two years, with just over half the sample (54.7%) having served between 0 and 5 years. Just over half the sample (52.5%) trained to run the Core Programme in 1999 or 2000, and nearly three-quarters of the sample had run only one or two Core Programmes. Fifty-six percent of participants were also involved in running other therapeutic programmes for prisoners, including other sex offender programmes (31.8% of the total sample). The other programmes run by Core Programme facilitators, such as the cognitive skills programmes, whilst not necessarily targeting sex offenders, would have included sex offenders amongst the group membership in most instances.

2.2.3.3 *Qualifications*

The distribution of qualifications by occupation indicated that 60.5% of facilitators were educated to degree level or above, including all psychology, probation and education staff. Forty-six percent of Prison Officers held GCSE qualifications, and 13% possessed degrees (data for the general Prison Officer population are not recorded, but until recently entry to the Prison Service as an Officer did not require formal qualifications).

2.2.3.4 *Living status*

A majority of the sample (77.3%) lived with family/partner, with 16% living alone and 6.6% living with non-intimate others. Half the sample (50.8%) did not have children, and of those that did, 20% had one child, 58.8% had 2 children, 17.7% had 3 children and 3% had 4 children. The mean age of first children was 17.93 years (SD=8.65), second children 16.30 years (SD=8.03), third children 14.11 years (SD=9.47), and fourth children 6.67 years (SD= 5.51). No facilitator had more than four children.

2.2.3.5 *Previous experience of trauma*

Participants were asked whether they had experienced any events in the last 6 months that they had found traumatic, and 31.9% answered positively. Only a very brief description of the event(s) was requested, and the range of responses would not have been possible to code effectively. Examples of events included deaths in families, diagnoses of potentially fatal illnesses, relationship break-ups, relocations and incidences of self-harm amongst family/friends.

2.2.3.6 *Previous experience of sexual abuse*

Participants were also asked if they had ever experienced "hands on" sexual abuse as an adult or a child, defined as abuse where the perpetrator made physical contact with the victim. Responses to these questions were optional but over 90% of participants responded. Of the 181 respondents, 22 (12.1%) disclosed abuse as a child and 19 (10.4%) as an adult. With the exception of one respondent, these were mutually exclusive groups, meaning that nearly a quarter of the sample (22.5%) had experienced sexual abuse at some time in their lives. The Rape Crisis Federation: England and Wales report that between 1 in 4 and 1 in 10 individuals will have experienced childhood sexual abuse, and 1 in 4 women would have been the victim of rape or attempted rape (2002).

2.2.4 *Procedure*

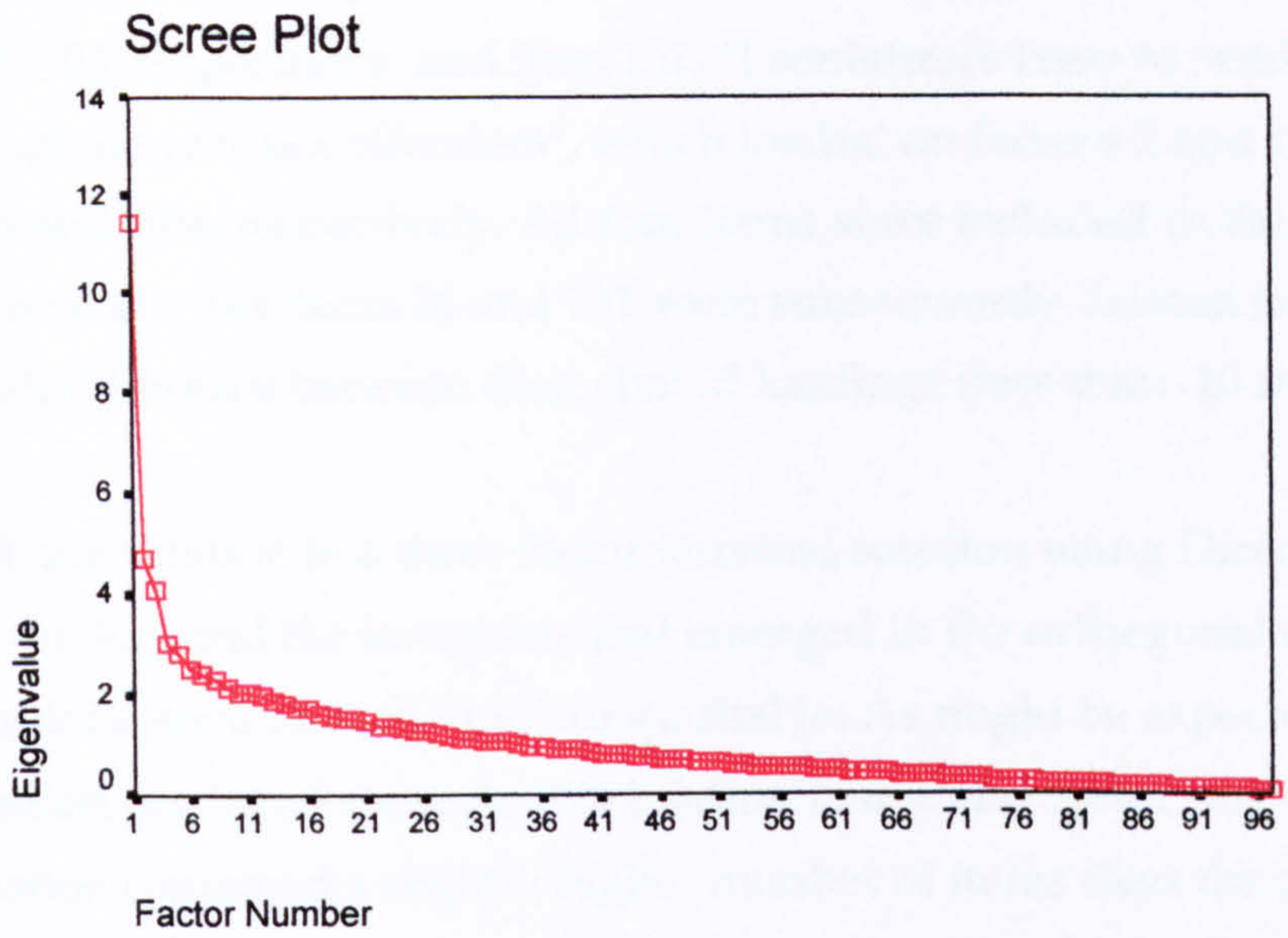
The survey pack, including the scale, an explanatory letter, a demographic questionnaire, consent form and return envelope, was personally addressed to every facilitator, and sent to the 26 treatment managers, who had previously agreed to distribute the information. A deadline of three weeks was set, by which time approximately 50% of the questionnaires had been returned. A thank you/reminder letter was then sent to every participant, via their treatment manager, two weeks later. This resulted in a further 33 scales being returned, bringing the total to 182.

2.3 Results

The response frequencies to all 176 items were examined and all items that failed to meet the 80/20 percentage split conventionally used in questionnaire construction (Kline, 1993) were omitted. The remaining 101 items were factor analysed using principal axis factoring from the Statistical Package for the Social Sciences (SPSS). The Scree Plot (Cattell, 1966) identified a probable three-factor structure (see Figure 2.1), which was produced using Varimax orthogonal rotation with a minimum loading exclusion criterion of 0.30 (Kline, 1993).

The three factor solution extracted 32 items on factor one, 19 on factor two, and 12 on factor three (see Appendix D for all significant factor loadings). The two highest loadings on factor one were item 78, "I don't like sex offenders who have negative attitudes to women"(o.612), and item 132, "If a sex offender gets emotional I am suspicious of his motives" (0.538). Other examples of items in this factor included item 139, "I feel angry at parents who let their children wander off' (0.448), and item 147, "If I suspect someone's motives for being with children, e.g. in the park, I will watch them very closely" (0.304). The factor was subsequently named Negative Reactivity to Offenders (NRO).

Figure 2.1 Scree plot



The two highest loading items on factor two were item 142, "I think about sex offenders when I am not at work" (.694), and item 146, "I refuse to let my work affect me" (-.599). Other items included item 164, "I have felt more vulnerable in my personal life since I started working on SOTP" (.548), and item 102, "I feel sad that my innocence has been affected by my work with sex offenders" (.373). This factor was labelled "Ruminative Vulnerability" (RV).

The highest loadings on the third factor were item 24, "I feel resentful when my line manager doesn't take into account the work I do for SOTP" (.692), and item 77, "I sometimes feel unsupported by my line managers, given the effort I put into SOTP" (.658). Other examples included item 173, "Non-SOTP colleagues have no idea what being a facilitator is like" (.375), and item 88, "There never seems to be enough time available for training" (.380). This factor was called "Organisational Dissatisfaction" (OD).

The three factor solution yielded four double loading items. These were item 174, "I feel cross that I am affected by my work", which loaded on factors 2 and 3 with loadings of .425 and .315, respectively, item 24, "I feel awkward about working with some colleagues", which loaded on factors 2 and 3 with loadings

of .378 and .333, respectively, item 144, "I feel sad that I have apprehensions about ordinary people", which loaded on factors 2 and 1 with loadings of .416 and .303, respectively, and item 131, "I sometimes have to remind myself that not all men are sex offenders", which loaded on factors 2 and 1 with loadings of .374 and .304, respectively. All four items were included in the initial validation of the scale, but items 24 and 131 were subsequently deleted in view of the very small difference between their shared loadings (less than .10 in both cases).

Oblique rotation to a three factor terminal solution using Direct Oblimin was conducted, and the structures that emerged in the orthogonal and oblique solutions were virtually indistinguishable. As might be expected, the oblique rotation produced more double loading items, and factor one in the oblique rotation contained a slightly higher number of items than the orthogonal solution, but the three factor Varimax solution was decided upon as the best fit for the data.

In order to fully explore the structure of the scale, a number of additional analyses were performed. For example, as a manipulation check, a one-factor unrotated solution was extracted to assess the dimensionality of the scale. Less than half of the items loaded above the criterion of +/- .30, and it was concluded that the scale did indeed possess structure.

A two-factor solution was examined which extracted 58 items, 34 of which loaded on the first factor. The two highest loading items on this factor were item 78, "I don't like sex offenders who have negative attitudes to women", and item 57, "When sex offenders justify their offending I want to tell them they're wrong". These were the first and fourth items, respectively, on factor one in the three-factor solution. The second factor in the two-factor solution was divided between items that had loaded on factors 2 and 3. The two highest loadings were on item 142, "I think about sex offenders when I'm not at work", and item 110, "I worry about what my partner would think if she knew what goes on in my head sometimes", but other items on this factor included 85, "When I'm asked to take on more work by my line manager, I think about how little my colleagues do who are not involved in SOTP", and 154, "I feel unsupported by

my non-SOTP colleagues". The three-factor solution made the important distinction between organisational and personal issues clear, and the three-factor solution was thus retained.

The first three factors in the four-factor solution yielded a very similar pattern of item loadings on the first three factors of the three-factor solution. The fourth factor contained 11 items, two of which also loaded on factor one. As has been pointed out elsewhere (Kline, 1993), a factor comprising only 9 items would probably sample too narrow a range of behaviour to provide a reliable estimate of behaviour. In addition, the factor was clearly mixed, with around half the items relating to a sense of responsibility on behalf of the facilitators and the remaining items describing a range of other behaviours. Finally, the coefficient alpha for this factor was much lower than each of the factors in the three-factor solution.

2.3.1 *Reliability analysis*

After an inter-test interval of 18 weeks, the scale was distributed to a subset of 90 facilitators from the original sample. Returns were received from 74 (82.2%) of the sample, 41.8% male (n=31) and 58.1% (n=43) female. The occupational breakdown mirrored that for the original sample.

The test-retest coefficients were acceptable for all three factors (see Table 2.3). The differences between separate re-test correlations for males and females were negligible for NRO and RV. For OD the correlation was lower for females (0.677) than for males (0.797), but the difference between the correlations was not significant (Z=1.68; n.s.).

Despite the emergence of discriminable dimensions, the internal consistency of the total scale showed a high coefficient alpha (r=0.89; N=165), and Table 2.3 shows that the coefficients were also highly acceptable for the three factors separately. The final scale was entitled the Assessment of Dynamic Adaptation (ADA).

Table 2.3 Coefficient alpha and test-retest correlation coefficients for the final scale

Factor	N	Coefficient Alpha	N	Re-test coefficient
NRO	170	.882	71	.776
RV	178	.764	74	.817
OD	177	.784	73	.743

NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability; OD=Organisational Dissatisfaction

2.3.2 *Descriptive statistics*

Correlation matrices were generated to examine the relationship between the three factors for the whole sample, and for males and females separately (see Table 2.4). The overall correlations between the three factors were significant and in the expected direction, although the magnitude of the correlations was modest, with the largest (between NRO and RV for females) accounting for little more than 20% of the common variance. The implications of these correlations are considered again in the discussion.

Table 2.4 Correlations between factors for whole scale and by gender

Factors		**NRO**		**RV**
Whole Scale	N		N	
NRO		X		
RV	169	.396**		X
OD	166	.304**	174	.282**
Males				
NRO		X		
RV	68	.393**		X
OD	67	.311**	70	.241**
Females				
NRO		X		
RV	101	.457**		X
OD	99	.280**	104	.334**

** Correlation is significant at the 0.01 level (2-tailed) NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability; OD=Organisational dissatisfaction

Given the heterogeneity of the sample, a number of one-way analyses of variance were performed to establish any differences on the basis of gender, age, occupation, length of time in service, number of Core Programmes run, whether or not other programmes were facilitated, experience of trauma in the past six months and experience of sexual abuse as an adult or child. These results are reported in tables 2.5 to 2.10 below.

2.3.2.1 *Gender*

Scores on the three factors were examined by gender using one-way ANOVA (see Table 2.5).

There were no significant gender differences on either RV scores (F(1,176)=2.485; p=0.117) or OD scores (F(1,175)=2.397;p=0.123). However, scores for males were significantly higher on NRO (F(1,168)=6.247;p<.05).

Table 2.5 Analyses by gender

	NRO			RV			OD		
	N	Mean	SD	N	Mean	SD	N	Mean	SD
Whole Sample	170	13.76	7.06	178	6.22	4.45	177	4.60	3.06
Males	69	15.32	7.34	72	5.58	4.22	72	5.03	3.03
Females	101	12.60	6.68	106	6.65	4.57	105	4.30	3.07
F-Value		6.247			2.485				2.397
Significance		.013			.117				.123
Range									
Males		2-31			0-16				0-12
Females		0-31			0-17				0-11

NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability; OD=Organisational dissatisfaction

2.3.2.2 *Age*

Data related to age were originally collected in age bands, in response to concerns of some facilitators about disclosing too much personal information.

Nine options were presented, starting at 20-24 yrs and increasing in 5 years bands to 60+. Descriptive statistics for these data are given in Table 2.6 and have been broken down by age group category to provide a detailed account of the sample.

One-way ANOVA was used to consider the impact that age may have on each of the three factors. No significant differences were reported for NRO.

(F(8,160)=0.774; p=0.627) or OD (F(8,167)=0.959; p=0.470), but a significant difference was indicated for RV (F(8,168)=3.581; p=<0.001), with the data indicating a clear trend for younger facilitators to experience more RV than older ones. To clarify the finding, the age groups were recoded into two groups, aged either 29 years and younger or 30 years or over. The comparison between the two means, 8.12 and 5.47 respectively, was highly significant (F(1,175)=13.424; p=<0.001), confirming the trend observed in the scores across age bands.

Table 2.6 Descriptive statistics for Age by Factors

Age Group	NRO			RV			OD		
	N	Mean	SD	N	Mean	SD	N	Mean	SD
20-24yrs	11	16.27	6.62	12	11.08	3.09	12	3.33	2.67
25-29yrs	37	14.39	5.87	37	7.16	4.09	37	4.84	3.35
30-34yrs	21	11.33	7.68	21	7.19	4.77	20	4.45	3.28
35-39yrs	22	13.77	8.16	23	6.04	4.82	22	5.00	2.78
40-44yrs	31	13.03	7.83	33	5.27	4.62	33	4.52	3.20
45-49yrs	22	13.31	6.09	24	4.46	3.76	24	4.79	2.84
50-54yrs	19	14.58	6.80	21	5.14	3.90	22	4.32	3.09
55-59yrs	5	16.60	10.11	5	3.40	1.34	5	3.80	1.48
60+yrs	1	8.00	.	1	4.00	.	1	11.00	.
Total	169	13.71	7.08	177	6.20	4.46	176	4.59	3.07

NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability; OD=Organisational dissatisfaction

2.3.2.3 *Occupation*

Facilitators are drawn from a range of occupations, including prison officers, probation officers, education staff, psychologists, psychological assistants, chaplains, and other grades (see Table 2.7). The requirements and tasks of each discipline are qualitatively different and it would be reasonable to expect differences to exist between the groups, in response to facilitating sex offender treatment.

One-way ANOV A indicated a non-significant result for NRO (F (6,163) =1.87; p=0.089) and a trend towards significance for OD (F (6,170)=2.172;p=<0.05), but only RV achieved significance (F (6,171) =3.337; p= <0.01).

Table 2.7 Descriptive statistics for occupation by factors

	NRO			RV			OD		
	N	Mean	SD	N	Mean	SD		Mean	SD
Prison Officer	62	14.98	7.57	66	5.20	4.25	66	5.35	3.08
Probation Officer	27	13.96	6.45	28	6.14	4.67	28	4.25	2.53
Chaplain	1	11.00	.00	2	6.50	2.12	2	1.00	.00
Psych. Asst	21	10.48	6.77	23	6.04	4.18	22	3.59	3.00
Education Staff	4	15.75	11.12	4	3.50	1.91	4	3.00	1.41
Psychologist	48	14.00	6.47	47	8.40	4.49	47	4.77	3.16
Other	7	8.43	3.41	8	3.88	3.04	8	3.13	3.60
Total	170	13.71	7.06	178	6.22	4.45	177	4.60	3.06

NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability;
OD=Organisational Dissatisfaction

Post hoc inquiry using Tukey HSD, after removal of three occupation categories on the grounds of small samples (Chaplains, n=2, Educational Staff, n=4, and Other, n=8), indicated a significant difference (p<0.001) between Psychologists and Prison Officers on the RV scale.

2.3.2.4 *Time in service*

Consideration was given to the length of time facilitators had worked in a prison environment, irrespective of involvement with sex offender treatment (see Table 2.8).

One-way ANOVA showed that those with fewer Years in Service scored significantly higher on RV (F (5,172)=2.778; p=0.01) than facilitators with more prison experience. No significant difference was found for NRO (F (5,164)=.898; p=0.487) or OD (F(5,171)=0.341; p=0.887).

Table 2.8 Descriptive Statistics for Time in Service

	NRO			RV			OD		
Time in	**N**	**Mean**	**SD**	**N**	**Mean**	**SD**	**N**	**Mean**	**--SD**
0-2yrs	57	13.25	6.59	59	7.17	4.43	60	4.25	3.19
3-5yrs	37	14.38	7.28	38	6.47	4.53	37	4.77	2.86
6-8yrs	23	13.87	6.25	25	6.60	4.70	23	4.39	2.76
9-11yrs	30	14.50	8.48	31	5.87	4.15	31	5.00	3.44
12-14yrs	8	9.12	4.01	9	2.11	1.05	9	4.89	2.98
15yrs+	15	14.40	7.59	16	4.50	4.43	17	4.88	3.04
Total	170	13.71	7.06	178	6.22	4.45	177	4.60	3.06

NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability; OD=Organisational dissatisfaction

2.3.2.5 *Occupation by age by time in service*

Analyses indicated that both Occupation and Time in Service impacted significantly on RV scores, with psychologists reporting more vulnerability than prison officers and less experienced staff reporting higher levels of vulnerability. However, the data showed that psychologists were both younger than prison officers (65% psychologists being under 30 years, compared to 5% of prison officers), and had less Prison Service experience (81% of psychologists

having less than 5 years in service and over 80% of prison officers having 6 years or more experience). In total, 94% of those under thirty years old had joined the prison Service in the previous five years, suggesting that this finding was a function of age rather than occupation or time working in the prison service. Multiple regression analysis was conducted to establish the nature of any interaction between the three variables. The three occupational groups removed from the analysis on the grounds of small numbers remained excluded, leaving 164 participants. The results indicated that age was the significant factor ($t=2.35$; $p<0.05$).

2.3.2.6 *Previous experience of sexual abuse*

Participants were asked if they had ever experienced "Hands-On" sexual abuse, either as an adult or a child (see Table 2.9.). One-way ANOVA indicated that those who had been abused in their childhood showed no significant differences on any of the three factors, from the rest of the sample (NRO ($F(1,162)=0.066$; n.s.); RV ($F(1,167)=1.97$; n.s.); OD ($F(1,166)=0.004$; n.s.). However, participants who had experienced abuse as an adult scored significantly more highly on both NRO ($F(1,159)=9.09$; $p<0.01$) and RV ($F(1,165)=9.85$; $p<0.01$), but not on OD ($F(1, 164)=2.14$; n.s).

Table 2.9 Statistics for Experience of Sexual Abuse by Factors

Abused as adult	NRO			RV			OD		
	N	Mean	SD	N	Mean	SD	N	Mean	SD
YES	18	18.55	7.72	18	9.22	5.13	18	5.50	2.71
NO	143	13.26	6.93	149	5.78	4.30	148	4.40	3.02
Abused as child									
YES	22	14.18	6.79	22	7.41	4.19	22	4.45	3.05
NO	142	13.76	7.21	147	6.00	4.53	146	4.50	2.99

NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability; OD=Organisational dissatisfaction

2.3.2.7 *Experience of trauma in the past 6 months*

Participants were asked if they had experienced any events in the 6 months prior to completion of the scale, which they had found traumatic.

Table 2.10 Descriptive Statistics for Experience of Trauma

	NRO			RV			OD		
Trauma	**N**	**Mean**	**SD**	**N**	**Mean**	**SD**	**N**	**Mean**	**SD**
No	114	13.26	6.96	122	6.01	4.39	121	4.21	
Yes	56	14.61	7.24	56	6.68	4.60	56	5.43	2.87
Total	170	13.71	7.06	178	6.22	4.45	177	4.60	3.06

NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability;
OD=Organisational Dissatisfaction

One-way ANOVA indicated a significant difference in the experience of OD for those facilitators who reported feeling traumatised ($F(1,175)=6.183$; $p<.05$). No significant differences were reported for either NRO ($F(1,168)=1.36$; n.s.) or RV($F(1,176)=0.87$; n.s.).

2.4 Confirmatory Factor Analysis

The use of Exploratory Factor Analysis (EFA) is an appropriate technique for the initial construction of psychometric instruments, but is primarily a method for uncovering the underlying structure of sample data. Structural Equation Modelling, on the other hand, offers researchers methods for assessing and modifying the models that emerge from EFA, using samples that are independent from those used in the original construction exercise (Anderson and Gerbing, 1988).

The confirmatory factor analysis (CFA) method estimates whether a factor model, derived from EFA, provides a good fit to the data by specifying the initial relationships of the observed variables to the underlying constructs. This can be done with or without allowing the constructs to inter-correlate freely. It can also be used to test whether the structure fits as well as, or better than,

competing models (e.g. Cole, 1987; Anderson and Gerbing, 1988; Byrne, 1994; MacCallum, 1995), or to refine or revise the factorial structure of existing instruments, although its success in this context is more likely if EFA was used in the initial construction of the instrument. Whichever way it is employed, CFA is considered a complementary method to EFA.

However, the use of CFA techniques can present a number of problems. This is particularly true when applied to scales containing large numbers of items, which are required if personality questionnaires are to achieve adequate internal reliability. Large numbers of items increase the potential for correlated error terms in CFA, an occurrence that has been identified as the most common problem in using items as indicators for latent factors in CFA (Floyd and Widaman, 1995). CFA has consequently been applied most successfully to scales containing relatively few items and having a relatively simple factor solution, loading either on a set of highly discrete constructs or on a single factor.

In order to overcome the difficulties associated with using items as indicators of latent factors in lengthy questionnaires, a number of researchers (Anderson and Gerbing, 1988; Floyd and Widaman, 1995; Yuan, Bentler and Kano, 1997) have recommended the use of item parcels - simple sums of several items assessing the same construct. Several parcels are normally constructed for each factor, where each item can only be assigned to one parcel (Kishton and Widaman, 1994). The advantage of this method is that characteristics considered idiosyncratic to individual items, such as response bias, are likely to be less influential. Parcel scores are also likely to have greater reliability and generality, and ratios of measured variables to corresponding factors and to estimated parameters are increased (Marsh, Antill and Cunningham, 1989; Yuan et al, 1997).

In the current study, the factor structure of the ADA produced from the exploratory factor analysis was subjected to a confirmatory factor analysis using data from a new sample. The three-factor structure was tested using parcels of items and the results are reported in section 2.4.3.

2.4.1 *Participants in the Confirmatory Factor Analysis Study - the NOTA sample*

Participants for the confirmatory factor analysis were approached via the National Organization for the Treatment of Sexual Abusers (NOTA). NOTA is a charitable organization dedicated to work with sexual aggressors. Its membership comprises practitioners, managers and policy makers from public, private and voluntary sectors who are concerned with reducing the prevalence of sexual offending. Participants were contacted through the National NOTA Conference held in September 2001, and through the January 2002 publication of the Quarterly Newsletter, NotaNews, with a letter explaining the purpose of the research (see Appendix E).

The final version of the ADA, together with the rumination subscale of the ECQ (Roger and Nesshoever, 1987; Roger and Najarian, 1989), the Compassion Satisfaction subscale of the Compassion Fatigue/Satisfaction Self-Test (Figley, 1995), and the full version of the Interpersonal Reactivity Index (Davis, 1980) were distributed. The three latter scales were included as part of the concurrent validation exercise and are described in Chapter Three.

Returns were received from 216 respondents, of which 165 were usable (representing 16.5% of the 1000 assessment packs originally distributed). The final sample comprised 44.2% male (mean age 45.82; SD 7.82) and 55.8% female (mean age 43.39: SD 9.03) respondents, and reflected a broadly similar gender profile to the Prison Service sample used in the construction of the scale. In terms of occupation 48% described themselves as social workers or probation officers, with the remainder comprising therapists (5.5%), psychologists (12.7%), child protection workers (7.3%), criminal justice workers (1.2%), managers (14.5%), and other (9.7%). Over 90% of the sample was educated to degree level or above. A majority of respondents reported male sex offenders as their major client group (89.1%), and 95.2% provided treatment services to this group. Compared with Prison Service facilitators who participated in the concurrent validation of the scale, NOTA members were generally older (mean age of 44.46 years; SD = 8.59) and had worked longer in the sex abuse field (mean 9.0 years;

SD 67.68). The same optional questions about direct experience of sexual abuse were asked of this group, and 27.3% reported being victims of sexual abuse as children and 12% as adults.

2.4.2 *Procedure*

Following Kishton and Widaman's (1994) guidelines for parcel construction, six parcels were constructed for Negative Reactivity to Offenders, four for Ruminative Vulnerability, and two for Organisational Dissatisfaction. The alpha coefficients for the individual parcels were within the acceptable range (Kishton and Widaman, 1994), with 2 falling just slightly below .5, and the parcels were subjected to confirmatory factor analysis (CFA) using Bentler's (1995) EQS software.

2.4.3 *Results*

The fit of the three-factor model was tested using the maximum likelihood method in EQS. The most widely used goodness of fit indices from confirmatory factor analysis are the Comparative Fit Index (CFI; Bentler, 1990), the NonNormed Fit Index (NNFI; Bentler and Bonett, 1980) and the root mean square error of approximation (RMSEA; Browne and Cudeck, 1993). Both the CFI and NNFI are evaluated using criterion values in the order of 0.90, while the RMSEA is based on values of 0.08 or below (Browne and Cudek, 1993). The CFI and NNFI for the present analysis were 0.893 and 0.867, respectively, and the RMSEA was 0.081, indicating an acceptable fit for the three-factor model suggested by the exploratory factor analysis.

2.5 Discussion

A comprehensive assessment of the impact on facilitators of working therapeutically with sex offenders has been restricted by a lack of specialised measures. Previous research has relied upon existing scales such as the MBI

(e.g. Ellerby, 1998; Shelby et al, 2001), which has been shown not only to lack relevance to this particular population (Shapiro et al, 2001), but also to be psychometrically flawed (Schaufeli et al, 1993).

The construction of a specific measure of impact using factor analytic techniques, yielded a 61-item scale. The Assessment of Dynamic Adaptation is comprised of three factors that were internally consistent and stable over time (see Appendix F). These factors, Negative Reactivity to Offenders (NRO), Ruminative Vulnerability (RV) and Organisational Dissatisfaction (OD), incorporated the broad range of affects reported in the literature.

For example, items within the NRO factor (32) reflected issues such as increased cynicism, anger and frustration (Farrenkopf, 1992) and depersonalisation of clients (Ellerby, 1998; Kadambi, 2000). RV items (17) included reference to increased feelings of vulnerability, intrusive images and fear for personal safety (e.g., Jackson et al, 1997), and items in the OD factor (12) incorporated the range of issues related to support and organisational recognition.

The magnitude of the significant positive correlations between the three factors was modest, with the largest of the overall correlations (between NRO and RV) accounting for less than 16% of the variance.

The initial factor structure of the ADA, originating from the exploratory factor analysis, was replicated on a new sample using confirmatory factor analysis. Using parcel analysis, the goodness-of-fit indicators were all within the acceptable range, indicating that the ADA is a psychometrically robust tool for the assessment of the impact on facilitators of their therapeutic work with sex offenders.

It is noteworthy that the ADA structure was confirmed on a sample that had potentially important differences from the Prison Service sample, the most apparent of which was the diversity of professional backgrounds and organisations represented in the confirmatory sample. It could reasonably be argued that an assessment tool developed using a very specific population (e.g.

staff from one organisation) might not generalise well to a wider population, especially when one of the emerging factors focussed specifically on organisational issues. Furthermore, the confirmatory sample were more experienced, older and more highly qualified than the original prison service sample, all factors that previous research has argued were implicated in the psychological well-being of sex offender treatment providers. That the factor structure of the ADA was confirmed using such a diverse population not only suggested that the areas being measured were common to therapists irrespective of those areas identified, but also that it was widely and reliably applicable to therapists irrespective of the specifics of their working practices.

When considering the relationship between the three factors by gender the highest correlation was between NRO and RV for females, accounting for 21% of the variance. This suggested that females perceived an association between hostility and vulnerability to a greater degree than did males, and one might speculate that females experienced greater hostility in response to feeling vulnerable.

Further consideration of gender differences indicated that males scored significantly more highly on NRO than females. It may be argued that male stoicism, amounting to strict control of pain, grief and vulnerable feelings, leads to restrictive emotionality (Levant, 1995), with anger appearing to be the only exception to the rule (Jansz, 2000). If this is the case it follows that males' emotional response to working with sex offenders should be expressed in a factor that is comprised of largely hostile and angry items. An additional consideration is the environment in which treatment occurs, which may further influence the nature of male emotional expression. Prisons are often described and experienced as harsh and unforgiving, where expressions of emotion or caring may be interpreted as weakness (Coyle, 1994). The inherently masculine culture that pervades in most prisons, and which often requires staff to be authoritarian and disciplinarian (Pogrebin, 1978) would suggest that the expression of hostility is a more acceptable emotional response for men in that environment, than say vulnerability.

Interestingly, other researchers have suggested that where gender differences are apparent, females usually report feeling more vulnerable (Farrenkopf, 1992; Ellerby, 1993). However, this has not been measured in a consistent way in previous research, and is not empirically supported by either sample used in this study, in terms of the way vulnerability is encapsulated in the ADA factor, RV.

Younger facilitators scored significantly higher on RV than older facilitators, when the ages were grouped into those below 30 and those aged 30 or over. However, examination of the means for this factor indicated that Age Group 1 (20-24 years) had a substantially higher mean than all other age groups, and it was this group accounting for the differences.

Age has been found to be discriminative when assessing for the impact of working with sex offenders by a number of researchers. Using the MBI and Compassion Fatigue self-test, Ellerby (1998) found younger facilitators to be at greater risk from emotional exhaustion and compassion fatigue than older colleagues, a finding replicating previous research which identified younger therapists as experiencing higher levels of personal depletion and distress (Boice and Myers, 1987; Farber and Heifetz, 1981). Similar findings have been reported in the trauma literature, with a higher incidence of depersonalisation and trauma related symptoms among younger therapists providing clinical services to trauma clients (Arvay and Uhlemann, 1996).

Further analysis indicated that the length of time a participant had worked in the Prison Service made a significant difference on RV scores, with less experienced staff reporting higher levels of vulnerability. This was accompanied by a significant difference in RV scores between psychologists and prison officers. However consideration of demographic data relating to these two occupational groups shows that while 80.5% of prison officers had worked for the Prison Service for over 5 years, the same was true for only 18% of psychologists. In recent years the Prison Service has run regular recruitment campaigns to attract psychologists to work as treatment providers. This has resulted in a substantial increase in relatively newly qualified, young

psychologists taking up posts, and would account for the difference between the two occupational groups in terms of experience.

It may be argued that younger facilitators are likely to have limited, if any, prior experience of working therapeutically with sexually deviant individuals, and therefore in the early stages of their facilitating work allocate psychological resources to assimilating this experience. For example, working with sexually deviant individuals, without the benefit of having worked with a variety of both sexually and non-sexually motivated offenders, presents a particular challenge in terms of putting such individuals in an experiential framework. In addition, it may be argued that younger, and less experienced facilitators have fewer and/or less established coping resources on which to draw, in their efforts to assimilate the content and the process of their work.

Analysis of the factors according to previous experience of sexual abuse yielded some interesting results. There was no significant difference on any of the factors among respondents who had experienced sexual abuse as a child, but for respondents who had experienced sexual abuse as an adult, significant differences were apparent for both the NRO and RV factors. Given the dearth of information relating to abuse survivors who become therapists, and sex offender treatment therapists in particular, the reasons for such results can only be speculated upon. It is hypothesized that the comparative recency of sexual abuse experienced as an adult results in an emotional vulnerability that may be elicited more easily by the detail of working with sex abuse perpetrators, such as use of weapons, the language used by the perpetrator, the victims description of odour or the specifics of sexual acts forced on the victim.

Lew (1993) makes the distinction between surviving sexual abuse and recovering from it, emphasizing the immediacy of employing survival strategies and the long-term nature of recovery. Although respondents were not asked how recently they had been abused, or details about the nature of the abuse, the likelihood that they were still in a process of recovering from the experience, or even that they were still employing survival strategies, is high, compared with survivors of childhood sexual abuse. Such a hypothesis is born

out in part by analysis of coping and emotion control data. This revealed that survivors of adult sexual abuse were significantly more likely to ruminate, significantly less likely to be detached and more likely to be emotionally sensitive. While causation cannot be inferred from retrospective data, detached coping and rumination are considered stable traits that are amenable to change only through intervention, or as a result of trauma (Roger, 2002), indicating that perhaps the trauma of the abuse has disrupted usual characteristic coping styles. This very complex and sensitive area requires more investigation before definite conclusions can be drawn.

Recent experience (i.e. in the past six months) of an event considered traumatic resulted in a significant difference in scores on the Organizational Dissatisfaction factor, with respondents who had experienced trauma scoring higher. Although type of trauma wasn't categorized, events included bereavements, ill health of self or a family member, relationship break down, and job/accommodation change. A finding such as this might be explained through individual perceptions of organizational support during times of difficulty, even if the organization is not directly involved in the trauma experienced. Winnibust et al (1988) argue that if an employee lacks adequate support under conditions of high stress (e.g. non-organisational trauma), he or she will suffer from emotional strain [in addition to the original trauma], and it maybe this outcome that is reflected in the Organisational Dissatisfaction factor.

Interestingly, research into police officer stress indicates that organisational factors appear more important than operational ones in determining distress and well-being (Hart et al, 1995a). This finding is replicated in teacher stress research, which suggests that the organizational context of teaching is more distressing than the actual job itself (e.g. Borg, 1990; Hart, 1994; Hart et al, 1995b), and to some extent in the sex offender therapist literature, where therapists experience differing levels of personal accomplishment depending on organizational factors such as the setting of the work, e.g. community or institutional (Ellerby, 1998). However, what has not been elucidated from such research is the role of individual differences in the attribution of distress to organizational or operational factors. It is argued that individual differences

may be central to understanding perceptions of organizational response in times of difficulty, and this area will be explored in greater detail in Chapter Seven.

2.6 Conclusions

The comparatively recent evolution of sex offender treatment provision as a distinct therapeutic role means that the empirical evidence that has emerged describing the affect of that role on the treatment providers is limited. To date, much of the literature has been based on anecdotal material and has only been assessed loosely by general measures such as the MBI.

The construction of a specific scale to assess the impact on treatment providers of their work is a new development and, it is argued, central to the continued effectiveness of treatment interventions. The Assessment of Dynamic Adaptation (ADA) appears to encompass the full range of affects identified in the existing literature and means that for the first time a reliable and valid assessment can be made of the degree to which facilitators are affected by their work, and in which spheres.

A number of recommendations are made for further development of the scale. Firstly, a number of items relating to the positive aspects of working with sex offenders were removed from the exploratory factor analysis due to a high percentage of endorsement from respondents. It is suggested that a comprehensive scale should incorporate measurement of all aspects of working with sex offenders, and the consistent finding that up to 96% of therapists find satisfaction in their work should be reflected.

Expansion and confirmation of the factor structure using culturally varied samples from, for example, Europe, North America and Australasia, where structured treatment of sex offenders is also well established, is also recommended. A scale that can accommodate cultural differences, or at least versions of the same scale, would provide a valuable clinical tool for the

assessment of therapist well-being.

Future work in this area involves developing an actuarial device whereby the critical factors that influence psychological well-being of treatment providers may be identified, not only in terms of their particular impact but also in terms of the way in which they interact with other factors to exacerbate or alleviate the potential psychological damage. The ADA will provide the basis of an outcome measure for this algorithm with a view to informing treatment providers and managers about the need for appropriate courses of action to avoid such damage and implement appropriate support measures.

Chapter Three

Concurrent Validation of the Assessment of Dynamic Adaptation (ADA)

3.1 Introduction

The previous chapter described the construction of a new scale developed to assess the impact on facilitators of working therapeutically with sex offenders. The results of the exploratory factor analysis indicated three partially independent factors, subsequently named Negative Reactivity to Offenders (NRO), Ruminative Vulnerability (RV), and Organisational Dissatisfaction (OD). All three factors were shown to be internally consistent, and to have satisfactory test-retest reliability over an eighteen-week interval. The factor structure was confirmed using EQS confirmatory factor analysis, with data collected from an independent sample.

The present chapter reports on the concurrent validation of the ADA against a series of other established psychometric measures, considered to encapsulate the key themes emerging from the literature concerning psychological affect. For example, several studies have referred to the high levels of job satisfaction reported by sex offender treatment providers (Ellerby, 1998; Kadambi, 2000, 2003a; Scheela, 2001; Turner, 1992) but few studies reported specific data investigating this area. Similarly, rumination over offence details (e.g. Turner, 1992), accompanied by an increase in negative emotions such as frustration, anger and cynicism (Edmunds, 1997; Jackson, et al, 1973; Ellerby, 1993, 1997), had been highlighted as distressing and invasive for facilitators. Several studies also referred to different methods of coping, noting either their ameliorative or dysfunctional outcome (e.g. Jackson et al, 1997), with a detached style being indicative of the former.

Finally, therapist empathy was highlighted as a potential catalyst for psychological ill-health (Figley, 1995), an assertion noted by Kadambi (2003b) that has found empirical support recently in several unpublished studies showing statistically significant relationships between empathic styles, cognitive disruptions associated with vicarious trauma, and PTSD symptoms among professionals working with traumatised clients (Maramas, 2001;

Moosman, 2002; Wertz, 2001). Paradoxically, the importance has also been identified of empathic concern for clients in terms of effective intervention. In particular, high levels of therapist empathy have been associated, at a statistically significant level, with improvements among sex offenders on a range of clinical measures of change, particularly denial (Marshall et al (in press)). Empathy may be an important therapist quality for effective treatment, but that it is also implicated in increased psychological distress among therapists is a cause for concern and requires further investigation.

These themes are discussed below in the context of emotional style and empathy, and the measures chosen for the validation process, selected to provide an overarching and psychometrically robust assessment of these areas.

3.1.1 Emotional style and empathy

With the exception of satisfaction with work, the affective issues relevant to therapist effectiveness have been incorporated in a model of emotional response 'style' proposed by Roger et al (2000). In their model, they integrated emotional sensitivity, emotional inhibition and rumination, together with detached and emotion-focused coping, into a sequential, staged process aimed at predicting psychological health status. For example, they found that highly emotionally sensitive (empathic) individuals, who expressed their emotion, did not ruminate and adopted a detached coping style, were more likely to be protected from stress related ill health, than individuals who were empathic, but inhibited their emotional response, ruminated, and adopted a more emotion- focused coping style.

In the context of effective sex offender treatment, the relationship between these variables may well be more complex. In a comprehensive review of the general therapy literature Marshall et al (2003) concluded that empathy was a critical feature of effective therapists in relation to treatment outcome, and considerable empirical evidence supported their conclusion (Burns and Auerback, 1996; Woody et al, 1989). Similarly, Orlinsky et al (1994), in a review of 47 studies, found that in 34, empathy was correlated positively with therapeutic outcome.

In the specific context of sex offender treatment, therapist empathy has been significantly correlated with overall positive treatment effects, and shown to result in a decrease in victim blaming, denial of harm, denial of responsibility, denial of premeditation and minimization on the part of the offender (Marshall, et al, in press).

Empathy has been described in a variety of ways since the phrase came into popular use in the 1930's, and has been used interchangeably with terms such as sympathy, role-taking and perspective-taking. Marshall et al (in press), when considering empathy as a therapeutic skill, employed the definition provided by Kottler et al, (1994) as the ability of the therapist to understand and relate to the feelings of the client. But this somewhat vague definition has not taken account of the psychological impact on the therapist of applying the skill.

Mehrabian and Epstein (1972) identified a distinction between cognitive and emotional aspects of empathy. Cognitively empathic individuals can imaginatively take the role of another and, as a result, can accurately predict thoughts, feelings and actions of that individual (Cliffordson, 2000; Hogan, 1969), while remaining detached from the situation. Emotional empathy, on the other hand, is defined as a vicarious emotional response to the perceived emotional experiences of others, resulting in the individual experiencing similar emotions (Mehrabian and Epstein, 1972; Scotland, 1969).

More recently, the emotional and cognitive aspects of empathy have been considered as facets of the same construct (Davis, 1980, 1983; Cliffordson, 2000), and have been expanded by Davis into a multidimensional model consisting of four discriminable dimensions. Davis (1980) described these as Perspective Taking (PT), Fantasy (FS), Empathic Concern (EC) and Personal Distress (PD), and developed the Interpersonal Reactivity Index (IRI) as a method of assessing these concepts. Davis's PT scale assessed the individual's tendency to adapt spontaneously the viewpoint of others, EC assessed "other-oriented" feelings of sympathy and concern for unfortunate others, PD referred to "self-oriented" feelings of personal anxiety and unease in tense situations, and FS assessed the extent to which individuals transposed themselves imaginatively into feelings and actions of fictitious characters in books films

and plays. Cliffordson (2000), following confirmatory factor analysis of the IRI, proposed that EC functioned as a higher order variable, subsuming the other three dimensions, with emphasis on emotional reactivity as well as cognitive processes.

Returning to the role of empathy as a therapeutic skill, it becomes easier to see how the paradox described previously might arise. In order to facilitate effective treatment, the ability of the therapist to perceive the offender's behaviour from an empathic perspective, i.e. demonstrating EC and PT, might well enable the therapist to facilitate progress through treatment by asking relevant questions, expressing appropriate emotion in response to an offender's distress, predicting and responding to an offender's reactions to treatment and so on. Arguably, it is the cognitive component of empathy that is being considered in relation to treatment effectiveness, as it is observable and measurable.

However, Cerney (1995) asserted that details revealed to therapists in the course of their work could be so sadistic and horrifying that it would become practically impossible for therapists to maintain the balance of empathy and objectivity required to facilitate the client's treatment. Such a response, he maintained, was symptomatic of the emotional aspects of empathy and the reason it has been implicated in therapist ill-health. The process of imaginatively taking on the role of an offender would have considerable emotional implications for the therapist, bearing in mind the deviance, hostility, denial and resistance considered typical of this client group. Anecdotal reports by male therapists, expressing concern about becoming abusers themselves, given their work experiences, could well be a consequence of role-taking, and would predictably result in high levels of personal distress.

This element of empathy has not been addressed with sufficient clarity in the therapist style literature. Indeed, it is proposed that characteristics of personal distress (anxiety and unease in tense situations) are likely to manifest themselves in behaviours that have been identified as reducing treatment effectiveness, such as defensiveness, coldness and nervousness (Marshall, et al, in press) - behaviours contrary to empathic skill. If this is the case, the claim that empathy is a therapeutic skill is misleading, on the basis that it has only

been partially assessed.

Unfortunately, adequate psychometric techniques for assessing empathy in relation to therapeutic style are lacking. Indeed, in the context of effective intervention, client appraisals of the therapist style have formed the basis for much of the research (Orlinsky et al, 1994). But it would be predicted that therapists exhibiting high levels of therapeutic empathy, or EC and PT as defined by Davis (1980), evidenced by high levels of pro-therapeutic behaviour, and low levels of anti-therapeutic behaviour (PD), have their experience of empathy mediated by another of the emotional style components, detachment. Roger et al (1993) defined detachment as the feeling of being independent of a potentially stressful event and the emotion associated with it. Thus, it would appear that a therapist who could take the perspective of a client, exhibit appropriate concern as a result, but remain detached from the stressful elements of the process, would be most likely to facilitate effective treatment while at the same time be adaptive in managing the negative aspects of that experience.

To conclude, it appears that the concept of empathy is integral to sex offender treatment, both in terms of effective interventions and in relation to the psychological well-being of therapists. What has yet to be established is whether researchers in both areas are conceptualising empathy in the same way, and indeed whether or not the components of empathy as defined by Davies (1980) can exist as mutually exclusive domains. While it is beyond the scope of this thesis to make a comprehensive investigation of this hypothesis, the validation of the ADA provides an opportunity for preliminary exploration.

In the context of validating a scale that aimed to assess the impact their work has upon therapists, the relationship of that scale to those assessing the areas highlighted above was of foremost significance. In the selection of validation measures, it was also necessary to consider the restricted nature of the population under study. For example, the maximum number of participants in HM Prison Service eligible for inclusion at the time the research was conducted was 289 (all currently active treatment providers). The membership of NOTA provided a much larger participant pool, although the number

involved directly in the provision of sex offender treatment programmes was unknown. These factors meant that participant fatigue was a very real concern. In order to maximise the number of criterion variables against which the ADA could be validated, the scales that each sample received varied slightly, and these variations are indicated in Section 3.2.2.

3.2 Method

The ADA was sent out with a set of criterion variables detailed in Section 3.2.2. A letter outlining the purpose of the study was included, together with a freepost return envelope. Participants were informed that return of their completed questionnaires would be taken as consent for inclusion of their data in the study. The data were collected over a six-month period in 2001, from the two samples described below.

3.2.1 Participants

The first sample comprised a sub-sample of Prison Service respondents. The second sample was the same as that used for the confirmatory factor analysis and is described fully in Chapter Two.

3.2.1.1 Sample 1 - the Prison Service sample

The first 50 per cent of responding participants (n=90) from the original scale construction study (described in Chapter Two) were considered most likely to complete further scales, based on their demonstrated commitment to earlier aspects of the research. They were contacted, and seventy-four useable responses were received, representing an 82.2 per cent response rate. The sample comprised 58.1 per cent females (n=43) and 41.9 per cent males (n=31). The modal age range was 25-29 years, with 31.1 per cent of the sample under 30 years old. Fifty-eight per cent of the sample had less than or equal to five years prison service experience, with the modal time in service being 0-2 years. The total sample comprised 33.8 per cent prison officers, 14.9 per cent probation officers and 46 per cent psychologists or psychological assistants, with the remaining respondents recording their occupation as "other". Of this

sample, 14.0 per cent reported experiencing sexual abuse as a child and 16.2 per cent as an adult.

3.2.1.2 Sample 2 - NOTA sample

Sample 2 comprised 165 members of NOTA who participated in the Confirmatory Factor Analysis study, described in full in Chapter Two. In comparison with the Prison Service sample, NOTA respondents were older (mean age 44.4 years), more experienced in the field of sex offender treatment (mean time as therapist = 8 years), were more likely to have been abused as a child (28 per cent compared with 12 per cent in the Prison Service sample) and less likely to have been abused as an adult (12 per cent as compared 19 per cent).

3.2.2 The criterion variables

The criterion variables included sub-scales from a revised version of the Emotion Control Questionnaire (ECQ 3 - (Roger and Najarian, 1989; Roger and Nesshoever, 1987), the Emotional Sensitivity Scale (ESS; Guarino, Roger and Olason, 2000), a revised version of the Coping Styles Questionnaire (CSQ - Roger et al, 1993), the Compassion Fatigue Self-Test (CFST; Figley, 1995), and the full scale Interpersonal Reactivity Index (IRI; Davis, 1980). Full scales are included in Appendices G to K respectively.

1. *Revised Emotion Control Questionnaire (ECQ 3; Roger and Nesshoever, 1987; Roger and Najarian, 1989) - Rumination (R) subscale only.* It is argued that controlling emotion, especially by mentally rehearsing emotional events, may predispose individuals to stress-related illness by delaying recovery from the autonomic arousal associated with emotion. Given the suggestion in the sex offender therapist literature that this is common among treatment providers, inclusion of the rumination subscale of the instrument was considered imperative. Rumination assesses the tendency to mull over events perceived to be emotionally upsetting (e.g. "I get worked up just thinking about things that upset me in the past."), and has been shown to be internally consistent, with a

coefficient of 0.86.

The sub-scale was taken from a revised version of the original four-factor Emotion Control Questionnaire, which comprised aggression control and benign control in addition to rehearsal and emotional inhibition. The two former scales were omitted from the revised scale (Roger, 2002; Roger et al, 2000), and the renamed rumination scale incorporated a number of future-orientated items to the original rehearsal factor. The Emotional Inhibition component was expanded by the addition of items adapted from the fear of disclosure and social coping subscales of the Interpersonal Trust Questionnaire (Forbes and Roger, 1999). The preliminary factor analysis and confirmatory factor analysis of this new expanded scale yielded two unambiguous factors concerned with rumination (18 items) and inhibition (21 items) (Roger et al, 2000), and the former sub-scale was sent to both samples.

2. *The Compassion Fatigue/Satisfaction Self-Test (CFST; Figley, 1995)- Compassion Satisfaction (CS) sub-scale only.* This is a measure that has evolved from research into secondary traumatic stress, incorporating features from the burnout literature (Pines, 1993). Although still considered to be under development, it is purported to be generalisable to nearly any group in the Human Services field, including psychotherapists, teachers and public safety personnel, and has been used in numerous studies across a variety of disciplines (Figley and Stamm, 1996). For the purposes of this investigation, only the compassion satisfaction subscale was employed. This is a more recent addition to the CFSST, developed in response to concerns about a lack of evidence of what was happening to carers on the positive side of their work (Stamm, 2002). Preliminary data regarding the reliability of the scale indicated an Alpha Coefficient of .87 for this subscale. Given the evidence that between 75 per cent and 96 per cent of SOTP treatment providers found their work both satisfying and rewarding (e.g. Turner, 1992; Kadambi, 2000), it was deemed not only appropriate but necessary to consider the positive aspects of providing a therapeutic intervention to sex offenders. This scale was sent to both samples.

3. *Emotional Sensitivity Scale (ESS; Guarino et al, 2000) - Positive Emotional Sensitivity (PES) subscale only.* This newly constructed scale redefines the

concept of emotional liability envisaged by the construct of neuroticism, which has several theoretical and psychometric shortcomings (Guarino, 2003). It comprises two orthogonal dimensions labelled negative and positive emotional sensitivity (NES and PES respectively). The latter is assumed to be a more adaptive and functional sphere of emotional reactivity. For the purposes of the current study, the PES dimension was used as a measure of the extent to which facilitators were emotionally orientated to others. The choice of this measure was based on evidence in the literature, described in the introduction to this chapter, that empathic concern might exacerbate facilitator's emotional responses to the individuals with whom they work, causing increased distress. The internal consistency of this dimension is reported as 0.80, with a test-retest reliability of 0.89. This scale was sent to the HM Prison Service sample only.

4. *Revised Coping Styles Questionnaire (CSQ; Roger et al, 1993) - Detached Coping (DetCop) sub-scale.* This four factor measure of coping styles includes assessment of the traditional rational, emotional and avoidance coping, and includes a new detachment scale, defined by the feeling of being independent of a potentially stressful event and the emotion associated with it. More recently, (Roger, 1995) analysis has merged the emotional and detachment scales into one bipolar measure of adaptive and maladaptive coping, with detachment at one pole and emotional coping at the other. Labelled "detachment", this subscale was employed in the current investigation on the basis of empirical evidence indicating that those who felt able to detach from their work experienced less distress. This scale was sent to the HM Prison Service sample only.

5. *The Interpersonal Reactivity Index (IRI; Davis, 1980) - Full scale.* This 28 - item, four-factor measure assesses both cognitive and affective dimensions of empathy. The two cognitive dimensions, Perspective Taking (PT) and Fantasy (F) consider other-oriented reaction to the distress of others, and the use of imagination to experience the feelings and reactions of others respectively. Empathic Concern (EC) and Personal Distress (PD) are affective in nature, assessing regard and sympathy for another's feelings, and self orientated response to difficult interpersonal situations of others (Atkins and Steitz, in press). Davis (1980) reports internal consistencies for the four factors ranging from .68 to .79. The measure was distributed to the NOTA sample only.

3.3 Results

3.3.1 Results from the Prison Service sample

A correlation matrix was generated to consider the relationship amongst the three ADA factors and the criterion variables. The results can be seen in Table 3.1, which shows all three of the ADA factors to be significantly negatively correlated with detached coping from the CSQ (NRO; r = -0.28; df = 72, p< 0.05: RV; r = -0.37, df = 72, p< 0.01: and OD r = -0.36; df = 72, p< 0.01), and significantly positively correlated with rumination from the ECQ (NRO; r = 0-44; df = 72, p< 0.01: RV; r = 0.49; df = 72, p< 0.01: and OD r = 0-43; df = 72, p< 0.01).

Both NRO and RV correlated significantly with the positive sensitivity subscale of the ESS (NRO; r = 0.27; df = 72, p< 0.05: RV; r = 0.36, df = 72, p< 0.01), and OD correlated significantly negatively with the compassion satisfaction factor of the Compassion Fatigue/Satisfaction Self Test, CS (r = -0.46, df = 64, p< 0.01).

Table 3.1 Correlations between the ADA factors and criterion variables Prison Service Sample

		N	1	2	3	4	5	6	7
1	NRO	74	1.0	.44**	.43**	.44**	-.28*	.27*	-.22
2	RV	74		1.0	.37**	.49**	-.37**	.36**	-.20
3	OD	74			1.0	.43**	-.37**	.23	-.46**
4	ECQ-R	74				1.0	-.75**	.40**	-.44**
5	CSQ-DetCop	74					1.0	-.32**	.43**
6	ESS-PES	74						1.0	.11
7	CFST-CS	66							1.0

* p< 0.05; ** p< 0.01 NRO = Negative Reactivity to Offenders; RV = Ruminative Vulnerability; OD = Organisational Dissatisfaction; ESS(PES)=Emotional Sensitivity Scale (Positive Emotional Sensitivity; CSQ(DETCOP)=Coping Styles Questionnaire (Detached Coping); ECQ(R)=Emotion Control Questionnaire (Rumination); CFST(CS)=Compassion Fatigue/Satisfaction Self-Test (Compassion satisfaction)

3.3.1.1 *Correlations between the criterion variables*

Table 3.1 also indicates significant negative correlations between rumination and detached coping ($r = -0.75$; $df = 72$, $p<0.01$) and rumination and compassion satisfaction ($r = -0.44$; $df = 64$, $p<0.01$), and a significant positive correlation between rumination and positive emotional sensitivity ($r = 0.40$; $df = 72$, $p<0.01$). The CSQ additionally correlated significantly negatively with positive emotional sensitivity ($r = -0.32$; $df = 72$, $p<0.01$) and significantly positively with compassion satisfaction ($r = 0.43$; $df = 64$, $p<0.01$). No relationship was evident between compassion satisfaction and positive emotional sensitivity.

3.3.2 *Results from the NOTA sample*

A correlation matrix considering the relationship between the ADA factors and the criterion variables used for concurrent validation with the NOTA sample can be found in Table 3.2, where results suggest a partial replication of previous findings for the relationships between the ADA factors, but also some interesting variations between NRO and OD, and OD and two of the criterion variables.

The correlations between RV and OD, and RV and NRO are broadly similar between the Prison Service and NOTA samples (OD and RV: 0.37 and 0.29, respectively; RV and NRO: 0.44 and 0.44 respectively). However, the correlation coefficients between OD and NRO were substantially different (0.43 and 0.17), accounting for 18.7 per cent and 2.7 per cent of the variance respectively for the PS and NOTA samples.

Further differences emerged for the relationships between OD and ECQ rumination (0.43 for the Prison Service sample and 0.19 for the NOTA sample), and OD and compassion satisfaction (-0.46 Prison Service, -0.05 NOTA). These findings will be discussed fully in Section 3.4.4.

Table 3.2 Correlations of ADA factors and criterion variables used with the NOTA sample

		N	1	2	3	4	5	6	7	8	9
1	NRO	158	1.0	.44**	.17*	.43**	-.10	-.17	.05	-.04	.19
2	RV	158		1.0	.29**	.37**	-.21**	-.12	.11	.08	.31**
3	OD	158			1.0	.19*	-.05	-.33**	.12	-.06	.13
4	ECQ-R	157				1.0	-.25**	-.21*	-.08	-.08	.24**
5	CFST-CS	154					1.0	.20*	.11	.05	-.31**
6	IRI-PT	101						1.0	-.14	.14	-.24*
7	IRI-FS	101							1.0	.30**	.15
8	IRI-EC	101								1.0	.13
9	IRI-PD	101									1.0

** p<0.01 level (2-tailed); * p<0.05 level (2-tailed). NRO=Negative Reactivity to Offenders; RV= Ruminative Vulnerability; OD=Organisational Dissatisfaction; ECQ-R=Emotion Control Questionnaire (Rumination); CFST(CS)=Compassion Fatigue/Satisfaction Self-Test (Compassion satisfaction); IRI-PT=Interpersonal Reactivity Index (Perspective Taking); IRI-FS=Interpersonal Reactivity Index Fantasy; IRI-EC=Interpersonal Reactivity Index (Empathic Concern); IRI-PD= Interpersonal Reactivity Index (Personal distress).

Comparing the ADA and IRI factors yielded two significant correlations. OD correlated significantly inversely with PT ($r = -0.33$; $df = 99$, $p < 0.01$) and RV correlated significantly positively with PD ($r = 0.31$; $df = 99$, $p < 0.01$). No relationship was found between the ADA factors and EC or FS.

3.3.2.1 *Correlations between the criterion variables*

Three statistically significant relationships emerged between the criterion variables used with the NOTA sample, only one of which is directly comparable with the Prison Service sample, that between ECQ rumination and compassion satisfaction. For both samples there was a significant inverse relationship at $p < 0.01$ (NOTA; $r = -0.25$ and Prison Service; $r = -0.44$), but the difference between the coefficients warrants further discussion (see section 3.4.4).

The two other significant correlations were between PD and rumination ($r = 0.24$; $df = 98$, $p < 0.05$) and PD and compassion satisfaction ($r = -0.31$; $df = 97$, $p < 0.01$).

3.4 Discussion

Given the diversity of data collected from different samples for the concurrent validation of the ADA, the discussion will focus initially on each of the three ADA factors and their relationship with the criterion variables used in both the Prison Service and the NOTA samples. Consideration will then be given to the relationships between the criterion variables themselves within both samples. Emerging themes from both discussions will be drawn together in the conclusion.

3.4.1 *Negative Reactivity to Offenders (NRO)*

NRO correlated significantly positively with the rumination subscale of the ECQ and the positive emotional sensitivity subscale of the ESS, and significantly inversely with the detached coping subscale of the CSQ. No relationship was found with compassion satisfaction. The magnitude of the correlation between NRO and rumination accounted for less than 20 per cent of the variance, and was similar to the NOTA sample finding, where the correlation between NRO and rumination accounted for 18.6 per cent of the variance.

The NRO factor captures a range of negative emotions that have been associated both with working therapeutically with sex offenders, as well as more general attitudes to sexual abuse, such as anger, suspicion, cynicism, frustration and anxiety. Rumination is defined as a pre-occupation with emotionally distressing events or experiences. While a relationship between the two measures would be expected, given the emphasis on negative emotionality, the key difference between them is the role of pre-occupation, which is not an aspect measured by NRO.

A similar argument may be put forward for the small correlation between NRO and positive emotional sensitivity. This subscale of the ESS assesses other-oriented sensitivity (Guarino et al 2001), including concern for others' emotions and well-being, ability to recognise others' emotions and intention to help others facing difficulties. The relationship between the two scales is likely to reflect the emphasis both place on the recognition and interpretation of

negative or distressing emotion, such as worry, upset or concern. Inspecting the items from the two scales indicates a difference in emotional tone, with ESS suggesting an emotional reaction more indicative of a therapeutic response to others, and NRO suggesting a more hostile response. Despite a strong correlation between PES and the Empathic Concern sub-scale of the IRI (Guarino et al, 2001), neither empathic concern, or the other sub-scales of the IRI, achieved statistical significance with NRO in the NOTA sample, suggesting that NRO and empathy are indeed discriminable, and supporting the explanation put forward regarding the relationship between PES and NRO.

A modest negative correlation between NRO and CSQ detached coping, would indicate that individuals high on detachment are less likely to experience negative reactivity to sex offenders, though the relationship accounts for less than eight per cent of the variance, indicative of the interplay of other relevant variables.

So far these three variables, detachment, NRO and positive emotional sensitivity, have been considered independently, but more complex interactions amongst them may become apparent with further analyses. These issues will be readdressed in Chapter Five, where a range of psychometric data were collected from the same sample over a 12 month period, allowing for more comprehensive analysis.

None of the four sub-scales of the IRI achieved statistical significance with NRO in the NOTA sample, suggesting that NRO and empathy are discriminable. But the significant relationship between PES and NRO in the Prison Service sample provides some empirical support for the concerns expressed in the introduction to this chapter, regarding the measurement of empathy, to be discussed in more detail in Section 3.4.4.

3.4.2 *Ruminative Vulnerability (RV)*

RV correlated significantly positively with ECQ rumination from both the Prison Service and NOTA samples, and to a similar magnitude. It also correlated significantly positively with PES, and significantly negatively with

CSQ Detachment, as measured in the Prison Service sample (these two measures were not used with the NOTA sample). While no relationship was apparent with compassion satisfaction in the Prison Service sample, a significant negative correlation was found between RV and compassion satisfaction in the NOTA sample.

Taking these findings in turn, a correlation between RV and ECQ rumination would be expected for two factors emphasising a preoccupation with emotionally distressing material. What is perhaps more interesting is that more of the variance isn't shared. ECQ rumination has been demonstrated to be significant in a wide range of contexts. Repeatedly, it has been shown to be related to self reports of deteriorating health status (Roger et al, 1994), physiological indices of adaption, including delayed heart rate recovery (Roger and Jamieson, 1988), prolonged elevations in urinary-free cortisol secretion following exposure to stress (Roger, 1988), differences in self-reported anger in young offenders (McDougall et al, 1991), and differences in analgesic demand in peri-natal women (Nieland and Roger, 1993).

Rumination has been argued to represent a higher order construct (Roger, 2003), and there is support for this assertion in the relationship between rumination and all three of the ADA factors. If this were the case, it might initially suggest that the ADA is essentially a measure of rumination, so fails to add any useful dimensions to the assessment of facilitator well being. But closer inspection of the items on both RV and rumination identify important differences. The three highest loading items on RV indicate elements of rumination, but the fourth (of 17 items), explicitly concerns vulnerability. Additionally, the first three items of the RV factor are not indicative of emotional upset, which is the case for the highest loading items on the rumination factor of the ECQ. This reveals that the ADA is indeed measuring aspects of psychological functioning related to sex offender treatment provision that are not encapsulated by ECQ rumination, although the latter may well have an important bearing on adaptation to the work.

The small amount of variance shared between RV and PES is likely to be a reflection of the emotional tone portrayed in both factors. For example, they both emphasise emotions such as concern, anxiety, worry and sensitivity,

though RV is more concerned with emotional reactions to ones own distress, while PES focuses is on emotional reactivity to others.

The negative correlation between RV and detachment suggests that individuals with higher levels of detachment are less likely to experience RV. Detachment, the extent to which an individual can remain emotionally independent from events, by definition prevents ruminating over them. The relationship between ECQ rumination and CSQ detachment has been consistently demonstrated across a range of contexts (e.g. Roger et al, 1993) including in this study, where the correlation accounted for over 56 per cent of the shared variance. The fact that RV and ECQ rumination are also significantly correlated suggests that the relationship between RV and detachment might be expected, though the magnitude of the correlation between RV and detachment, at 13 per cent, is substantially smaller than ECQ rumination and detachment, and provides support for the discriminant validity of the ADA factors.

There was an inverse correlation between RV and compassion satisfaction for both samples but was significant only for the NOTA sample. Compassion satisfaction assesses the extent to which individuals are contented on both a personal and professional level, with items asking how often in the previous week the individual has, for example, felt invigorated by those they help, felt calm, trusted their co-workers or depended on their co-workers. An inverse correlation, between this scale and RV is not unexpected, given that an individual is unlikely to report contentment if they are also experiencing persistent feelings of vulnerability, and the significance level in the NOTA sample is likely to be accounted for by sample size.

However, the correlation was modest, which is interesting in the context of the repeated finding that sex offender treatment providers report high levels of satisfaction with their work despite some clearly deleterious effects. The inverse relationship between RV and compassion satisfaction may indicate that facilitators' enjoyment of their work is relatively unaffected by their experience of vulnerability.

The final significant correlation with RV was the Personal Distress (PD)

subscale of the IRI, a scale that focuses on self-oriented response to others' interpersonal difficulties. Self-orientation is likely to account for the relationship between the two factors, where the RV factor tends to describe the individuals' emotional responses to their own rather than others' circumstances.

3.4.3 Organisational Dissatisfaction (OD)

The OD factor of the ADA was the one in which most anomalies existed between the two samples used in the concurrent validation of the scale. Two points need to be raised here. The first is that the confirmation of the factor structure described in Chapter Two indicates that the OD factor was relevant across a wide range of organisational settings, indicating that the general tone of the OD factor was applicable across settings and common to facilitators generally.

The second is that the range of organisations represented in the NOTA sample probably explains those cases where the relationships between the OD factor and the criterion variables were not replicated across the samples. For example, even when accounting for variations between prisons, respondents in the Prison Service sample share a number of common features, such as organisational structure, practice setting and treatment methodologies. NOTA respondents, on the other hand, represent a diverse range of public, private and voluntary organisations which practise in a variety of institutional or community based settings, and which work from a range of therapeutic perspectives.

The extent to which the ADA factors correlated with each other was discussed in detail in Chapter Two. However, in the context of the current study, the magnitude of the difference in correlations between OD and NRO across the two samples warrants further discussion. Specifically, OD and NRO correlated 0.48 in the Prison Service and 0.17 in the NOTA sample.

As was previously highlighted, the NRO factor encapsulates a range of negative emotion such as cynicism, hostility, anger and suspicion that have

been identified by practitioners in the field as common responses to their work with sex offenders. It has also been pointed out that prison environments are particularly harsh and unforgiving, where expressions of emotion or caring may be interpreted as weakness (Coyle, 1994). The culture that tends to pervade most prisons, often requiring staff to be authoritarian and disciplinarian (Pogrebin, 1978), would suggest that the expression of hostility is a more acceptable emotional response than, say, vulnerability (Clarke and Roger, in preparation). The implication of organisational issues in the expression of hostility might account for the higher correlation between these two factors among Prison Service respondents.

Where ECQ rumination correlated to a similar degree with NRO and RV in both samples, this was not the case with OD. Correlation in the Prison Service sample was considerably higher than the NOTA sample (0.47 and 0.19 respectively), and the difference between the correlations proved to be significantly different ($p<0.026$). It is argued that this is more likely to be indicative of organisational rather than individual differences. Levels of staff support, attitudes of colleagues, methods of management and so on, as encapsulated by the OD factor, will vary substantially between the large number of organisations represented in the NOTA sample. Also, the interpretation of items in the OD factor may be slightly different for NOTA respondents compared with Prison Service respondents, on whose experience the items are based. But the fact that both correlations were significant suggests that ECQ rumination impacts on the extent to which therapists experience dissatisfaction with the organisation.

The significant negative correlation between OD and compassion satisfaction, evident in the Prison Service sample, was not replicated in the NOTA sample, although the relationship was in the same direction. The compassion satisfaction subscale emphasises the compassion experienced as a result of working in a "helping profession", and has a strong emphasis on co-workers as well as clients. It would thus be expected that high levels of satisfaction on this factor would be inversely related to OD.

The lack of support for this finding amongst the NOTA respondents is again likely to reflect the diverse range of organisations and also the client groups

represented in this sample. It is noteworthy that as well as working with male sex offenders, 48 per cent of NOTA respondents also worked with female sex offenders, 48 per cent with male child survivors of sexual abuse, 40 per cent with female child survivors, 75 per cent with male adult survivors and 60 per cent with adult female survivors.

In the Prison Service, sex offender treatment facilitators do not formally undertake work with survivors of sex abuse, and indeed any additional client caseload would comprise only other offenders. It is argued that the issues relating to working with victims are different from those related to offenders, and the interplay of such factors for NOTA respondents may have influenced the relationship between compassion satisfaction and OD. This is likely to be in addition to the differences highlighted in the previous paragraphs.

The relationship between OD and Perspective Taking (PT), evident in the NOTA sample, raises an interesting debate concerning the role of individual differences and the attribution of psychological distress to organisational issues. Hart et al (1995) cited empirical evidence that in the case of police officers, organisational experiences resulted in more distress than operational ones (Band and Manuelle, 1987; Brown and Campbell, 1990; Greller et al, 1992), despite the generally held opinion that policing was stressful due to the dangerous and unsavoury tasks that form part of the everyday work. This evidence has received further support from research into teacher stress, showing the organizational context in which teaching took place to be more distressing than the job itself (Borg, 1990; Hart, 1994; Hart et al, 1995; Kyriacou, 1987).

However, consideration of individual differences in such research is typically based on measures of neuroticism (N) and extraversion (E), despite the widely recognised influence of negative affectivity bias associated with individuals high on N. Research has shown such individuals are prone to experiencing negative emotions, such as anxiety, anger, sadness and disgust, to be often tense, worried, depressed or angry, and to have low self-esteem (Costa and McCrae, 1987; Eysenck and Eysenck, 1964; Watson and Clark, 1984). Consequently, they would be more likely to focus on negative aspects of themselves and their environment (Costa and McCrae, 1990), confounding

data related to occupational stress (Parkes, 1990; Schaubroeck et al, 1992; Watson, 1990).

While it is beyond the scope of this thesis to review the literature concerning attributional process, it is argued that the relationship between organisational dissatisfaction and perspective taking may be usefully discussed in this context. Joseph (1999), when considering the relevance of attributional processes to coping and post-traumatic stress disorder, highlighted the perceived importance of locus attributions in psychosocial functioning. Referring to Janoff-Bullman's (1992) typology of blame, Joseph highlighted that, although the relationship between "other-blame" and mental health had not been extensively addressed, there was evidence from a variety of studies that other-blame, thought to be driven by the need to maintain self-esteem, was associated with impaired emotional well-being (Tennen and Affleck, 1990).

Contrary to the prediction in the helplessness and hopelessness theories (e.g. Abramsonn et al, 1978; Abramson et al, 1988), that external attributions should buffer the effect on self-esteem of a negative event, Tennen and Affleck (1990) suggested that when someone else was blamed for a threatening event, the victim disconnected from the outcome and thus did not believe that he or she could control its sequelae.

High scorers on the OD factor of the ADA are more likely to endorse statements such as "I feel unsupported by non-SOTP colleagues", "When things go wrong with SOTP it is invariably the facilitators that get the blame" and "I feel resentful when my line manager doesn't take into account the work I do for SOTP", statements indicative of "other-blame". However, high scorers on perspective taking are significantly more likely not to endorse such statements on the OD scale, suggesting that they feel more in control of events, and consequently experience less distress. These relationships will be explored further in Chapter Six.

3.4.4 *Relationships amongst criterion variables common to both samples*

The only criterion variables used with both samples in this study were rumination and compassion satisfaction, and, as expected, in both samples a significant negative relationship emerged, indicating that replaying emotionally distressing material was inversely related to satisfaction with ones' work.

In the Prison Service sample, rumination was significantly positively correlated with Positive Emotional Sensitivity (PES), suggesting that other oriented awareness was associated with mulling over emotionally distressing material In the context of therapist qualities associated with effective interventions, this finding might shed some light on the psychological processes implicated in empathic therapists apparently experiencing more distress (Figley, 1995) - an important development as, although there is face validity to this claim, the processes involved have not been comprehensively explicated. The inference from these findings, that rumination may be associated with such sensitivity, provides some indication of the processes that might be at work.

Interestingly, Empathic Concern (EC) from the IRI did not correlate with rumination in the NOTA sample, suggesting that, despite the strong correlation between PES and EC found by Guarino et al (2001), in the context of sex offender treatment provision, the two dimensions tap into different aspects of therapeutic functioning. This would lend some support to the discussion in section 3.1.2 concerning the complexity surrounding the measurement of empathy, and suggest that perhaps therapeutic effectiveness is a function of EC as measured by the IRI, whereas empathic therapist distress is a result of high levels of PES. This requires further exploration.

Detached Coping, used only with the Prison Service sample, correlated significantly negatively with rumination and PES and positively with compassion satisfaction. The first of these findings supports the consistent results from a range of studies illustrating the inverse relationship between detachment and rumination (e.g., Roger et al, 1993). The relationship with PES supports the notion that detachment may mediate the effects of distress

induced by empathy, in that those scoring high on detachment appear to score lower on PES. This is further supported by the positive relationship between detachment and CS.

Although reached through the use of different measures, similar conclusions can be drawn through considering the relationships between perspective taking and personal distress (PD) with rumination and CS. Here, high levels of PT, arguably' an important component of detachment, were associated with higher degrees of satisfaction with work and lower levels of rumination, whereas PD was indicative of high levels of rumination and low levels of satisfaction with work.

These areas require further investigation, but if, through robust empirical testing, they are proved to be true, the implications for reducing therapist distress while at the same time maintaining therapeutic effectiveness are substantial This will be returned to in Chapter Seven.

3.5 Conclusions

The results from the validation study indicate that the three factors of the ADA correlated well with conceptually similar constructs, with discriminant validity evident from differential correlations against this range of constructs, and no correlations with conceptually dissimilar scales.

Themes emerging from the investigation included the complexity of the assessment empathy, the role of empathy as a therapist skill and its implication in therapist distress, the relationship between perspective taking and satisfaction with the organisation, and the potential mediating role of detachment in reducing negative emotional reactivity as a consequence of working with sex offenders. These themes are addressed in later chapters of this thesis and will be addressed again in the concluding chapter.

Chapter Four

A Cross-Sectional Investigation of Psychophysiological Responses to Material Typically Encountered by SOTP Therapists

4.1 Introduction

To date, all published studies investigating the effect on individuals of working therapeutically with sex offenders have been based on retrospective self-report, with data being gleaned either through interview and/or questionnaires and/or general psychometric tools. Further, none of these studies have incorporated control groups with which reliable comparisons can be made. Where comparative references are made (Ellerby, 1998; Kadambi and Truscott, 2002), it is with normative data relating to a particular psychometric assessment. Consequently, there are a number of significant shortcomings, including the absence of any *objective* assessment of impact on treatment providers, lack of comparison with professionals in a similar field and a failure to account for the impact of therapists no longer working in the field, who by definition will have been excluded from retrospective research. As Kadambi and Truscott have pointed out, investigations involving professionals who have chosen to stop working with sex offenders may offer otherwise untapped information on the potential impact, while comparisons with professionals from other spheres of mental or forensic health would prove valuable in assessing the need for unique preventative strategies for sex offender treatment providers.

This chapter aims to address these shortcomings by employing a cross-sectional design to compare current therapists, ex-therapists and non-therapists in their physiological responses, measured by changes in blood pressure, to material typically encountered by individuals working therapeutically with sex offenders.

Few would dispute that some constructs, owing to their perceptual nature (Schmidt, 1994; Spector, 1994), are most appropriately measured by self-report. These include attitudes, values and affective responses to the work environment. Self-report methods are also uniquely suited to tasks such as

obtaining individuals' personal theories about their experiences and their feelings (Norwick et al, 2002). So it has made intuitive and clinical sense to use data from self-report measures as the foundation for understanding the nature of the perceived impact their work has on sex offender therapists, and this method remains central to continued investigation in the area.

However, developments in the field suggest that it is no longer tenable to rely on self-report data *alone* to inform individuals and organisations about the nature of the impact, the course it might take, or potential psychological outcomes for therapists. The same might also be argued for continuing to base conclusions about the impact of the work on retrospective data. The relative infancy of research in this field has meant that, initially at least, data were drawn largely from individuals who had built up some experience in the field. But the increase in the systematic treatment of sex offenders over the past 10 years (Mann and Thornton 1998) provides ample opportunity for cross sectional and longitudinal research (Chapters Five and Six of this thesis report on longitudinal investigations).

There are recognised limitations to self-report methodology. Systematic biases associated with self-report measures are likely to result in response distortion, not only of each measure, but also when self-report is used to assess all variables in a study, of the correlations between them too (see Frese and Zapf, 1988; Spector and Brannick, 1995). Contrada and Krantz (1987), in a review of the difficulties associated with retrospective measures, put this down to respondents striving for consistency in their responses, and a tendency to edit recollections in the direction of socially desirable responses. Such biases indicate a need for caution when attempting to make causal attributions based on self-report data, largely because it is never clear precisely what is being measured (Kessler, 1987; Paulhus, 1991).

Razavi (2001), when commenting on the use of self-report in organisational behaviour research generally, suggested that "reliance on self-report for the measurement of both dependent and independent variables raises concern about the validity of causal conclusions for a range of reasons, including systematic response distortions, method variance and monomethod bias, and

the psychometric properties (reliability and validity) of questionnaire scales" (p.2).

Response distortions in general have been extensively investigated (e.g. Lanyon and Goodstein, 1997; Frese and Zapf, 1988; Spector and Brannick, 1995) and while it is beyond the scope of this chapter to provide a full review, the influence of socially desirable responding requires further consideration in the current context.

It is argued that the tendency to answer self-report items in such a way as to deliberately or unconsciously represent oneself in a favourable light might be exacerbated by the nature of the environment in which sex offender treatment occurs, a factor implicated strongly in influencing a participant's motivation to respond in a way that suggests coping rather than in any other manner. It was noted in Chapter One that prison environments are often experienced as harsh and unforgiving, where expressions of emotion are interpreted as weakness (Coyle 1994). As a likely consequence, treatment providers might have a vested interest in not disclosing personal distress, perhaps in the belief that it could be interpreted as inability to cope with the nature of the work, or could affect their opportunities to remain working in a field that they also experience as rewarding and satisfying (Clarke and Roger, 2002).

In contrast, treatment providers may attribute personal distress to their experience of working with sex offenders when other events or experiences may be impinging on their psychological well being. In either case it cannot be reliably stated that the nature of sex offender treatment provision is the sole cause of psychological distress experienced by around one-fifth to one-quarter of treatment providers (Ellerby 1998; Turner 1992).

Norwick, Choi and Ben-Schachar, (2002) cited the work of Nisbett and Cohen (1996), who in their "culture of honour" research, used a multi-method approach consisting of physiological and behavioural measures, as well as self-report, to make a powerful claim for their theory, resulting in "an impressively tight and cogent profile of the culture of honour" (Norwick et al, p4). In terms of outcomes, Razavi (2001) argued that independent measures of behaviours, such

as physiological assessment, could supplement subjective evaluation and enhance the interpretation of causal relationships, particularly in the stress process.

In response to the shortcomings outlined regarding retrospective data and self-report, an experiment was designed to compare three groups of prison staff (currently active facilitators, ex-facilitators and prison staff who had not worked with sex offenders in any therapeutic capacity) in terms of their physiological reactions to material that might typically be encountered by SOTP therapists in the course of their therapeutic work. Psychometric measures were also incorporated to allow for comparisons to be made between self-report and objective assessment.

The experimental design, and the context in which the experiment would be conducted, required that specific attention be given to A) the type of physiological measure used and B) the nature of the stimuli employed to provoke a physiological reaction. The following two sections provide a rationale for the decisions that were made.

It was expected that current and ex-facilitators would demonstrate different physiological responses to the material than non-facilitators, but no specific hypotheses were generated about the direction of the difference. It was postulated, however, that the investigation would yield data that could provide preliminary information regarding the processes involved in adaptation to the work.

4.2 Method

4.2.1 Psychophysiological assessment

Objective assessment of stress responses usually involves measurement of physiological indices, such as blood pressure, heart rate, skin conductance or cortisol secretion. For the purposes of this research, a number of factors needed to be considered regarding the choice of physiological measurement. Constraints were imposed by cost, as well as the practical application of the

measure in the experimental setting, which was, of necessity, conducted within prison establishments.

Blood pressure (BP) measurement is a relatively non-invasive measure, equipment is easily transportable, quick to set up and has minimal cost implications. Continuous monitoring is the preferred strategy, but this involves less portable equipment and the placement of electrodes. A practicable alternative is to use interval assessment, which provides three measurements at each reading: systolic (reactive) pressure, diastolic (at rest) pressure and heart rate. This measurement is highly sensitive to movement artefact, as well as the confounding effects of stimulants such as caffeine and nicotine on blood pressure itself that are not easy to control for.

Cortisol can be assayed from samples of urine, saliva or plasma, and is considered a precise and reliable measure of stress response, but is expensive to implement, relatively invasive for participants and requires specialist storage, processing and interpretation of the results. Unless assessed as urinary-free cortisol, levels may also fluctuate relatively quickly over short-term assessment intervals.

Electrodermal measurement is generally considered both accurate and sensitive as an index of stress or arousal, but is complicated and lengthy to implement and might be considered invasive, particularly with regard to electrode positioning.

Given the advantages and disadvantages outlined above, it was decided that interval BP measurement was the most appropriate method of physiological assessment for this experiment.

The job strain model proposed by Karasek, Baker, Marxer, Ahlbolm and Theorell (1981) has provided a useful framework for investigating the relationship between work-related stress, blood pressure and hypertension. It is beyond the scope of this chapter to evaluate critically the wide range of theoretical models addressing work-related stress and blood pressure (see Schwartz, Pickering and Landsbergis, 1996, for a review), but in summary, the

two main components of the job strain model are psychological demands and decision latitude (or autonomy). According to the model, those with greater autonomy have more flexibility to meet the demands of their work and are therefore predicted to experience little or no distress. Those roles that combine high psychological demands and low decision latitude are labelled high strain, and are most likely to cause distress (Scwartz, Pickering and Landsbergis, 1996).

These two factors also characterise the role of the sex offender treatment facilitator, who faces high psychological demands but has little flexibility for responding within the therapeutic setting. Thus, although the current investigation was not explicitly formulated within the job strain model, empirical evidence validating the model does provide support for the use of blood pressure monitoring as a measure of physiological responding. For example, Steptoe, Cropley and Joekes (1999), in a study of school teachers experiencing high and low job strain, found that job strain was associated with heightened blood pressure to uncontrollable but not controllable tasks, with high job strain participants failing to show a reduced blood pressure into the evening. Facilitators are arguably faced with many uncontrollable events, not only in relation to their client group, but also in relation to colleagial and public responses to their role. Harenstam, Theorell and Kaijser (2000) found that systolic blood pressure was significantly associated with coronary heart disease in male prison staff, a finding similar to that of Light, Turner and Hinderliter (1992), who found job strain was associated with higher work blood pressures in men. Theorell, DeFaire, Johnson, Hall, Perski and Stewart (1991), in a study of 161 men with borderline hypertension found job strain (expressed as the ratio of psychological demands to control) was significantly related to diastolic blood pressure during work and sleep.

Other studies of the role of cardiovascular reactivity in specific occupational groups have included air-traffic controllers (Cobb and Rose, 1973), prison staff in Sweden (Harenstam and Theorell, 1988; Harenstam, Theorell and Kaijser, 2000), nurses (Theorell, Ahlberg-Hulten, Jodko, Sigala, Soderholm and de la Torre, 1993) and paramedics (Jamner, Shapiro, Goldstein and Hug, 1991). In the latter study, Jamner et al, (1991) reported that hostility and defensiveness among paramedics were associated with higher diastolic blood pressure in

settings that potentially involved interpersonal stress. However, the nature of the interpersonal interactions were not directly assessed, highlighting one of the recognised shortcomings of such investigations - the difficulty in determining what specific characteristics of the work situation adversely affect incumbents' health.

In view of the methodological problems posed by the investigation of naturalistic stressors, cardiovascular reactivity is widely assessed in laboratory preparations using analogue stressors such as tasks performed under incentive conditions (for example, Waldstein, Bachen and Manuck, 1997; Smith, Nealey, Kircher and Limon, 1997). Though often questioned for their ecological validity, these studies do provide precision and control over both stressors and outcome measures, and the method was felt to be particularly appropriate for the present study where intrusions into the therapeutic setting might significantly confound the effects. The analogue stressors used in these studies are of course crucial to the validity of the findings, and these issues will be discussed in the next section (4.2.2).

4.2.2 *Stress inducing stimuli*

As with the type of physiological measurement to be used, detailed consideration was given to the nature of the stimuli to be used to induce stress, with particular regard to ethical issues (see Section 4.2.3). The use of video clips taken directly from treatment groups was deliberated, and whilst the reality of such stimuli was considered likely to induce a stronger stress reaction than other available stimuli, there were a number of experimental difficulties.

It would be necessary to set the potentially stressful part of the clip in context, resulting in several minutes of footage per scenario. Use of video clips from treatment groups would assume the participant had some knowledge of the treatment process, not possessed by the control group (non-SOTP staff), which could potentially bias the results. Further, no equivalent video footage would exist for other aspects of treatment provision that facilitators identified as stressful, such as management and peer support, knowledge of victim statements, volume of work and so on. There were, in addition, the practical

difficulties of transporting video equipment, or finding suitable equipment and appropriate testing areas in prisons.

Given the practical difficulties with video stimuli, it was decided to generate a range of scenarios that had previously been identified by facilitators as stress inducing, and present them in written form. The use of pre-recorded text was considered, but rejected on the grounds that reader emphasis might affect participants' imaginative response to the stimuli. Specifically, over emphasis of a particular aspect of the scenario might affect participants' response, while monotone presentation would be unlikely to elicit any response whatever. It was considered that participants could avoid engagement with material if they were not required to interact with it in some way.

In order to produce stressful stimuli, ten scenarios were constructed based on the experiences of a number of established facilitators, five of which related to situations involving peers and managers, and five to offender specific situations. A further two neutral scenarios were created by the author (see Appendix L for all scenarios). None of the scenarios replicated those used in the construction of the ADA detailed in Chapter Two.

All 12 scenarios were then distributed to 25 experienced facilitators, who were asked to record their immediate, intuitive response to each scenario, and to rate them on the scale of personal distress from 1 to 6, where 1 was "Not at all personally distressing" and 6 was "Very personally distressing".

Their participation in this element of the research was anonymous and no demographic information was collected. Fifteen completed sets of scenarios (60%), were returned, with the ratings given in the Table 4.1.

Based on these results, Scenarios J and H were chosen as the two offender and organisational scenarios likely to evoke the greatest stress response.

Scenario J (Offender based)

While reading a *prisoner's file you come across* a *bundle of court papers, including victim statements and details of forensic evidence. The forensic evidence includes* a *Teletubbies duvet cover stained with semen and blood.*

This scenario is referred to as the Forensic scenario hereafter.

Scenario H (Organisationally based)

For the last year you have worked as a facilitator for the Sex Offender Treatment Programme. It is a core part of your establishment's business and contributes to national targets. However, your line manager has not included this work in your annual performance review, and hints at it being a "side-line". You end up with an "Almost Achieved" marking and the comment "Although all the targets were met, this was done with minimal effort. Too much attention was given to other areas."

This scenario is referred to as the Management scenario hereafter.

Table 4.1 Descriptive statistics for scenario stimuli ratings

Scenario-K	Range				
	N	Min	Max	Mean	Std. Deviation
AORG	15	3	6	4.13	.92
BOFF	15	1	5	2.73	1.16
COFF	15	2	6	3.80	1.32
DOFF	15	2	5	3.53	1.06
EOFF	15	2	6	4.40	1.30
FORG	15	2	5	3.27	.96
GORG	15	1	5	3.00	1.00
HORG	14	2	6	4.14	1.41
IOFF	15	1	5	2.87	1.36
JOFF	15	2	6	4.40	1.50
LNEUT	15	1	1	1.00	.00
KNEUT	15	1	1	1.00	.00

off = offender based; org = organisationally based; neut = neutral; A-K=scenario identification

Despite the high mean of Scenario E, it was rejected on the grounds that it was likely to be more applicable to female facilitators.

Similarly, scenario A was rejected as the content had both an organisational and offence based focus and could thus be considered ambiguous, as indicated by the comments made by the raters.

The two neutral scenarios (K and L) were both consistently rated as "Not at all personally distressing". Scenario K was selected on the grounds that it was probably more realistic.

Scenario K

You are walking along the road on your way home after a days work. It's warm and bright and you are planning what to do for the evening. You notice an advertisement for a film that has just been released that you'd really like to see, so decide to phone a friend to make arrangements to go to the cinema.

4.2.3 Ethical considerations

The nature of the experiment required the use of material that potentially some people might find distressing. The details of the experiment were submitted to the ethics committee at the University of York and the procedure was agreed to be acceptable. All participants were informed that as a consequence of the involvement in the research they would be asked to read material typically encountered by SOTP therapists. They were also informed that they could withdraw from the process at any time, and that if they wished to discuss any element of the research, time would be available at the end of the session.

4.3 The Pilot Study

In order to test the effectiveness of the scenarios in eliciting a stress response, and to test the experimental procedure, a pilot study was conducted.

4.3.1 *Participants*

Eight members of staff from HMP Full Sutton participated in the study, three of whom facilitated SOTP and five of whom had had no formal experience of treating sex offenders. Although demographic information was collected, it was not utilised for the purposes of evaluating the experimental procedure or design, but, briefly, half the sample was female, three were Prison Officers, three were psychologists and two described their role as "other". Fifty percent facilitated on programmes other than SOTP. Fifty percent of the sample lived with a partner and 50% had children. Two participants reported having experienced trauma in the past six months, one reported experiencing sexual abuse as a child and one as an adult.

4.3.2 *Apparatus*

4.3.2.1 *Blood pressure measurement*

Reactivity measures were taken using a fully automated electronic Omron cuff monitor, which provided measures of systolic blood pressure (SBP), diastolic blood pressure (DBP) and heart rate (HR). Measures were all taken on the left arm for each subject, with the cuff at approximately heart level and the arm resting on the table palm up. This process was employed on both the pilot and actual experiment.

4.3.2.2 *Psychometric measures*

Four psychometric scales were used in this experiment, including:

- Assessment of Dynamic Adaptation (ADA; Clarke and Roger (in preparation))
- Coping Styles Questionnaire (CSQ: (Roger et al, 1993; Roger, 1996) Detached Coping (DetCop) subscale. The revised CSQ comprises three subscales assessing rational, avoidance and detached coping. Only the latter subscale, which is a bipolar detached/emotional coping index was used in this study.
- Emotional Sensitivity Scale (ESS; Guarino et al, 2001) ; Positive Emotional

Sensitivity subscale (PES)

- Emotion Control Questionnaire (ECQ; Roger and Najarian, 1989) Rumination (R) and Emotional Inhibition (EI) subscales.

With the exception of the Emotional Inhibition subscale of the ECQ, which is described below, these measures are described in detail in Chapter Three. The *Emotional Inhibition* subscale of the ECQ assesses the extent to which individuals inhibit their expression of experienced emotion. It is considered distinct from the hypothesised emotional arousal or arousability encompassed by neuroticism (Roger et al, 2001).

4.3.3 Procedure

The experiment was carried out in a quiet office, equipped with a desk and two chairs. Efforts were made to remove any visual distractions from the environment. On arrival, participants were read the following instructions:

Thank you for agreeing to participate in this study. As you may know, the Prison Service is supporting a three-year research project, investigating the impact on SOTP facilitators of working therapeutically with sex offenders. The research is divided up into a number of studies, one of which (this one) is looking at physiological stress responses to material typically encountered on SOTP. Stress is measured using this blood pressure monitor in response to written scenarios that have been identified by experienced facilitators as stressful.

The procedure involves putting this cuff on your arm and taking two readings (baseline measures). I will then show you a scenario, ask you to indicate when you have read it, and take your blood pressure again. After a few minutes I will show you another scenario and so on. All together you will have your BP taken six times. At the end of the procedure you will be asked to rate each of the scenarios in terms of how distressing you found them. I will then ask you to complete a number of questionnaires. You will also be given the opportunity to ask about any aspect of the research or discuss your opinions about it.

All the information collected remains confidential to this research project and you have the right to withdraw at any time.

Participants were then asked to sign a consent form (see Appendix M).

The cuff was placed on the participant's left arm and two initial readings were taken to acquaint the participant with the measurement system. The second of these readings was used as the baseline measure on which comparisons were made with readings in response to the experimental scenarios.

On completion of the experimental procedure, participants were asked to complete the psychometric scales described above.

4.4 Results from the Pilot Study

Mean scores were obtained on each of the three dependent variables (SBP, DBP and HR). Using One-Way ANOVA, the means for the three data collection points - second baseline measure, response to the Management Scenario and response to the Forensic Scenario - were compared. The mean scores and F ratios are summarised in Appendix N.

None of the three ratios was significant, indicating that there was no change in any of the three physiological measures across administration. As a consequence, the methods that would encourage participants to engage with the stimuli at an emotional level at the time of presentation were amended. It was decided that participants should be asked for their immediate response to the scenario, and to rate it on the scale of 1 to 6, at the time it was presented, (rather than at the end). The experimenter would record this information. The instructions were modified to this end.

Owing to practical difficulties of obtaining additional participants, the amended procedure could not be tested empirically, but consultation with experts in the field suggested that the new procedure should be adequate. The procedure described above was amended accordingly and used in the main study.

4.5 Main Study

4.5.1 Participants

Participants for the two experimental groups (current and ex-facilitators) were canvassed from prisons where Sex Offender Treatment Programmes were established, and participants for the control group were drawn from three prisons where SOTP was not, and had not been available. Governors of the prisons were contacted in writing requesting permission to research in their establishment, and where a positive response was received, contact was then made with a nominated person who in turn recruited participants. The demographic data indicated that the samples were generally similar (see Table 4.2), with the key difference being between occupations. Prison officers largely represented the ex-facilitator sample, but logistical difficulties prevented efforts to match the groups more closely.

The format for the collection of demographic information collected for this study was the same as that collected for other phases of the research (see Appendix B). A summary of demographic information is presented in Table 4.2.

4.5.2 Equipment

4.5.2.1 BP measurement

Reactivity measures were taken using the same equipment as that used in the pilot study.

4.5.2.2 Psychometric measures

The psychometric measures employed in the main study were the same as those described in Section 4.3.2.2, though the ADA could only be administered to current and ex-facilitators, as completion of the scale requires prior experience of facilitating sex offender treatment. All participants completed all other scales.

Table 4.2 Demographic information

Variable	Whole Sample	Experimental Group			p
		Control Group	Current Facilitators	Ex-Facilitators	
Gender(%)					
Male	27(51.9)	9(45)	9(45)	9 (56.3)	0.73 (ns)
Female	25 (48.1)	7(43.8)	11(55)	7(43.8)	
Mean age (SD)	39.0(10.8)	36.2(11.0)	38.2 (11.9)	42.9(8.5)	0.20(ns)
Mean months till retire (SD)	98.2 (83.8)	77.9 (92.1)	76.2 (70.8)	144.6 (74.4)	o.24(ns)
Mean months facilitating (SD)	27.3 (32.0)	-	39.2 (34-6)	41.9(28.3)	0.00**
Mean months since quitting	-	-	-	30.44(22.91)	
Occupation (%)					
Off	28 (53.8)	9 (56.3)	5(25)	14(87.5)	0.002*
PO	4(7.7)	1 (6.3)	2(10)	1 (6.3)	
Psych Asst	7(13.5)	2 (12.5)	5(25)	-	
Psych	10 (19.2)	1 (6.3)	8(40)	1 (6.3)	
Admin	1 (1.9)	1 (6.3)			
PSO	1(1.9)	1 (6.3)			
Other	1 (1.9)	1(6.3)			
Qualifications (%)					
None	6 (11.5)	-	2(10)	4(25)	0.26(ns)
GCSE	12 (32.1)	6 (37.5)	1(5)	5(31.3)	
A Level	6 (11.5)	2 (12.5)	3 (15)	1 (6.3)	
HND/BTEC	7 (13.5)	2 (12.5)	1(5)	4(25)	
BSc	7(13-5)	3 (18.8)	4(20)	-	
MSc	11(21.2)	2 (12.5)	8(40)	1 (6.3)	
Other	3 (5.8)	1 (6.3)	1(5)	1 (6.3)	
Facilitates other programmes (%)					
Yes	36(69.2)	13(81.3)	20(100)	3 (18.8)	0.00**
No	16 (30.8)	3(18.8)	-	13 (81.3)	
Living Status (%)					
Alone	13 (25)	2 (12.5)	6 (30)	5 (31.2)	0.48(ns)
With partner	38(73.1)	14(87.5)	13 (65)	1168.8)	
With others	1 (1.9)	-	1(5)	-	
Children (%)					
Yes	25(48.1)	11(68.8)	9 (45)	5 (31.3)	0.099(ns)
No	27(51.9)	5 (31.3)	11(55)	11(68.8)	
Trauma in last 6 months (%)					
Yes	30 (57.7)	8 (5o)	13 (65)	9 (56.3)	o.66(ns)
No	22(42.3)	8 (5o)	7(35)	7(43.8)	
Abused as Child (%)					
Yes	46 (88.5)	15 (93.8)	17(85)	14(87.5)	0.71(ns)
No	6 11.5)	1 (6.3)	3(15)	2 (12.5)	
Abused as Adult(%)					
Yes	47(90.4)	15 (93.8)	19(95)	13(81.3)	0.33(ns)
No	5 (9.6)	1 (6.3)	1(5)	3(18.8)	

*p<0.01;** p<0.001; p = Exact X²where data are categorical; ANOVA where data are continuous. Off=Officer; PO = Probation Officer; Psych Asst=Psychological Assistant; Psych=Psychologist; Admin = Administrative Assistant; PSO=Probation Service Officer

4.5.3 *Procedure*

Initially, participants were seen in small groups to have the purpose of the procedure explained. It was thought that group briefings would cut down on the overall time required to conduct the experiment and therefore reduce disruption to the operational duties of the participants. Individual briefings were provided where necessary. Participants were then given the option to continue with their involvement by attending an allotted appointment, which they all did. At this time, the procedure was summarised and the participant asked to sign a consent form. The instructions (detailed in section 6.3.3) were read out in full, with the amendment that a question would be asked after each scenario presentation, together with a request to rate the scenario in terms of personal distress. Responses were recorded by the researcher, and opportunity given for questions to be asked.

The first two BP measures were taken at three-minute intervals. After a further three-minute interval the neutral scenario was presented. The presentation order of the two experimental scenarios was counter-balanced by participant to preclude ordering effects, and each was presented at three-minute intervals. The recovery measure was taken two minutes after presentation of the last scenario.

Once the experimental procedure had been completed, participants were asked to complete the psychometric assessments. In a majority of cases, participants took these away and returned them to the researcher by the end of the day. Although not ideal, the procedure was run in this way to minimise interference with operational duties.

4.5.4 *Statistical analyses*

Three key areas were investigated using the available data. Firstly, comparisons were made between experimental groups on the psychometric measures, using one-way ANOVAs and t-tests, to provide information regarding potential individual differences between the three groups of participants.

Secondly, a series of 2 (experimental scenario) x 3 (group) way ANOVAs were performed to consider the influence of facilitator status (i.e. current, ex-or non-facilitator) on physiological reactivity to the two different types of scenario.

Finally, correlations between the dependent and independent variables were performed, followed by a number of regression analyses, to identify the most reliable predictors, both demographic and psychometric, of physiological reactivity to material typically encountered by SOTP therapists.

Prior to these analyses, manipulation checks were performed to assess the effectiveness of the stimuli to provoke a response by correlating participant ratings of the scenarios with BP measures and by comparing each scenario by ratings. Further manipulation checks using ANOVA were carried out to ensure no differences were apparent between BP responses to the three conditions which ought not to provoke a response, namely baseline measures 1 and 2, and the neutral scenario presentation, and the baseline measures and recovery measure. These results are presented in the next section.

4.6 Results from the Main Study

4.6.1 Experimental manipulation checks

4.6.1.1 Analysis of distress ratings

Comparisons of the distress ratings of the three scenarios (neutral, forensic and organisational) were made across the overall pooled sample of participants, to ensure that the neutral scenario was indeed rated as less distressing than the two experimental scenarios, and to see whether self-reported distress levels differed as a function of organisational or forensic issues. The results indicated that the three scenarios were rated significantly differently ($F=98.26; p<0.001$), with the neutral scenario having the lowest mean rating (1.02). Mean ratings for the forensic scenario (3.83) were higher than the mean for the management scenario (3.42), but the difference between them only approached significance ($F=3.03; p=0.09$).

4.6.1.2 *Analysis of distress ratings by BP*

The ratings of the pooled sample to the three scenarios were considered in relation to the BP measures, indicating no significant change in SBP (F=o.03; p=0.74) or DBP (F=o.03; p=0.97) to the three scenarios, but a significant drop in HR (F=4.54; p<0.05). This shows that while the two experimental scenarios were rated as more distressing than the neutral one, and the forensic scenario as slightly more distressing than the management one, this was not reflected in physiological measures. Indeed, HR in response to the forensic scenario dropped significantly. However, these manipulation checks did not take account of experimental group, which will be considered in section 6.6.3.

4.6.1.3 Analysis of the three baseline BP measures

The baseline data were then checked to ensure that the three measures i.e. baseline 1, baseline 2 and response to the neutral scenario, did not evoke significantly different BP responses. The results indicated a significant difference in SBP between the three testing periods (F=4.84; p=0.01), with the mean SBP at the first baseline measure being highest. There were no differences between DBP (F=2.33; p=0.10) or HR (F=0.30; p=0.74).

The significant difference in SBP was considered to be an effect of the novelty of the first measure being taken and habituation by the second and third testing. For this reason, the second baseline measure was used as a covariate for the analyses of measures taken in response to the experimental scenarios.

4.6.1.4 *Analysis of baseline and recovery BP measures*

The next manipulation check compared the two baseline measures and the recovery measure. There were significant differences in SBP (F=20.61; p<0.001) and DBP (F=10.871; p<0.001) with the means for the recovery measures being lower than the two baseline measures. There was no significant difference for HR (F=0.51; p=0.60).

The significant differences in systolic and diastolic pressure suggested full

recovery by the end of the procedure.

The results from the manipulation checks will be discussed in more detail where appropriate in Section 4.7.

4.6.2 *Psychometric measures by experimental group*

The data from the psychometric assessments were analysed by experimental group, using one-way ANOVA. Results are summarised in Table 4.3. The data indicated only two significant differences between the groups on the psychometric measures. These were on the NRO and OD subscales of the ADA between current and ex-facilitators, with ex-facilitators scoring significantly more highly on both sub-scales (NRO = $F(1,35)=20.65$, $p<0.01$; OD = $F(1,31)=4.33$, $p<0.05$). There were no significant differences on any other measure (RV = ($F(1,35)=0.00$, $p=0.96$), Emotional Inhibition ($F(2,51)=0.67$, $p=0.52$), Rumination ($F(2,51)=1.46$, $p=0.24$), Positive Emotional Sensitivity ($F(2,51)=0.44$; $p=0.65$) and Detached Coping ($F(2,51)=0.00$, $p=1.0$).

Table 4.3 Summary of One-Way ANOVAs performed on psychometric data

	Experimental Group				
Scale	Control	Current	Ex	F	p
ECQ (EI)	5.62 (3.7)	4.15 (3.26)	5.37 (5.37)	0.67	0.52
ECQ (R)	7.70 (4.8)	5.55 (3.80)	5.62 (4.03)	1.46	0.24
CSQ(DetCop)	40.00 (6.8)	40.10 (6.32)	40.00 (5-49)	0.00	1.0
ESS(PES)	9.60 (2.4)	10.40 (2.70)	10-44 (3.20)	0-44	0.65
NRO		***11.90 (7.41)***	***22.37 (6.11)***	***20.65***	***0.001****
RV		6.35 (5.33)	6-44 (3.86)	0.00	0.96
OD		***4.70 (3.45)***	***6.87 (2.63)***	***4.33***	***0.05****

*p< 0.05; ** p< 0.001; ECQ(EI)=Emotion Control Questionnaire (Emotional Inhibition); ECQ(R)=Emotion Control Questionnaire (Rumination); CSQ(DetCop)=Coping Styles Questionnaire (Detached Coping); ESS(PES)=Emotional Sensitivity Scale (Positive Emotional Sensitivity); NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability; OD=Organisational Dissatisfaction

4.6.3 *Analysis of the BP measures by experimental group*

In order to consider the degree to which BP discriminated reliably between the groups, blood pressure data (DBP, SBP and HR) were subjected to 2 (scenarios)

x 3 (groups) ANOVAs, with data from the second base-line measure used as the covariate. Results are presented in Tables 4.4. to 4.6.

Table 4.4 Summary of 2 (scenarios) by 3 (groups) ANOVA on Heart Rate

Source	SS	Df	Mean SS	F	Sig
Group	102.61	2	51.31	0.92	0.41
Scenario	6.79	1	6.79	0.98	0.33
Scenario by group	9.76	2	4.89	0.71	0.50

Table 4.5 Summary of 2 (scenarios) by 3 (groups) ANOVA Diastolic pressure

Source	SS	Df	Mean SS	F	Sig
Groups	172.82	2	86.41	0.10	0.38
Scenario	33.86	1	33.86	1.46	0.23
Scenario by group	78.81	2	39.40	1.69	0.20

Table 4.6 Summary of 2 (scenarios) by 3 (groups) ANOVA Diastolic pressure

Source	SS	Df	Mean SS	F	Sig
Groups	364.31	2	182.15	3.24	0.048*
Scenario	32.32	1	32.32	1.25	0.27
Scenario by group	132.04	2	66.02	2.55	0.09

*p<0.05

There was indication of only one significant result, that for the effect of experimental group on DBP, $F(2,48)=3.24$; $p<0.05$. Comparing individual means using Tukey's HSD ex-facilitators had a significantly higher DBP than both current facilitators ($q=3.51$; $p<0.05$) and the control group ($q=8.59$; $p<o.01$. Current facilitators in turn had a higher DBP than the control group ($q = 5.08$; $p<0.01$).

4.6.4 Correlations between the independent variables

Correlations between the independent variables, reported in Table 4.7, were broadly comparable to those obtained previously (see Chapter Three). Any

differences between the two data sets were likely to be attributable to differences in sample size (52, reduced to 36 for the ADA factors in the current sample, and 158 in the sample from Chapter 3), especially as four of the five differences related to the ADA factors approaching but not achieving significance in the current sample. By contrast, results from the larger sample reported in Chapter Three showed significant correlations between, for example, NRO and PES, NRO and R and OD and CSQ (DetCop).

4.6.5 *Correlations between BP measures and independent variables*

The second set of correlations looked at the relationships between the six dependent and all the independent variables (i.e. psychometric and demographic variables). Occupation and qualification levels (collected as categorical data) were recoded into dummy variables for inclusion in this and further analyses. Only the independent variables that correlated significantly with any of the dependent variables are reported here (see table 4.8.).

Given the magnitude of the correlations between DBP and SBP and age, partial correlations controlling for age and excluding cases listwise, were computed for each relationship.

Results indicated that, when controlling for age, none of the independent variables correlated significantly with DBP for either scenario. RV, Gender and Abuse as an Adult remained significantly negatively correlated with SBP in relation to the Management scenario ($r = -0.46$; $p<0.001$; $r = -0.43$; $p<0.05$; $r = -0.47$; $p<0.001$, respectively). In relation to the forensic scenario, RV remained significantly negatively correlated with SBP ($r = -0.038$; $p<0.05$) and Abuse as an Adult became significant ($r = -0.38$; $p<0.05$). Significance with the other independent variables, including gender, was lost.

Partialling out age did not effect the correlations between HR and the independent variables for either scenario.

Table 4.7 Correlations of independent variables with each other

Variables	N	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. Gender	52	1.00																	
2. Age	52	-.29*	1.00																
3. Occ	52	.57**	-.66**	1.00															
4. Time in	51	-.30*	.75**	-.54**	1.00														
5. Yrs SOTP	49	-.07	.43**	-.23	.50**	1.00													
6. Other prog	52	-.03	-.17	.31*	-.33*	-.11	1.00												
7. Quals	52	.39**	-.39**	.60**	-.44**	-.25	.29*	1.00											
8. Live stat	52	-.19	.13	-.02	.03	-.10	.12	-.06	1.00										
9. Children	52	-.31*	.72**	-.54**	.51**	.36*	-.31	-.33*	.10	1.00									
10. Trauma	52	.11	-.09	.07	-.10	-.11	-.10	-.02	-.16	.05	1.00								
11. A as child	52	-.11	.20	-.18	.01	.10	-.02	-.02	-.21	.11	.18	1.00							
12. A as adult	52	.34*	-.04	-.09	.05	.11	-.21	.01	-.26	-.08	-.15	-.12	1.00						
13. ESS (PES)	52	.34*	-.30*	.26	-.32*	-.08	-.12	.29*	-.18	-.18	.16	.20	.31	1.00					
14. NRO	36	-.05	-.056	-.35*	.10	-.16	-.61**	-.41*	-.07	.09	.24	-.03	.06	.19	1.00				
15. RV	36	.39*	-.47**	.36*	-.21	.05	-.18	.15	-.47**	-.37*	.12	-.12	.22	.53**	.40*	1.00			
16. OD	36	-.42*	.00	-.46**	.28	.37*	-.28	-.49**	-.19	.13	.07	.07	-.02	-.05	.48**	.27	1.00		
17. CSQ (DET)	52	-.29*	.13	-1.0	.05	.03	.15	-.09	.17	-.03	-.23	-.00	-.06	-.33*	-.24	-.60**	-.01	1.00	
18. EI	52	-.30*	.27	-.39**	.23	.00	-.19	-.23	-.03	.18	-.21	-.16	.27	-.13	.15	.08	.12	-.15	1.00
19. R	52	.043	-.12	-.03	.01	-.10	-.15	-.05	-.15	.04	.27	-.09	.01	.11	.32	.49**	.35*	-.68**	.13

*p<0.05; **p<0.01; Occ=occupation; Time in=Time in Service; Yrs SOTP=years facilitating SOTP; Other Progs=Other programmes run in addition to ore SOTP; Quals=Qualifications; Live stat=Living status; Trauma= trauma in the previous six months; A as child=Abused as a child; A as Adult=Abused as an adult; ESS(PESS)=Emotional Sensitivity Scale (Positive Emotional Sensitivity); NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability; NRO=Negative Reactivity to Offenders; CSQ(DET)=Coping Styles Questionnaire (Detachment); EI= Emotional Inhibition; R=Rumination

Table 4.8 Correlations and partial correlations between SBP, DBP and HR to both scenarios and significant independent variables

			SBP to S4		DBP to S4		HR to S4		SBP to S5		DBP to S5		HR to S5	
	n	Partial n	r	Partial r	R	Partial r	r	Partial r	r	Partial r	r	Partial r	r	Partial r
Age	52	29	0.59**		0.50**		-0.05		0.60**		0.53**		-0.14	
RV	36	29	-0.52**	-.46**	-0.18	-0.03	-0.00	0.18	-0.48**	-0.38*	-0.30	-0.15	-0.00	0.18
NRO	36	29	-0.13	-0.17	0.22	0.28	0.42*	0.45*	-0.11	-0.09	-0.03	0.01	0.39*	0.42*
Gender	52	29	-0.53**	-0.43*	-0.38**	-0.28	0.05	-0.10	-0.49**	-0.34	-0.37**	-0.25	0.04	-0.06
Yrs SOTP	52	29	0.35*	0.07	0.35*	0.04	0.10	-0.03	0.31*	0.07	0.31*	-0.01	0.16	0.01
Time in Service	52	29	0.52**	0.13	0.50**	0.20	-0.04	0.25	0.52**	0.10	0.47**	0.13	-0.01	0.30
Any children	52	29	0.47**	0.05	0.36**	-0.09	0.06	0.04	0.39**	-0.11	0.37**	-0.11	0.03	-0.11
Trauma	52	29	-0.03	0.09	-0.00	0.07	0.35*	0.39*	-0.08	-0.07	0.00	0.05	0.34*	0.37*
Abused as adult	52-	29	-0.31*	-0.47**	-0.23	-0.32	0.12	0.12	-0.25	-0.38*	-0.14	-0.15	0.09	0.15
Prison Officer	52	29	0.42**	0.09	0.43**	0.31	0.06	0.40*	0.37**	0.05	0.34*	0.10	0.07	0.37*
No quals	52	29	0.15	0.10	0.37**	0.36*	0.24	0.31	0.19	0.19	0.27	0.25	0.23	0.28

*p<0.05; **p<0.01 SBP=Systolic Blood Pressure; DBP=Diastolic Blood Pressure; HR=Heart Rate; S4=Management Scenario; S5=Forensic Scenario;
RV=Ruminative Vulnerability; NRO=Negative Reactivity to Offenders; Yrs SOTP=years facilitating SOTP; Trauma= trauma in the previous six months;
No quals = no qualifications

The partial analyses were repeated using pairwise exclusion, thus increasing the sample size. As a result, SBP and RV failed to achieve significance to the Forensic scenario, but no other changes occurred. The discussion (Section 6.7) therefore focuses on the results from the partial analysis using listwise exclusion, on the basis that it is drawn from a more restrained and less contaminated, cleaner database.

4.6.6 Regression analyses

Previous research has identified a number of demographic variables thought to be implicated in the psychological well being of SOTP therapists (see for example Ellerby, 1998). To explore further the correlational findings the data were finally subjected to a series of regression analyses.

To avoid the difficulties often associated with regression analysis in relation to the over inclusion of independent variables (Miles and Shevlin, 2001), the analyses were undertaken in two stages. In the first stage, only the psychometric variables were considered in terms of their predictive value. In the second stage, demographic variables were considered, but were restricted to those variables already identified in this and previous research, as either statistically significant or otherwise clinically relevant to facilitator well being.

4.6.6.1 Assessing the importance of psychometric variables in predicting blood pressure responses to material typically encountered by SOTP facilitators.

In the first instance, the relationship between each of the dependent variables with the psychometric measures was considered using the general linear model. Only the statistically significant results are reported here.

The only significant predictor of SBP to the management scenario was the RV subscale of the ADA (Beta -0.50, $t = -2.21$, $p<0.05$). The negative t value suggested that higher SBP was recorded for those with lower scores on RV, as with the correlation.

The OD subscale of the ADA was the only predictor of DBP response to the management scenario (Beta = 0.43, t = 2.22, $p<0.05$).

The NRO subscale of the ADA was the only significant predictor variable of heart rate in response to the management scenario (Beta = 0.50, t = 2.50, $p<0.05$).

None of the psychometric measures entered into the regression analysis were shown to be predictive of SBP to the forensic scenario, although RV approached significance (Beta = -0.45, t= -1.98, $p=0.057$).

As with DBP to the management scenario, none of the psychometric measures were indicated as significant predictors of DBP in response to the forensic scenario.

As with HR to the management scenario, NRO was the only significant predictor of HR to the forensic scenario (Beta = 0.47, t = 2.30, $p<0.05$).

4.6.6.2 Assessing the importance of demographic variables in predicting blood pressure responses to material typically encountered by SOTP facilitators.

Cardiovascular reactions to psychological stress are influenced by age and gender (Carroll, Harrison, Johnston, Ford, Hunt, Der and West, 2000), so hierarchical regression, with age and gender entered in the first block and other predictors in the second block, was used in this analysis. Predictors in the second block included time in service, years facilitating SOTP, having children, living status, experience of trauma in the previous six months, and the experience of abuse as a child and as an adult. The results are provided in Tables 4.9 - 4.14.

Table 4.9 Summary of variables included in hierarchical regression analysis on systolic blood pressure to the management scenario

Variables in the equation		*Beta*	*t*	*p*	*F -change*	*df*
Model 1:	Gender	-.32	-2.90	.006	22.31**	2,45
	Age	.53	4.74	.00		
Model 2:	Gender	-.25	-2.01	.05	1.07	6,39
	Age	.48	2.33	.03		
	Time in service	-.00	-.02	.99		
	Years facilitating SOTP	.18	1.41	.17		
	Any children	-.00	-.03	.98		
	Trauma	.00	.02	.98		
	Abused as a child	-.07	-.61	.55		
	Abused as an adult	-.25	-2-14	.04		

**p<0.01 Tables 4.9-4.14

Table 4.10 Summary of variables included in hierarchical regression analysis on diastolic blood pressure to the management scenario

Variables in the equation		*Beta*	*t*	*p*	*F-change*	*df*
Model 1:	Gender	-.23	-1.77	.08	10.40**	2,45
	Age	.44	3.39	.001		
Model 2:	Gender	-.16	-1.10	.28	0.71	6,39
	Age	.25	1.02	.31		
	Time in service	.17	.78	.44		
	Years facilitating SOTP	.16	1.09	.28		
	Any children	-.01	-.05	.96		
	Trauma	.001	.01	.99		
	Abused as a child	.07	.51	.61		
	Abused as an adult	-.19	-1.36	.18		

Table 4.11 Summary of variables included in hierarchical regression analysis on heart rate to the management scenario

Variables in the equation		*Beta*	*t*	*p*	*F -change*	*df*
Model 1:	Gender	.05	.35	.73	0.44	2,45
	Age	-.11	-.71	.48		
Model 2:	Gender	-.08	-.48	.63	1.90	6,39
	Age	-.17	-.63	.53		
	Time in service	.05	.19	.85		
	Years facilitating SOTP	.22	1.30	.20		
	Any children	-.04	-.20	.85		
	Trauma	.44	2.90	.01		
	Abused as a child	-.13	-.86	.39		
	Abused as an adult	.19	1.25	.22		

Table 4.12 Summary of variables included in hierarchical regression analysis on systolic blood pressure to the forensic scenario

Variables in the equation		*Beta*	*t*	*p*	*F -change*	*df*
Model 1:	Gender	-.29	-.250	.02	19.92**	2,45
	Age	.54	4.66	.00		
Model 2:	Gender	-.24	-1.80	.08	0.68	6,39
	Age	.59	2.71	.01		
	Time in service	-.02	-.09	.93		
	Years facilitating SOTP	.13	1.00	.32		
	Any children	-.13	-.78	.44		
	Trauma	-.06	-.47	.64		
	Abused as a child	-.05	-.4	.66		
	Abused as an adult	-.20	-1.61	.11		

Table 4.13 Summary of variables included in hierarchical regression analysis on diastolic blood pressure to the forensic scenario

Variables in the equation		*Beta*	*t*	*p*	*F -change*	*df*
Model 1:	Gender	-.19	-1.49	.14	11.30**	2,45
	Age	.49	3.78	.00		
Model 2:	Gender	-.20	-1.34	.19	0.56	6,39
	Age	.54	2.18	.04		
	Time in service	-.03	-.13	.90		
	Years facilitating SOTP	.16	1.05	.30		
	Any children	-.09	-.48	.63		
	Trauma	.08	.61	.55		
	Abused as a child	-.19	-1.44	.16		
	Abused as an adult	-.08	-0.60	.55		

Table 4.14 Summary of variables included in hierarchical regression analysis on heart rate to the forensic scenario

Variables in the equation		*Beta*	*t*	*p*	*F -change*	*df*
Model 1:	Gender	.07	.43	.67	0.22	2,45
	Age	-.05	-.34	.74		
Model 2:	Gender	-.08	-.51	.61	2.16	6,39
	Age	.02	.06	.95		
	Time in service	-.01	-.05	.96		
	Years facilitating SOTP	.29	1.77	.09		
	Any children	-.21	-.99	.33		
	Trauma	.46	3.07	.00		
	Abused as a child	-.17	-1.19	.24		
	Abused as an adult	.16	1.04	.32		

The regression analyses indicated that age was the best predictor of SBP and DBP to both the management and forensic scenarios, and experience of trauma the best predictor of HR to both scenarios.

4.7 Discussion

The purpose of conducting the procedure described in this chapter was two-fold. Firstly, while considerable research effort has been put into identifying the nature of the impact their work has on sex offender treatment providers, the resulting data, by its retrospective nature, had to be interpreted with caution. The cross-sectional design of this investigation provided the first data allowing for comparisons to be made between SOTP therapists, ex-therapists and a control group of peers with no experience of sex offender treatment.

The second purpose was to consider the use of an objective measure of the reported impact of the work in an effort to overcome the difficulties associated with self-report. Psychophysiological assessment in the form of blood pressure measurements was adopted to achieve this.

With this in mind, the findings will be discussed in these two sections, with a final section focusing on the identified shortcomings of the experimental procedure, recommendations for improvements and conclusions.

4.7.1 Cross-sectional findings - psychometric data

The nature of the cross-sectional analysis was two-fold. In the first instance the psychometric data were analysed to identify variations in individual differences. This was followed by analyses of differences in physiological reactivity to material typically encountered by SOTP therapists, which might be accounted for by experience of working in a therapeutic capacity.

In terms of the psychometric measures, all participants completed the full-scale Emotion Control Questionnaire (ECQ; Roger and Najarian, 1989, consisting of Rumination (R) and Emotional Inhibition (EI), the Detached Coping Sub-scale

(DETCOP) of the Coping Styles Questionnaire (CSQ - Roger et al, 1993) and the Positive Emotional Sensitivity (PES) sub-scale of the Emotional Sensitivity Scale (ESS - Guarino et al, 2001). In addition, current and ex-facilitators completed the full-scale ADA, consisting of Negative Reactivity to Offenders (NRO), Ruminative Vulnerability (RV) and Organisational Dissatisfaction (OD). There were no significant differences between the three groups on measures of R, EI, DETCOP and PES. Indeed, inspection of the means indicated that the groups were very closely matched on these measures, and ex- and current facilitators scores on RV were virtually indistinguishable. But a significant difference emerged between ex-facilitators and current facilitators on NRO and OD, with ex-facilitators scoring significantly more highly.

The significant findings were not accounted for by gender (see Chapter Two), outliers, or any of the other measured individual differences, and appeared to be a genuine reflection of a difference in attitudes between the two groups. The NRO factor of the ADA, characterised by items expressing general and therapy specific negativity, had previously been found to correlate significantly positively with R and PES, and significantly negatively with DETCOP. The elevated scores of ex-facilitators on this factor, as well as higher scores on the OD factor, raised concern and require further exploration.

A number of hypotheses arise as potential explanations for the findings. The most obvious relates to the ex-facilitator's reasons for withdrawing from SOTP facilitation. A decision was taken not to ask individuals for their reasons on the grounds that it would not be possible to verify participant's responses. It was considered likely that individuals who had withdrawn from SOTP as a consequence of psychological difficulties with the work would "fake good" their reasons, based on the issues discussed previously regarding self-report, as well as organisational issues associated with avoiding acknowledgement of personal distress. On these grounds the response set would be unreliable. However, there was a strong case for arguing that the very nature of sex offender treatment would result in a high rate of self-deselection due to personal distress. Not until individuals gained first hand experience of the treatment process (no matter how realistic the training) could they make informed choices about their continued involvement as therapists. The reality

of regular exposure to details of sexual deviance and abuse might understandably repulse some therapists, resulting in a heightened sense of hostility not only to the offenders, but also to the therapeutic process itself.

For this to be a viable explanation of the current findings, it would be expected that ex-facilitators would have less experience of facilitation than current facilitators, and the demographic information indicated otherwise.

Alternatively, it might be argued that far from de-selection occurring early in a therapeutic career, individuals persisted in order to avoid acknowledging personal distress, but eventually reaching a point when they felt unable to continue. This would be more aligned to (Farenkopf, 1992) Phases of Impact model, the last phase of which is characterised by feelings of exhaustion and depression, a sense of treatment futility and the experience of resentment. For this to be broadly applicable, most or all of the ex-facilitators would need to have quit for this reason.

An alternative, and arguably more comprehensive explanation might be sought in the experience of ex-facilitators once they have ended their involvement with the programme, irrespective of the reason. Kadambi and Truscott (2002), in the first research of its kind, identified seven distinct themes, comprised of a total of 83 statements, concerning the rewarding aspects of sex offender treatment provision for therapists. Themes included professional benefits, connection with colleagues, protection of the public, enjoyment of counselling, socially meaningful curiosity, offender change and wellness and offending specific change. Based on a Canadian sample of 93 therapists, Kadambi and Truscott's research evidence supported many of the anecdotal reports in England and Wales about what therapists found fulfilling.

In terms of the current findings, it is suggested that the therapeutic milieu surrounding sex offender treatment, particularly in terms of the aspects described above, compensates for the more difficult or distressing aspects of the work, for example, having the support of fellow therapists when elements of the work are experienced as distressing, believing that no matter how difficult or distressing the work may be, the therapist is making a valuable contribution to society, feeling positively challenged by the demands of a skilled and unique type of work, which for many facilitators is beyond their

usual professional role. The evidence that ex-therapists experience significantly more negative reactivity to the work might result from the loss of an infrastructure that has provided such support. For example, when therapists resign from the programme, they are unlikely to work with other SOTP therapists in any other capacity, they will not be involved in the substantial peripheral work relating to assessment, report-writing, case conferences and so on, and will no longer have easy access to a counselling service. Kearns (1995) suggested that the lack of peer support might discourage therapists from processing negative reactions associated with the work. This assertion was supported by findings from a study by Ennis and Horne (2003), indicating that mutual validation and reinforcement from peers were likely to contribute to effective self-care. Loss of these aspects might result in therapists feeling less able to contain some of the more invidious aspects of the work, later expressed in negative attitudes to sex offenders.

Another explanation within the same framework could be that the therapeutic infrastructure is one in which negative reactivity is suppressed as anti-therapeutic, and it is not until individuals have completed their work as therapists that they feel more able to express their negative emotions towards the client group, which most recognise as particularly challenging. Farrenkopf (1992) referred to suppression of emotion, feelings of anger, confrontative attitudes and intolerance of criminal thinking errors as characteristic of Phase Three of his Phases of Impact model, and it may be that this is reflected in the high NRO scores. However, that would also assume that all 16 participants left SOTP for this reason, and as previously mentioned, this cannot be verified. The area will be returned to in the conclusions and recommendations section of this chapter.

It is clearly important to establish, as far as possible, the causes for such a significant difference in NRO scores between current and ex-facilitators, but is also suggested that, in some respects, the elevation in ex-facilitators' NRO scores are as operationally important as the reasons for them. As will be discussed later, NRO is significantly predictive of HR responses to material typically encountered by SOTP therapists, and has been found to be significantly positively correlated with ECQ rumination (R) in others elements

of this research. Individuals who score high on R have been shown to have significantly delayed HR recovery after exposure to stress (Roger and Jamieson, 1988), higher levels of cortisol secretion (Roger and Najarian, 1998), and compromised immune function (Thomsen, 2003). Such a combination of findings would indicate that high NRO scores may have a deleterious effect on health and this requires further exploration.

Aside from the potential physiological impact, it would also be predicted that high NRO scorers form part of the fifth to a quarter of therapists who have experienced their therapeutic practice as psychologically damaging (Ellerby, 1993; Turner, 1992). Ryan and Lane (1991) referred to the more pervasive and insidious effects of the work that resulted in permanent attitude change, and although to date this has been more anecdotally than research-based evidence, the current finding offers empirical support for such a conclusion. It also provides further evidence against the use of the burnout construct to explain the impact on SOTP providers. Burnout is considered a temporary, reversible state and the current findings suggest that therapists continue to be affected long after ceasing their therapeutic role.

Furthermore, it might be expected that individuals scoring high on NRO would manifest their attitudes in their behaviour. The anger, suspicion and hostility that characterise high NRO scores are unlikely to be conducive to functional and pro-social relationships in any context, not just a therapeutic one, and it would be interesting to investigate how the experience of working with sex offenders has impacted on ex-facilitators working relationships with offenders in general. This should be an objective for further research.

In addition to higher NRO scores, ex-therapists also scored significantly higher on OD, suggesting they were less satisfied with their experience of peers, managers and the organisation as whole in relation to their SOTP experience. This finding further supports the conclusion drawn in relation to high NRO scores regarding the loss of an organisational infrastructure that many therapists cite as a substantially rewarding part of the work (Kadambi and Truscott, 2003). It also has implications regarding the organisational behaviour of ex-therapists and requires further exploration.

The clearest conclusion to be drawn from these findings is the need to follow-up ex-facilitators in the context of their well-being and organisational experience. This will be discussed in more detail in the conclusions.

4.7.2 Cross-sectional findings - physiological data

The data were subjected to a number of 2 (scenarios) x 3 (groups) ANOVAs to consider the impact of experimental group (current, ex- and non-facilitators) on measures of systolic and diastolic blood pressure (SBP and DBP, respectively) and heart rate (HR), to the two scenarios representative of SOTP material. The results indicate that there was no effect of experimental group, other than on DBP to the management scenario, where ex-facilitators had a significantly higher response than non-facilitators. Bearing in mind that DBP is a measure of resting blood pressure, and that it was correlated with age, it is likely that this result is a product of age rather than a significantly different reaction of this group to that particular scenario. Although there is not a significant difference between the mean ages of the two groups, the ex-facilitator group were older and the difference was approaching significance ($p=0.06$).

The finding that facilitator status had little effect on physiological reactions to the scenarios may be explained in a number of ways. It may simply be that there is no difference between the groups, and if such a conclusion can be reliably drawn, this is as important as a finding of difference in the context of facilitator well-being. To draw such a conclusion at this preliminary stage though, would be premature and attention should first be paid to improving aspects of the experimental design. This will be addressed in detail later in this section.

An alternative explanation of the findings might come from examination of the participant population. All participants in the study would have been familiar with the nature of the scenarios at least, if not the scenarios themselves, suggesting that the differences between the groups may not have been substantial enough to evoke differential responses. It could reasonably be

predicted that a control group of non-prison staff, unfamiliar with the detail of child sexual abuse, may have reacted differently to the forensic scenario. However, there are serious ethical considerations to be taken into account before exposing participants to material that is potentially distressing. Further, the nature of the management scenario would have been meaningless to non-prison service staff as it refers to an organisational procedure that is unlikely to be familiar outside the Prison Service. A control group drawn from another branch of criminal justice or mental health may help establish more reliably the presence or otherwise of a difference between therapists and non-therapists.

An alternative or additional explanation might come from the use of BP monitoring as an objective assessment of differences between the groups. BP measurement is known to be particularly sensitive and can fluctuate substantially as a result of different factors ranging from age, gender, fitness level, caffeine intake, individual differences in anxiety, and disturbance during measurement to name a few. The sample size in this investigation was insufficient to control for such effects and increasing the sample size would be a necessary improvement to future investigation.

In summary, the cross-sectional aspect of the investigation identified differences between current and ex-facilitators on measures of NRO and OD. No differences were apparent between the three groups on measures of physiological reactivity to material typically encountered by SOTP therapists, and this may be explained in terms of experimental design.

Attention was then turned to analyses looking at the use of an objective measure of distress, in this case BP measurement, to overcome the identified difficulties if relying in self-reported distress.

In the first instance, correlations between participant ratings of distress and BP reactivity were considered, and no relationships were found. This was considered likely to be a function of the experimental design issues previously discussed, but could also support the contention that self-reported distress does not always reflect physiological distress.

Further correlations between the BP measures and independent variables produced an interesting pattern of relationships (only those correlations where the independent variables correlated significantly with one or more of the BP measures are reported in the chapter). Age was found to correlate strongly with both SBP and DBP, and was thus partialled out. The subsequent results are the focus of this discussion.

With age partialled out, six significant correlations remained across both scenarios. These were the negative relationship between RV and SBP, a positive relationship between NRO and HR, and a positive relationship between Experience of Trauma in the Previous Six Months and HR.

The relationships between NRO, Trauma and HR in response to both scenarios were repeated in regression analyses, where they were independently found to be the only significant predictors of heart rate to both scenarios (Table 4.15 provides a summary of variables predictive of the three BP measures). It is suggested that NRO and recent experience of trauma result in increased sensitivity to events that are likely to provoke an emotional response, such as those depicted in the scenarios, and this is reflected in the measurement of HR.

Table 4.15 Summary of variables found to be significantly predictive of BP measures

		Psychometric variables	Other independent variables
SBP	S4	RV	Abused as Adult
	S5	- (RV p=0.056)	-
DBP	S4	OD	-
	S5	-	-
HR	S4	NRO	Trauma in last 6 months
	S5	NRO	Trauma in last 6 months

SBP=Systolic Blood Pressure; DBP= Diastolic Blood Pressure; HR=Heart Rate; S4=Management Scenario; S5=Forensic Scenario.

RV was significantly negatively correlated with SBP to both scenarios with age partialled out, predictive of SBP to the management scenario and approached significance in relation to the forensic scenario. Interestingly, Abuse as an Adult remained significantly negatively correlated with SBP to the Management scenario when age was controlled for, and *became* significantly

negatively correlated in relation to the forensic scenario. The reason for considering these results together was based on the premise that experiencing sexual abuse as an adult would be related to feelings of vulnerability about working with sex offenders, though the results found here appear paradoxical in that those with higher RV, and those who reported experiencing sexual abuse as an adult, showed lower SBP responses to both scenarios, with is contrary to what might be expected. One possible explanation is that BP is known to drop if an individual experiences a shock. It's possible that high RV scorers, or those who had been sexually abused as adults experienced the scenarios as more shocking than others and this is reflected in their lower SBP scores. Further exploration would be needed before a firm conclusion could be drawn.

In terms of DBP, all but one significant correlation was lost once age had been partialled out, indicating that DBP is primarily a function of age. The only remaining significant correlation concerned those with no qualifications, and is considered anomalous with the overall findings. Regression analysis indicated that OD was significantly predictive of DBP to the management scenario alone. Given that the OD factor is orientated to managerial issues it is wholly consistent that it should predict DBP response to this scenario, and provides general support for the applicability of the ADA.

In summary, the pattern of correlations between the dependent and independent variables, together with the regression analyses, indicate a number of variables that are associated with, or predictive of, BP responsivity. It is encouraging that all three factors from a scale designed specifically to assess the impact of their work on therapists have been found to be predictive of physiological reactivity, and these results lend further support to the validity of the ADA.

The analyses have also identified two factors in particular that need to be taken into account when considering facilitator well-being. These are the experience of trauma in the previous six months and sexual abuse as an adult, both of which were predictive of aspects of physiological reactivity. Both these factors have emerged as important in other aspects of this research, and will be

addressed again in the final chapter.

4.8 Conclusions

The results from the current investigation suggest that any physiological changes that occur as a result of provocation from sex offender treatment related material are not related to status as a facilitator. Nevertheless, it is argued that it would not be appropriate to base this conclusion on the procedure described in this chapter and further investigation is needed.

Improvements to the current investigation could be made to A) the psycho-physiological assessment, B) the stimuli used to provoke a stress response and C) the nature and size of the sample.

Blood pressure measurement was chosen as the least invasive, most economic and least logistically problematic of all the psychopysiological assessments considered, and this remains the case. However, continuous rather than interval monitoring would provide more detailed and accurate data regarding responses the SOTP related material and this should be considered for the future. In addition, although manipulation checks indicated that the scenarios used did provoke both an emotional and physiological response, they did not differentiate between the three experimental groups. This may either be due to the scenarios themselves, or the nature of the sample population. To avoid the problems of video scenarios described earlier in the chapter, it is suggested that a number of computer generated virtual scenarios be constructed that cover a range of aspects of the work including interactions with peers, facilitating groups, attending SOTP related meetings and group preparation, including reading victim statements. It is suggested that a combination of these two improvements should offer more comprehensive and reliable data on which conclusions could be based.

Consideration should be also given to assessing a control group of non-prison staff. The use of virtual scenarios would overcome the problems associated with participants needing to understand Prison Service procedures, although ethical considerations would need to remain paramount. Increasing the overall

sample size would also be beneficial, and incorporating therapists from a range of organisations would produce more reliable data.

In relation to the significant differences between current and ex-facilitators on NRO and OD, it is recommended that participants be asked why they decided to stop facilitating SOTP. This should be done anonymously. Ideally, a separate study of ex-facilitators should be conducted, involving completion of the ADA and collection of minimal demographic information. Replication of the current findings could have important implications for the ongoing support of individuals once they have completed their SOTP career, both in terms of psychological well-being and organisational performance.

What can be concluded from the data, however, is that the factors of the ADA have been shown to be significant predictors of physiological reactivity to SOTP related material, and this provides further evidence for the scale's validity. However it should be noted that the ADA was only administered to two thirds of the sample and the results need replicating before further claims are made about its predictive power. The finding that trauma in the previous six months and abuse as an adult are predictive of physiological reactivity is important. Both variables have been identified in other aspects of this research as directly related to facilitator well-being, and their emergence here strongly indicates the need for monitoring. This will be discussed further in Chapter Eight.

Chapter Five

A Longitudinal Investigation into the Impact of Working Therapeutically with Sex Offenders.

5.1 Introduction

It has been highlighted in previous chapters that, to date, all research into the impact on facilitators of working therapeutically with sex offenders has been a) based on "snap-shot", retrospective methodology, b) lacked comparisons with credible control samples, c) been over reliant on self-report, and d) failed to consider the psychological processes implicated in the negative symptoms described. The result has been a wealth of descriptive information regarding the nature of negative psychological symptoms reported by treatment providers at any given time, but a dearth of any meaningful information regarding situational and individual factors that might precipitate, predispose, ameliorate or amplify them (Paton, 1996). Consequently, little is understood about the nature of the psychological adaptations made by therapists as they adjust to their work over time, and an objective corroboration of the psychological effects described has not been possible. Bearing these points in mind, the fact that so much research in the sex offender therapist field has relied on cross-sectional, retrospective methodology suggests that what is currently understood about the impact of working therapeutically with sex offenders is at best inaccurate and at worst misleading.

Several authors (e.g. Farrenkopf, 1992; McCann and Pearlman, 1990; Ryan and Lane, 1991) have referred to the psychological adjustments experienced by therapists as they adapt (or not) to their work. Farrenkopf commented on an evolving progression in emotional reactions to sex offender treatment provision that he likened to the trauma/grief cycle proposed by Frederick (1986), characterised by shock, fear, repression, anger, depression and finally acceptance/recovery. However, Farrenkopf's "Phases of Impact" model evolved from retrospective self-report data collected from a small sample of therapists (24), and assumed that individuals either reach a point of stability where they are no longer affected by their work, or leave the profession.

A comprehensive exploration of the processes of adaptation requires the use of continuing longitudinal and multi-measure studies of psychosocial development, which would circumvent many of the problems associated with retrospective and snapshot research (Reid, 1990). Paton (1996) argued that the collection of baseline data from individuals at the point of entry into their chosen profession is fundamental to systematic analysis of the impact of the work. Measurements taken at regular intervals thereafter not only provide insight into changes that take place over the course of the working life of the individual, but also facilitate an understanding of the ways in which different variables interact at different times to influence psychological outcome. This in turn allows for the development of norms that reflect differences or changes associated with variables such as experience in the field, age, availability of social support and so on. Further, such data allow for analysis of how repeated or continual exposure to potentially traumatic events influences adaptation or not, thereby reducing the risk of erroneous conclusions being drawn regarding negative outcome (Alexander and Wells, 1991). Insights into some of the long-term benefits of working in potentially traumatic contexts might also be provided, together with opportunities to systematically evaluate interventions designed to reduce negative impact.

It is hypothesised that adaptation to the atypical experiences often presented by sex offender treatment provision, such as the content of the work, the nature of the presenting clients and the context in which treatment takes place, is an ongoing rather than finite process that facilitates the maintenance of the psychological status quo. Evidence from the current research, suggesting that therapists continue to adjust to their experience, even beyond the point of direct provision of therapeutic services to sex offenders (see section 4.7.1), provides some support for this.

Paton (1996) argued that in most cases, previous learning, training or experience is insufficient for therapists to assimilate and make sense, not only of the content of their work, but also their emotional reactions to it, resulting in critical pressure being exerted on existing psychological schema. It was this hypothesis that led Paton to adopt the term 'critical occupations' to describe roles which have the potential to exert critical pressure on an individual's psychological infrastructure and thus require psychological adjustment for

functional adaptation. Paton's assertion is supported by anecdotal references in the sex offender treatment provider literature, to changes in fundamental beliefs as a consequence of working with sex offenders (e.g. Ryan and Lane, 1991).

It is proposed that adaptation of existing beliefs may, at one end of the scale, be relatively minor, with no obvious psychological discomfort to the individual. At the other end however, the magnitude of the adjustments may be so great (or perhaps not possible at all) that without support or intervention the dissonance created may result in dysfunctional adaptation and in extreme cases, clinical diagnoses of conditions such as PTSD. It might reasonably be hypothesised that the most radical adjustment is required in the early stages of a therapist's career, as a consequence of the newness of the experience. However, later and possibly extensive adaptation might also be required as a result of, for example, changes in personal circumstances, a client or client material outside the range of experience, organisational issues and so on. The model presented in the introduction to this thesis (section 1.6), aimed to represent this interaction of factors as a continual rather than finite process.

The repeated, though rarely explicated, references in the sex offender therapist literature to challenges to the individual's schema or world-view, indicate an area central to therapist well-being, but which so far has evaded systematic investigation in this context. In terms of longitudinal research, this presents a number of methodological and measurement issues for consideration. For example, how might challenges to the individual's schematic representations of the world be assessed in terms of change, and how might such challenges be manifest in behaviour or attitude change over time?

5.1.1 Methodological considerations

To redress the shortcomings of the existing research, consideration was given to methods that might enhance existing knowledge and understanding about the nature of the psychological adaptation experienced by sex offender therapists. The overall study was predicated on the hypothesis that sex offender treatment providers, as members of a critical occupation, undergo a

process of psychological adaptation throughout their career as therapists and beyond. The most intense period of adaptation is likely to occur in the early stages of the career as indicated by evidence relating to higher levels of psychological distress in new therapists (e.g. Neumann and Gamble, 1995; Steed and Bicknell, 2001). For this reason, it was decided only to recruit participants to the study who were at the start of their career as therapists but had not yet undergone training, in other words, facilitators who had been successfully appointed (undergone the national selection process) and were imminently to attend a training programme.

Several factors influenced the choice of appropriate measures to assess the hypothesised change process. The first concerned the number of participants who could be recruited to the study in the available time. On average, two training programmes for newly recruited therapists are run per year, with approximately 45 trainees on each course. In order to maximise participant numbers, and taking into account attrition rate over the duration of the study (12 months), it was decided to recruit participants from separate courses. As with previous aspects of this research, there was also concern regarding participant fatigue and practice effects in relation to the number of measures that could be used and with what frequency (see section 5.2.2).

This latter factor led to deliberation about the number and types of measure to use. The necessity for psychometric assessment of areas previously identified as salient in the adaptation of therapists was obvious. Details of the measures used and a rationale for their use are provided in section 5.2.2.1. The use of objective behavioural measures was also considered necessary to provide corroborative evidence of the effects reported by therapists, thereby addressing the criticism levied at previous research regarding over reliance on self-report measures. Details of this process are given in section 5.2.2.2.

In addition to psychometric and objective assessment, and in light of the previous discussion, the evaluation of individual schema and change over time was considered necessary if a comprehensive understanding of impact over time was to be achieved. However, it was also recognised that inclusion of all the essential assessment elements was likely to result in an overly complex study that negated the previous concerns of participant fatigue and assessment

frequency.

It was therefore decided to conduct the study in two parts, the results of which are presented in two separate chapters. This chapter reports on a multi-wave, dual-method, 12-month longitudinal study designed to overcome the methodological shortcomings highlighted at the start of the chapter. The design included the introduction of an objective assessment of therapists' practice, as well as the completion of a range of psychometric measures, and comparisons with a non-therapist control group comprised of other prison service personnel.

Chapter Six reports on a shorter longitudinal investigation (6 months) designed specifically to provide qualitative data about individual changes in fundamental beliefs or schema, often referred to in the literature, but rarely explicated and not always evident from the more usual reliance on psychometric assessment. Limited psychometrics were included in this aspect of the study to enable comparisons to be made, but a control group was not incorporated.

Additional advantages of the two-stage approach to the longitudinal investigation included the introduction of a *multi-method* element to the overall investigation and a reduction in the likelihood of participant fatigue.

5.2 Method

5.2.1 Participants

Participants were drawn from two opportunity samples of Prison Service staff (see sections 5.2.1.1 and 5.2.1.2), an experimental sample, comprised of trainee SOTP therapists, and a control sample of individuals who had no therapeutic involvement with sex offenders and were unlikely to encounter sex offenders on a regular basis. Demographic information relating to these samples are presented in Table 5.1.

5.2.1.1 *Experimental participants*

The researcher attended two separate national training events for new SOTP facilitators, the first in October 2001 and the second in January 2002. At this stage, the facilitators had all experienced a standardised selection process at their establishments, but had little formal knowledge or experience of sex offender treatment. A brief presentation was made to all trainees about the nature of the research and the requirements of involvement in the longitudinal study i.e. completion of a questionnaire battery at three points in time, the first being at the start of the training course, and the second two at consecutive 6 month periods. Reassurances were given about the confidential nature of the data, and the right to withdraw from the procedure at any point over the duration of the study. Questionnaires were distributed to all trainees, with the instruction that completion and return of the data set was entirely optional, and that consent to use the data was implicit in that return. Participants were provided with a stamped addressed envelope for the return of completed questionnaires.

Forty-seven of a potential 90 participants completed and returned the first battery of questionnaires over both training events. Response attrition reduced this number to 28 by the third testing period.

5.2.1.2 *Control participants*

Initially control participants were recruited from a national training event for facilitators of the Living Skills programme, held in November 2001. The Living Skills programme is a cognitive behavioural course aimed at enhancing cognitive skills and is not offence-focussed. It was considered that facilitators of this programme would provide a reasonably matched sample with the experimental group, the key difference being the nature of treatment programme facilitated. As with the SOTP trainees, the participants were informed about the nature of the research and the need for comparisons to be made with similar groups of individuals to allow for differences to be identified. But despite a potential participant pool of 28, only 12 individuals responded. It is noteworthy however that of these 12, 11 remained by the end

of the third testing period.

Table 5.1 Demographic information

Variable		Whole Sample	Experimental group: Control Group N=17	Experimental group: Current Facilitators N=28	p
Gender (%)	Male	20	9	11	0.37
	Female	25	8	17	
Mean age (SD)		33.38 (9.59)	33.35 (11.11)	33.39 (8.75)	0.98
Mean months in service (SD)		32.95 (43.78)	35.56 (37.01)	31.46 (47.80)	0.77
Occupation (%)	Off	26.7	23.5	28.6	0.39
	PO	8.9	11.8	7.1	
	Psych Asst	28.9	23.5	32.1	
	Psych	22.2	17.6	25.0	
	Chaplain	2.2	-	3.6	
	PSO	4.4	5.9	3.6	
	Other	6.7	17.6	-	
Qualifications (%)	None	4.4	5.9	3.6	0.61
	GCSE	13.3	5.9	17.9	
	A Level	6.7	5.9	7.1	
	HND/BTEC	11.1	17.6	7.1	
	BSc	48.9	41.2	53.6	
	MSc	11.1	17.6	7.1	
	PhD	2.2	5.9	-	
	Other	2.2	-	3.6	
Facilitates other progs (%)	Yes	40	76.5	17.9	0.00**
	No	60	23.5	82.1	
Living Status (%)	Alone	24.4	17.6	28.6	0.26
	With partner	68.9	82.4	60.7	
	With others	6.7	-	10.7	
Children (%)	Yes	37.8	35.3	39.3	0.79
	No	62.2	64.7	60.7	
Trauma last 6 months (%)	Yes	22.2	23.5	21.4	0.53
	No	75.5	70.6	78.6	
Abused as Child (%)	Yes	8.9	11.8	7.1	0.25
	No	84.4	82.4	85.7	
Abused as Adult(%)	Yes	11.1	17.6	7.1	0.50
	No	86.7	76.5	92.9	

**p<.001; p= Exact X^2 where data are categorical; ANOVA where data are continuous.
Off=Officer; PO= Probation Officer; Psych Asst=Psychological Assistant; Psych=Psychologist;
Admin=Administrative Assistant; PSO=Probation Service Officer

The low numbers necessitated recruitment of further subjects for the control group, and this was done at HMP Leeds. Staff in the Regimes Group (a multi-disciplinary team responsible for the daily routine and activities of the establishment), were informed about the purpose of the research and invited to participate, which yielded 15 responses. It was decided that, due to time restrictions, only one follow-up period would be undertaken, 6 months after the initial testing period. Attrition resulted in 6 completed assessment batteries being returned, resulting in a control group sample of 17. Table 5.2 details participants by testing period.

Table 5.2 Number of experimental and control participants by testing period

	T1	T2	T3
Experimental Group	28	28	28
Control Group	17	17	12

T1 = testing period 1; T2 = testing period 2; T3 = testing period 3

5.2.2 Apparatus

5.2.2.1 The test battery

Careful consideration was given to the scales to be included in the test battery for the longitudinal study, to yield a broad but also sufficiently detailed data set At the same time, participant fatigue and practice effects were also borne in mind. The scales used are outlined below with a rationale for their inclusion.

The core test battery consisted of the:

Emotion Control Questionnaire (ECQ - R - Roger and Najarian, 1989;Roger et al, 2000) comprising Rumination (R) and Emotional Inhibition (EI). The role of R in stress and its statistically significantly relationship with the ADA factors has been described in detail in earlier chapters of this thesis. Consequently it may be argued that this has resulted in sufficient information being available about the importance of rumination in SOTP facilitator well-being. However,

although R is considered a stable factor, it has been suggested that change may occur as a result of trauma or intervention (Roger, 2002) (personal communication), so it was thought useful to investigate potential longitudinal change in R scores. EI has not previously been studied in the context of therapeutic work with sex offenders. The inclusion of this factor was based on the assertion by several researchers, that failure to express emotional responses to the work may be damaging.

Coping Styles Questionnaire (CSQ-R - Roger et al, 1993; *Roger,* 1996) comprising Detached Coping (DetCop), Rational Coping (RatCop) and Avoidance Coping (AvoCop). Although DetCop has been included in previous questionnaires, and was demonstrated to be inversely correlated with the three ADA factors, RatCop and AvoCop have not previously been investigated. It was considered helpful to consider all three coping styles in the context of facilitator well-being and, where possible, make comparisons between the impact of each of them. Like the DetCop subscale of the CSQ, RatCop is considered an adaptive coping style, and is characterised by a task-focused approach to problem solving. Avoidance coping forms the maladaptive coping cluster of the CSQ with emotion focused coping, and is characterised by a reluctance to deal with difficulties and a preference to either ignore them or trust in fate to provide a solution.

Interpersonal Reactivity Index (Davies, 1980) comprising Fantasy (FS), Empathic Concern(EC), Perspective Taking (PT) and Personal Distress (PD). The latter three factors of the IRI have all preciously been implicated in therapists' psychological reactions to their work. The importance of empathy as a therapeutic skill as well as a potentially damaging factor was discussed in Chapter Three. The relationship between PD and OD was also highlighted, and the role of PD and FS as measured by the IRI have yet to be fully examined.

Emotional Sensitivity Scale (Guarino et al, 2001) comprising Positive Emotional Sensitivity (PES) and Negative Emotional Sensitivity (NES). PES is statistically significantly associated with both RV and NRO and it was thought useful to consider the role of this factor in adaptation or otherwise to SOTP work. Although NES is considered a variation on the measurement of neuroticism

(N) as assessed by the EPQ (Eysenck and Eysenck 1975), it describes a tendency to experience high levels of self-orientated concern and negative emotions such as helplessness, vulnerability and self-criticism. NES has been related to greater emotional arousal following exposure to stress, and evidence suggests the construct may also be important in moderating health outcomes. Thus it was decided to include the ESS in its entirety to allow for comprehensive assessment across the range of personality variables.

Compassion Satisfaction (CompSat) sub-scale of the Compassion Fatigue/Satisfaction Self-Test (Figley and Stamm, 1996). This scale, as described in Chapter Three, focuses on the positive aspects of working in a helping profession. It was considered important to include a measure of satisfaction with therapeutic work with sex offenders and to investigate any fluctuations over time.

The scales were sent to control and experimental participants at each testing period, and at test periods 2 and 3, experimental participants also received the Assessment of Dynamic Adaptation (ADA), consisting of Negative Reactivity to Offenders (NRO), Ruminative Vulnerability (RV) and Organisational Dissatisfaction (OD).

5.2.2.2 *Treatment manager feedback*

Further to the psychometric data, assessment was sought from each participant's treatment manager regarding his/her performance as a facilitator. The assessment consisted of a 7-item survey including modelling, treatment style, positive reinforcement, questioning skills, understanding sex offending, group process skills and personal coping, with each item rated in a 6 point Likert scale. All items were drawn from the video-monitoring scales widely used by treatment managers as a part of the national accreditation process. It should also be noted that the first three items assessed those therapist features empirically linked with positive clinical impact of sex offender treatment programmes (see section 1.2.1). It was not possible to establish inter-rater reliability on the feedback forms prior to their use, so guidance was provided with each item in relation to behaviours that would warrant a high score (see Appendix O).

The purpose of collecting feedback from treatment managers was to provide a more objective assessment of facilitator progress and to enable investigation into potential relationships between observed treatment behaviours and self-reported coping, emotion control, emotional distress and satisfaction with the role.

5.2.3 *Procedure*

Given that the reliability of change measurement is considered to be markedly improved by the addition of more time observations (Willett, 1988, 1989), participants in both the control and experimental groups were tested at three periods over the 12 months. For experimental participants, the first test period was at the commencement of SOTP training. The original intention was for therapists to then complete the second test battery mid-way through their first programme, and the third at the end of that programme. Despite extensive planning on behalf of treatment managers in the Prison Service, this proved to be impractical, so six month time periods were chosen, which also made it easier to match testing periods with the control group.

Owing to a low return rate by experimental participants at the second testing period, at the third testing period test batteries were distributed via treatment managers in an effort to secure greater compliance by participants. Additionally, it was agreed that as a result of each participant returning completed questionnaires, five pounds would be donated to charity. Letters informed participants of this soon after the second testing period (the point at which the decision was reached). The researcher nominated two charities from which participants could chose, to avoid large numbers of organisations being sent small donations. These were the National Organisation for the Treatment of Abusers (NOTA) and the National Society for the Prevention of Cruelty to Children (NSPCC).

Control group participants were also contacted by letter, having agreed to participate in the study. As previously described, low return rates at the second testing periods prompted recruitment of a second cohort of

participants. The retest intervals were disrupted to some extent, resulting in the first cohort being tested on three occasions at five to six month intervals and the second cohort being tested twice, approximately six months apart.

5.2.4 *Statistical analyses*

Two sets of manipulation checks were performed. The first compared the control and experimental groups on the psychometric scales at the first testing period to ensure the groups were matched. The second check considered the relationship between the two sets of Treatment Manager Ratings (TMRs) collected from the experimental group at the second and third testing period. The method was intended as a measure of test-re-test reliability in the absence of inter-rater reliability.

The first analysis of the data centred on the 2 (experimental group) x 3 (administrations) way design on which the overall investigation was predicated. ANOVAs were performed on each of the 15 psychometric variables to consider the interactions of experimental group and times of administration. The anomalous results that emerged prompted further investigation of the experimental group data in isolation, with particular emphasis on changes in scores over the 6 and 12 month testing period.

The next set of analyses focused exclusively on the data from the experimental group. The relationships between the demographic variables, the Treatment Manager Ratings (TMRs) and scores on each of the 15 psychometric factors measured at the 3 testing periods were considered. This was followed by deliberation on the TMRs as predictor variables, with a view to using TMRs as objective measures of therapist well-being.

5.3 Results

5.3.1 *Experimental manipulation checks*

A manipulation check revealed that three of the means on the 15 psychometric scales were significantly different at the first testing period between the

experimental and control group (see Table 5.3), an indication that the samples were not matched and that the results from subsequent analyses would need to be treated with caution.

Table 5.3 Statistically significant mean differences at the first testing period

	Experimental group Mean (n=28)	Control Group Mean (n=17)	t
Emotional Inhibition	3.46 (2.77)	6.41 (4.21)	-2.84**
Rumination	4.03 (2.60)	6.29 (3.65)	-2.42*
Compassion Satisfaction	100.32 (11.50)	89.53 (12.50)	2.95**

*p<o.o5; **p<0.01

5.3.1.1 Correlations between TMRs at both testing periods

As inter-rater reliability had not been established on the TMRs prior to use, correlations between the scores at the first and second testing period were run to consider test-re-test reliability. The results indicated that 6 of the 7 ratings were significantly correlated: Modelling (r=0.67; p<0.001); Questioning Skills (r=0.65;p<0.001); Positive Reinforcement (r=0.694; p<0.001); Understanding Sex Offending (r=o.69; p<0.001); Group Process Skills (r=0.55; p<0.05) and Personal Coping (r=0.55; p<0.05). Treatment Style failed to correlate significantly (r=0.30; p=0.195). These findings indicate a satisfactory relationship between the TMRs at the 2 testing periods.

5.3.2 Changes in psychometric scales over time by experimental group

Data for each psychometric scale were analysed separately, with each being entered into a 2 (groups) x 3 (administrations) mixed ANOVA. A summary of the results is presented in Table 5.4.

There was a main effect for both EC (F (2,86) = 3.32, p<0.05) and PD (F(2,68)=3.73, p<0.05) but for no other scale. Significant interactions were apparent between groups over time for R (F(2,74)=5.33, p<0.01), PD (F(2,68)=3.46, p<0.05) and CompSat (F(2,74)=4.53, p<0.05).

Table 5.4 Summary of ANOVAs

	Group		Scale		Interaction	
	F	p	F	P	F	P
PES	0.64	o43	1.72	0.19	0.94	0.39
NES	0.31	0.58	0.10	0.90	2.64	0.08
DetCop	0.01	0.94	0.30	0.74	0.80	0.45
RatCop	0.01	0.91	0.35	0.71	0.84	0.43
AvoCop	1.06	0.31	0.14	0.87	2.00	0.14
EI	0.66	0.42	1.54	0.22	0.67	0.52
R	0.00	0.97	1.11	0.33	5.33	***0.01***
FS	0.17	0.68	2.08	0.13	0.54	0.59
EC	0.40	0.53	3.32	***0.04****	0.38	0.69
PT	1.52	0.23	1.90	0.16	1.21	0.30
PD	0.67	0.42	3.73	***0.03****	3.46	***0.04****
CompSat	0.74	0.39	1.41	0.25	4.53	***0.01****

**p<0.01; *p<0.05; NES=Negative Emotional Sensitivity; PES=Positive Emotional Sensitivity; DetCop=Detached Coping; RatCop=Rational Coping; AvoCop=Avoidance Coping; EI=Emotional Inhibition; R=Rumination; FS=Fantasy; EC=Empathic Concern; PT=Perspective Taking; PD=Personal Distress; CompSat=Compassion Satisfaction; NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability; OD=Organisational Dissatisfaction

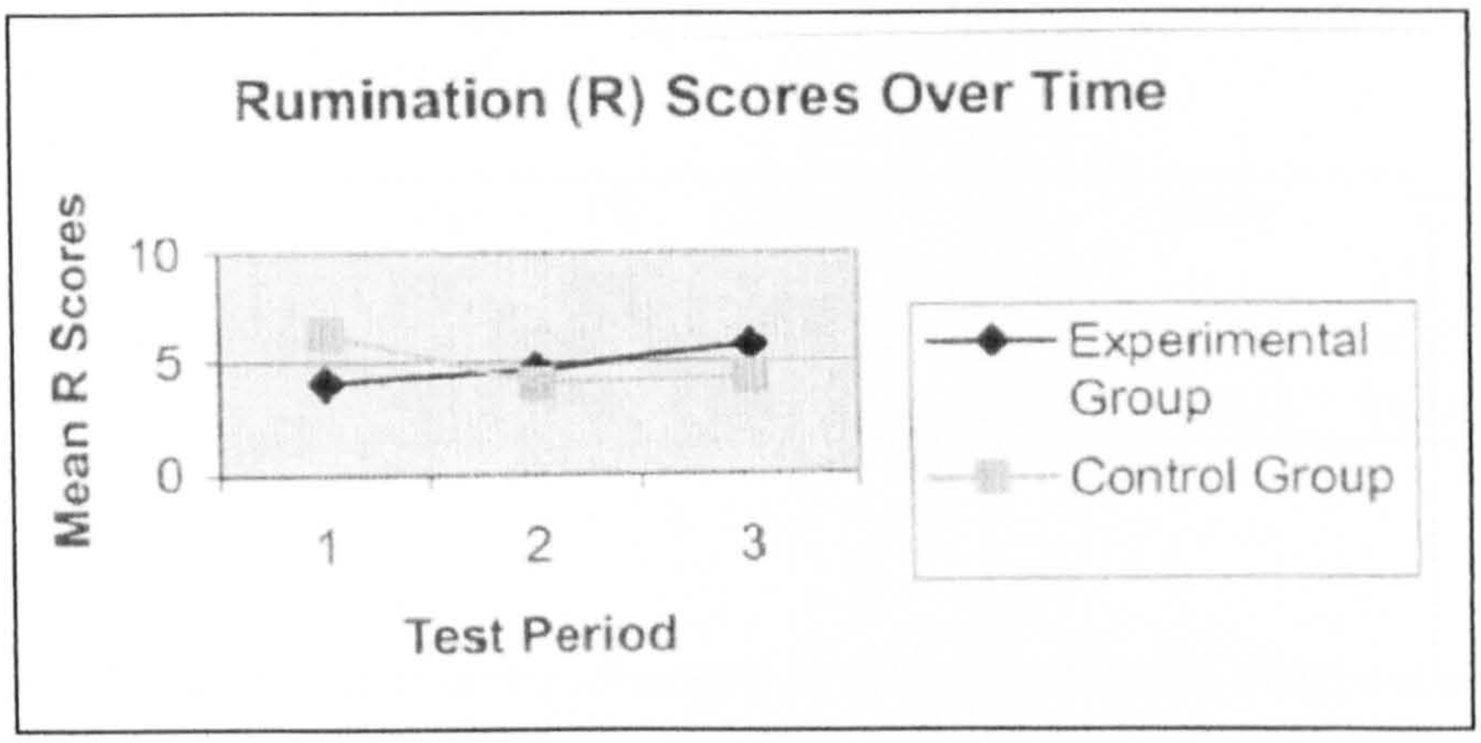
5.3.2.1 Changes in Rumination scores

The analysis for rumination revealed a significant interaction between group and time of administration ($F(1,37)=7.00$; $p<0.05$), although examination of the means indicated unexpected scores from the control group, as shown in Table 5.5 and illustrated in Figure 5.1.

Table 5.5 Means of rumination scores over the three administrations

	N	T1 Mean	(SD)	T2 Mean	(SD)	T3 Mean	(SD)
Experimental group	28	4.04	(2.60)	4.64	(3.34)	5.75	(4.05)
Control Group	17	6.27	(3.32)	4.00	(3.35)	4.27	(2.83)

Figure 5.1 Graph illustrating changes in rumination scores over time by group

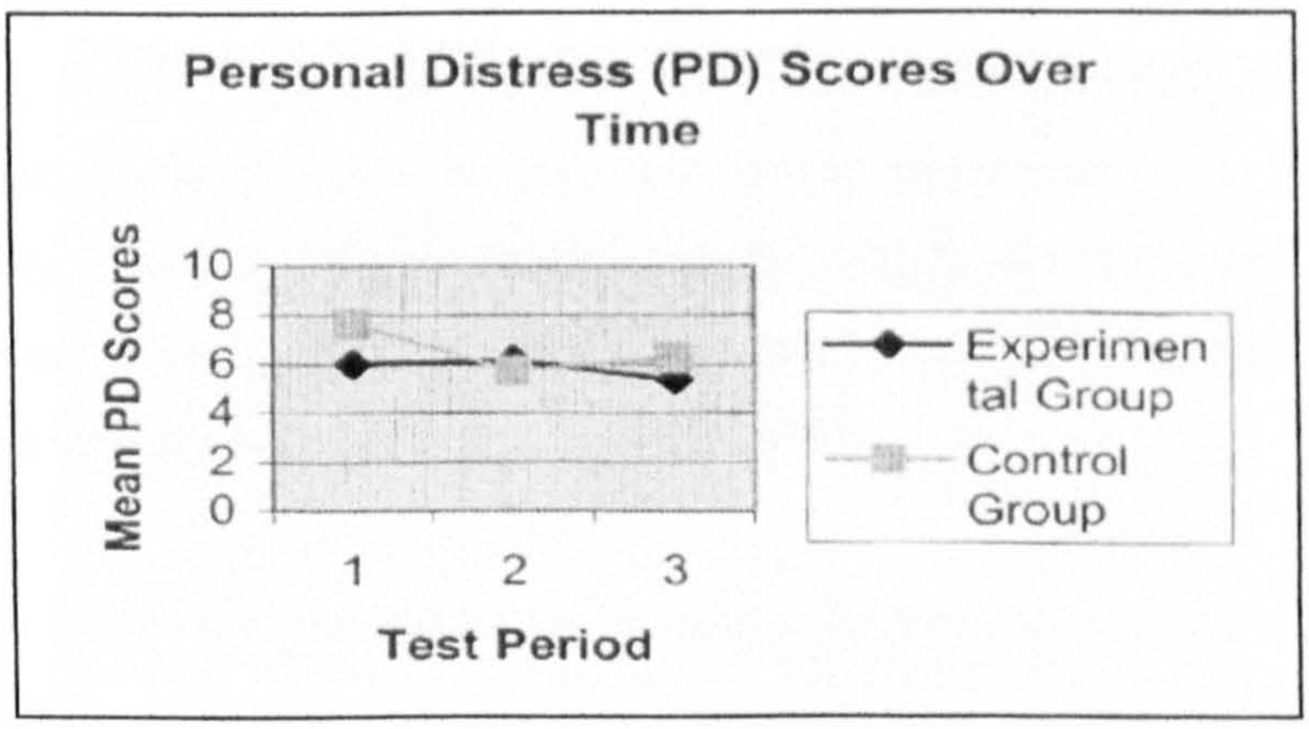


5.3.2.2 Changes in Personal Distress scores

Table 5.6 Means and standard deviations of Personal Distress scores over the three administrations

	N	T1 Mean	(SD)	T2 Mean	(SD)	T3 Mean	(SD)
Experimental group	25	6.00	(2.71)	6.16	(2.29)	5.36	(3.37)
Control Group	17	7.64	(2.69)	5.73	(2.72)	6.27	(1.68)

Figure 5.2 Graph illustrating changes in Personal Distress scores over time by group

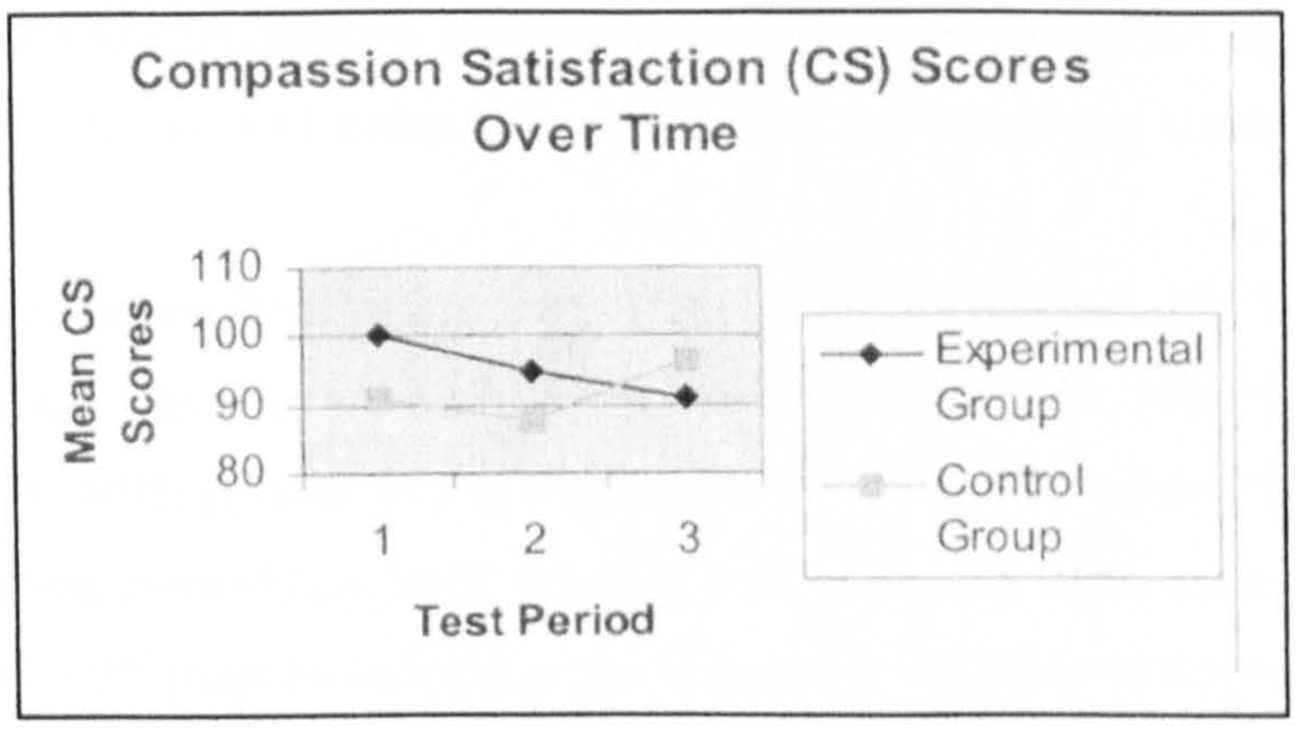


5.3.2.3 *Changes in Compassion Satisfaction scores*

Table 5.7 Means and standard deviations of Compassion Satisfaction scores over the three administrations

	N	T1 Mean	(SD)	T2 Mean	(SD)	T3 Mean	(SD)
Experimental group	28	100.32	(11.51)	94.54	(18.99)	90.75	(15.88)
Control Group	17	90.73	(9.36)	87.46	(10.81)	96.36	(15.71)

Figure 5.3 Graph illustrating changes in Compassion Satisfaction scores over time by group



Because of the anomalous results indicated by the graphs above and the significant differences between the control and experimental group in the baseline scores reported in section 5.3.1, the means for each scale at the three testing periods were further scrutinised. This revealed marked inconsistencies for the control subjects, suggesting that their responses may not be reliable (see Appendix P). Some consideration was given to transforming the scores and repeating the analyses, but in view of the statistical robustness of the analysis of variance it was felt that transformations would not necessarily redress the problem (see also Roberts and Russo, 1999).

Instead, it was decided to focus on changes in scores for the experimental group only. Although it was recognised that this would reduce the capacity to make reliable causal inferences, the analyses would nonetheless be useful in identifying trends amongst the experimental participants.

5.3.3 *The relationship between the experimental group demographic variables and psychometric measures*

Study of the relationships between the experimental group demographic variables and the psychometric measures taken at the three testing periods identified only a few significant correlations. Examination of these indicated they were likely to be a result of random variation, as expected or sustained patterns over the three testing periods did not emerge. For example, gender was significantly negatively correlated with Negative Emotional Sensitivity ($r = -0.41$; $p<0.05$) at the second testing period, but not at the first or third; age was significantly positively correlated with Empathic concern at the first testing period ($r= o.5o$; $p<o.05$) but not at the second or third (see Appendix R for all correlations). Consideration was given to testing the significance of the difference of the correlations but was rejected on the grounds that it would capitalise on chance and reduce the statistical power of the data.

The only consistent finding amongst the correlations related to the Organisational Dissatisfaction (OD) subscale of the ADA, which correlated significantly ,with gender at the second ($r = -0.39$; $p<0.05$) and third ($r =o.o5$; $p<0.01$) testing period (i.e. both times it was utilised), with men scoring more highly, and with time in service at the second ($r =0.39$; $p<0.05$) and third ($r=0.54$; $p<0.01$) testing period. As it may have been the case that males had spent a longer time in service, a one-way ANOVA was conducted, but proved to be nonsignificant ($F=3.54$; $p=0.067$).

5.3.4 *Experimental group analyses*

The means for each scale over the three testing periods for the experimental group are presented in Table 5.8, together with the results of the one-way ANOVAs comparing scores at each time period.

Table 5.8 Summary of mean scores and standard deviations on scales over time for the experimental group

Scale	T1 (SD)		T1 (SD)		T1 (SD)		F	p
PES	9.392	(3.22)	9.18	(2.72)	8.82	(3.41)	0.66	0.54
NES	5.50	(3.28)	5.54	(4.04)	7.18	(6.00)	2.58	0.09
DetCop	42.96	(5.50)	42.43	(5.73)	41.50	(6.86)	1.04	0.25
RatCop	20.04	(3.55)	19.39	(3.97)	18.93	(3.81)	1.42	0.25
AvoCop	6.54	(3.44)	7.39	(4.52)	7.36	(3.64)	1.16	0.32
R	4.04	(2.60)	4.64	(3.34)	5.75	(4.05)	***3.38***	***0.04****
EI	3.46	(2.77)	3.89	(3.65)	5.00	(4.03)	***4.07***	***0.02****
FS	10.36	(3.56)	9.89	(3.69)	10.29	(4.03)	0.40	0.67
EC	15.28	(2.54)	13.71	(3.14)	13.64	(3.07)	***4.42***	***0.02****
PT	16.00	(2.71)	15.54	(2.92)	16.50	(2.44)	1.31	0.28
PD	6.00	(2.71)	6.36	(2.56)	5.21	(3.41)	1.62	0.21
CompSat	100.32	(11.51)	94.54	(18.99)	90.75	(15.88)	***5.57***	***0.01*****
NRO			14.43	(6.78)	13.54	(7.07)	0.62	0.44
RV			4.07	(3.21)	4.82	(3.91)	2.03	0.17
OD			2.89	(2.74)	3.54	(2.70)	2.29	0.10

*p<o.o5; **p<0.01; T1=Test Period 1; T2=Test Period 2; T3=Test Period 3; NES=Negative Emotional Sensitivity; PES=Positive Emotional Sensitivity; DetCop=Detached Coping; RatCop=Rational Coping; AvoCop=Avoidance Coping; EI=Emotional Inhibition; R=Rumination; FS=Fantasy; EC=Empathic Concern; PT=Perspective Taking; PD=Personal Distress; CompSat=Compassion Satisfaction; NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability

Inspection of the above means indicated changes in the expected direction on 11 of the 15 scales, with four of those proving significant. Fantasy and Perspective Taking remained relatively unchanged over the 12 months testing period. A statistically significant decline was seen in EC and CompSat scores and non-significant declines in PES, DetCop, RatCop and NRO. Significant increases were seen in R and EI, with non-significant increases in NES, AvoCop, RV and OD. An unexpected (but non-significant) decline was seen in PD and will be included in the discussion in Section 5.4.

5.3.5 The relationship between the TMRs and psychometric measures

Two sets of correlations were considered, the first between the TMRs and psychometric scores at the second testing period (T2), and then again at the third testing period (T3). By T2, participants had run an average of 31.27 sessions (SD 21.47), with a range of 0 to 75 sessions. At T3 this had risen to an

average of 76.70 sessions (SD 25.56) with a range of 20 to 130 sessions.

The results indicated an inconsistent pattern of correlations across the two testing periods, with different factors correlating with the TMRs at either T2 or T3. Whilst this might normally be a cause for concern in terms of the validity and reliability of the scales used, in the context of the current research such differences were anticipated. Indeed, it would be expected that the experience of running therapy sessions would result in changes in TMRs, as well as some of the psychological factors assessed by the psychometric scales used. Table 5.3 indicates which factors correlated significantly with the TMRs at either of the two testing periods.

The only factor showing a consistently significant correlation with TMRs at both testing periods was the Negative Emotional Sensitivity subscale of the Emotional Sensitivity Questionnaire. As described elsewhere in this thesis, this factor is essentially a reconstruction of neuroticism, which is recognised as a confounding variable in stress research. Consequently, it was either partialled out or excluded entirely from further analyses in this investigation.

5.3.6 TMRs as predictor variables

Based on the correlations a number of linear regressions were run using each of the psychometric factors as dependent variables and the TMRs that correlated significantly with them as independent variables. The decision was taken to run only regressions with data from the third testing period. This was based on a number of factors, including the differences in the correlations highlighted in the table, and the mean number of sessions run by T3. Although it could be argued that predictors would quite likely change over time as a consequence of running SOTP, and that early predictors of performance are as important as those based on greater experience, it was considered that a mean of 31.27 sessions was insufficient in terms of gauging the likely impact on therapists of their work. By T3 therapists' average experience (76.70 sessions) was almost equivalent to one full programme (on average 85 sessions long), and this was considered a more realistic level of experience on which to base predictive analyses.

Table 5.9 Correlations between treatment manager ratings and psychometric measures at both testing periods

	A		B		C		D		E		F		G	
	T2	T3	T2	T3	T2	T3	T2	T3	T2	T3	T2	T3	T2	T3
NES	-.68**	-.072**	-	-	-0.61**	-0.55**	-0.63**	-0.45**	-0.66**	-.0.58**	-0.69**	-0.57**	-0.66**	-0.47**
PES	-	-	-	-	-	-	-	0.43*	-	-	-	-	-	-
DetCop	-	0.54**	-	-	-	-	-	-	-	-	0.66**	0.55**	0.64**	-
RatCop	-.41**	0.42*	0.45*	0.45*	-	-	0.41*	-	0.44*	-	0.55**	-	0.58**	-
AvoCop	-	-0.43*	-	-	-	-	-	-	-	-	-	-0.52**	-0.48*	-
EI	-	-	-	-	-	-	-0.49*	-	-	-	-	-0.52**	-	-
R	-0.51*	-0.69**	-	-	-	-	-	-	-0.52**	-0.47*	-0.54**	-	-0.62**	-
FS	-	-	-	-	-	-	-	0.54**	-	-	-	-	-	-
EC	-	-	-	-	-	-	-	0.42*	-	-	-	-	-	-
PT	-	0.58**	-	-	-	0.41*	-	-	-	-	-	-	-	-
PD	-	-0.41*	-	-	-	-	-	-	-	-	-	-	-	-
CompSat	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NRO	-	-0.44*	-	-	-	-	-	-	-	-0.43*	-	-	-	-0.41*
RV	-	-0.53**	-	-	-	-	-	-	-	-	-	-0.417*	-	-0.41*
OD	-	-0.52**	-	-	-	-0.49*	-0.42*	-	-	-0.51*	-0.47*	-	-	-

*p<o.o5; **p<0.01; A = Modelling; B = Treatment Style; C = Questioning Skills; D = Positive Reinforcement; E = Understanding Sex Offending; F = Group Process Skills; G = Personal Coping; T2=Test Period 2; T3=Test Period 3; NES=Negative Emotional Sensitivity; PES=Positive Emotional Sensitivity; DetCop=Detached Coping; RatCop=Rational Coping; AvoCop=Avoidance Coping; EI=Emotional Inhibition; R=Rumination; FS=Fantasy; EC=Empathic Concern; PT=Perspective Taking; PD=Personal Distress; CompSat=Compassion Satisfaction; NRO=Negative Reactivity to Offenders; RV=Ruminative Vulnerability; OD= Organisational Dissatisfaction

5.3.6.1 *TMRs as predictors of ADA factors*

The ADA was constructed specifically to assess psychological distress associated with sex offender treatment, so it was decided to treat the three factors of the ADA separately in terms of the extent to which TMRs might be predictive of scores on each of them.

NRO

Three TMRs, A) modelling, B) treatment style and E) understanding sex offending, correlated significantly with NRO at the third testing period. Linear regression indicated that none of the these were significantly predictive (modelling ($t = -0.72$, $p=0.48$); treatment style ($t = -1.44$, $p=0.17$); understanding sex offending ($t = -0.94$, $p=0.36$).

RV

A) modelling, F) group process skills and G) personal coping correlated significantly with RV, but again, none were significantly predictive of RV (modelling ($t = -1.66$, $p=0.11$); group process skills ($t = -0.54$, $p=0.55$); personal coping ($t = -1.33$, $p=0.20$).

OD

Four TMRs correlated significantly with OD at T3, but again none were predictive of OD (A) modelling ($t = -0.96$, $P=0.35$); B) treatment style ($t = -1.21$, $p=0.24$); C) questioning skills ($t = -0.45$, $p=0.66$); and E) understanding sex offending ($t = 0.48$, $p=0.64$).

5.3.6.2 *TMRs as predictors of all psychometric factors*

Examination of the correlations of TMRs with the psychometric factors indicated that only a maximum of two significant correlations were evident for each factor. Therefore, it was decided to consider all TMRs as predictors for each psychometric measure. Although this is a large number of variables to include for analysis with such a small sample, Ennis and Horne (2003) suggested that the emergence of significant findings under conditions of low statistical power improved the confidence with which the findings may be accepted as valid. The results are summarised in Table 5.4. None of the TMRs were predictive of EI, RatCop or CompSat.

Table 5.10 Summary of regression analysis

	A Modelling			C Questioning skills			D Positive Reinforcement			F Group Process Skills			G Personal Coping		
	ß	t	p	ß	t	p	ß	t	p	ß	t	p	ß	t	p
PES							2.74	2.15	0.02						
DetCop	8.60	3.16	0.006**	-6.09	-0.25	0.03*							3.47	2.35	0.03*
AvoCop							343	3.88	0.001***	-3.73	-2.71	0.02*			
R	-5. 77	-3.47	0.003**				2.14	2.19	0.04*						
FS	-4.31	-2.42	0.03*				3.84	3.67	0.002**						
EC							2.39	2.14	0.05*						
PT	2.86	2.27	0.04*												
PD	-4.36	-2.55	0.02*												

***p<0.001; **p<0.01; *p<o.o5; PES=Positive Emotional Sensitivity; DetCop=Detached Coping; AvoCop=Avoidance Coping; R=Rumination; FS=Fantasy; EC=Empathic Concern; PT=Perspective Taking; PD=Personal Distress

5.4 Discussion

Current understanding about the nature of the psychological impact their work has on sex offender therapists has been based on data from retrospective research. Although hypotheses have been made about the nature of the progression of the effects (e.g. Farrenkopf, 1992), and a number of studies have compared new and experienced therapists (e.g. Pearlman and MacIan, 1995; Steed and Bicknell, 2001) in relation to trauma symptoms, no published research to date has systematically followed a cohort of new therapists through their first months as sex offender treatment providers. Therefore, the data elicited from the current study provides potentially the first insight into the nature and process of psychological change that result from starting to work therapeutically with sex offenders.

Because of difficulties with data from the control group, caution needs to be exercised when making causal inferences about the role of facilitation. Manipulation checks revealed that although the control and experimental groups were broadly matched on demographic variables, they were not matched on at least three of the psychometric measures at the start of the study. Later analyses indicated an unusual pattern of responding by the control group throughout the study, particularly at the second testing period, and this rendered comparisons between the control and experimental groups unsound. Nonetheless, the results from the experimental group support clinically- and intuitively-based assumptions about the impact of the work, and are the focus for the discussion.

It was noteworthy that examination of the demographic variables in relation to the psychometric data collected at the three testing periods did not yield any consistent pattern of results. Indeed very few significant relationships emerged. This suggests that the relationships between variables are likely to be a function of SOTP experience rather than demographic variables.

Comparisons of the scores on each of the scales used indicated four significant results. Over the 12 months period of the study, facilitators significantly increased on Rumination (R) and Emotional Inhibition (EI), and significantly decreased on Empathic Concern (EC) and Compassion Satisfaction (CompSat).

Examining a possible inter-play between these variables, rather than considering each in isolation, would be likely to most comprehensively explain these changes.

In the previous chapter (section 4.7.1), the differences between ex- and current facilitators in terms of Negative Reactivity to Offenders, was discussed in the context of the therapeutic environment in which SOTP occurs. It was hypothesised that the therapeutic infrastructure was one in which negative reactions to offenders were suppressed as anti-therapeutic, and it was not until individuals had completed their work as therapists that they felt more able to express their negative emotions towards the client group which most recognise as particularly challenging. The current findings provide some support for this, suggesting that in the first 12 months of facilitating, therapists become more emotionally inhibited. The paradox here is that they have become involved in a career that by definition requires them to encourage others (sex offenders) to express often complex and disturbed emotional states, and to provide a supportive environment in which to do so. That therapists become less likely to express their own emotion might be indicative of the development of the helper stereotype (Short, 1979), whereby therapists perceive themselves as resourceful and powerful and, as a result of personal and professional characteristics, suppress or deny problems that may be psychological or emotional in nature (Paton,1996). It also lends support to the observation of Paton (1996) that while members of helping professions may possess the technical skills required to meet the demands presented by their clients, their training may not equip them with the psychological and self-maintenance skills required to readily understand their own reaction to the work.

The identified reduction in emotional expression is accompanied by a significant increase in Rumination. Given the empirical evidence for a link between rumination and indices of ill-health (Roger and Jamieson, 1988; Roger and Najarian, 1998; Tomsen, 2003) and the fact the evidence is stronger if people also inhibit emotion, this finding is cause for concern. It suggests that therapists, as a result of inhibiting emotion, possibly though not necessarily, become more likely to ruminate over emotional upset. It is unclear whether

this is general or work specific, but it is argued that making a distinction between the two might assist in identifying the psychological processes involved in the changes identified. For example, if the increase in rumination reflects therapists' thinking more about sex offence related emotional upset, which would make intuitive sense, it might be expected that Ruminative Vulnerability (RV) scores would also increase, as RV is specific to sex offender treatment. Absence of a statistically significant increase in RV could simply be a consequence of the six-month rather than 12 month administration period, but it might also indicate that therapists' increase in rumination reflects a general change in emotional response style. If this is the case, then the observed changes might provide the first empirical evidence to support Ryan and Lane's (1991) assertion that working with sex offenders can change therapists in subtle and potentially permanent ways.

The increases in Rumination and Emotional Inhibition were accompanied by decreases in Empathic Concern (EC) and Compassion Satisfaction (CompSat). Figley (1995) argued that therapists with a high capacity for feeling and expressing empathy were more at risk of experiencing compassion stress. It is therefore postulated that the reduction in Empathic Concern observed in the current study might reflect an adjustment in therapists' empathic responses to their clients in an attempt to minimise the dissonance created by empathising and the distress this could induce. It would then follow that therapists experience less satisfaction with their work, reflected in a reduction in CompSat scores.

Non-significant trends also emerged from the data, with facilitators showing a reduction in Positive Emotional Sensitivity (PES), Detached (DetCop) and Rational Coping (RatCop), and Negative Reactivity to Offenders (NRO). It is suggested that the drop in PES scores mirrors the decline in EC, and the decline on NRO scores further supports the assertion that negative responses to offenders are suppressed as contrary to effective therapy. The decrease in functional coping styles over the 12 months period is marginal (1-2 points) but should, nonetheless, be observed as part of the adaptation process. Personal Distress (PD) scores showed an initial increase at T2 and then a decline by T3. As with DetCop and RatCop the change was small but worthy of observation over time, given the possible long-term effects of therapeutic work with sex

offenders. Recommendations regarding this will be discussed later in this chapter.

It could be argued that it would be specious to draw firm conclusions on the basis of 12 months data and so an alternative explanation to those proffered above should also be considered. There is some empirical evidence in both the trauma literature (e.g. Pearlman and MacIan, 1995) and the sex offender therapist literature (e.g. Steed and Bicknell, 2001), that newness to the field effects self-reported difficulty with psychological adjustment to the work. For example, Steed and Bicknell, using an adapted version of the CompSat Fatigue Self-Test (Stamm, 1995) and the Impact of Events Scale - Revised (Weiss and Marmar, 1995), identified a pattern of adjustment represented by a "u" shape, and concluded that regardless of overall experience as a therapist, when beginning work with sexual abuse perpetrators there was a considerable risk of secondary traumatic stress. This reduced between two to four years experience and increased again by nine to twelve years. Other researchers have identified similar trends (e.g. Ellerby, 1998) and indeed results from earlier elements of the current research, namely the scale construction exercise reported in Chapter Two, indicate that younger and less experienced therapists experience greater RV than their more experienced counterparts. However, the findings regarding level of experience and psychological adaption are equivocal, with researchers such as Rudolph et al (1997) suggesting that for mental health practitioners, qualification level was more important.

It is proposed that the contradictory findings regarding level of experience and well-being are as a result of failure to consider the role of individual differences in the adaptation process. For example, none of the published studies considered the role of coping styles on early adjustment to working with sex offenders. The small numbers involved made it impossible to investigate this in the current study without substantially compromising statistical power, but it is proposed that individual differences in adaptation to SOTP work need to be thoroughly researched before it can be assumed that new therapists are at significantly more risk of psychological ill-effects. The final section of this chapter will make recommendations for further investigation in this area.

In addition to considering changes in specific measures over time, the longitudinal investigation also considered the relevance of behaviour ratings by therapy managers to facilitator well-being. The behaviour ratings, described in section 5.2.2.2, (see also Appendix O) comprised seven items, regularly used by treatment managers in monitoring therapists' performance whilst running therapy sessions. Ratings were collected at the six and 12 months periods. Two of the items in particular, modelling and positive reinforcement, emerged as repeatedly predictive of a number of psychometric factors. Questioning Skills, Group Process Skills and Personal Coping were each predictive of one factor and Treatment Style and Understanding Sex Offending were not predictive of any psychometric measures.

For the purposes of rating facilitators in this study, modelling referred to professional behaviour, such as appropriate self-disclosure and anti-discriminatory behaviour and attitudes, and was found to be statistically significantly predictive of Detached Coping (DetCop) and Perspective Taking (PT), and negatively predictive of Rumination (R), Fantasy (FS) and Personal Distress (PD). This suggests that facilitators receiving a higher score for Modelling were more likely to achieve high scores on DetCop and PT and lower scores on R, FS and PD. Such a pattern of scores on these measures would indicate a psychologically healthy individual who was able to detach from their work, take perspective, not ruminate or experience distress and not become over involved with the process of therapy. Further, as appropriate self-disclosure by therapists has been linked with improved perspective taking, coping skills and responsibility taking among offenders (Fernandez, 1999), modelling appears to be a critical feature both in terms of therapist well-being and therapeutic effectiveness.

Positive reinforcement has also been linked with improvements among offenders on dimensions including acceptance of future risk, group participation, perspective taking, coping skills and taking responsibility (Fernandez, 1999; Marshal et al 2003), and also recognised as an important therapeutic skill. In the current study it was significantly positively predictive of Positive Emotional Sensitivity (PES), Avoidance Coping (AvoCop), R, FS and Empathic Concern (EC). This pattern of associations is less

straightforward to describe and, as with empathy discussed in Chapter Three, raises some concerns about a particular therapeutic skill being associated with potential difficulties with psychological adjustment to work as an SOTP therapist. A relationship between Positive Reinforcement, PES and EC might be expected, as it is arguable that both the latter characteristics are central to noticing and responding to change in offenders' attitudes and behaviours. However, it is postulated that the attentiveness and vigilance required to achieve this might also be implicated in the association with R and FS, as, particularly among inexperienced therapists, such observation might only be achievable through extensive involvement and rehearsal in the group process. Avoidance coping might then be adopted as a way of dealing with the more unpleasant aspects of such immersion in that process.

A similar process might also explain the relationship between DetCop and questioning skills. The latter is negatively predictive of the former, suggesting that individuals scoring high on questioning skills are less detached copers. It is suggested that in order to develop the questioning skills required, therapists become so attentive and involved in the group process that it becomes more difficult to be emotionally detached.

Conversely, good group process skills are negatively predictive of Avoidance Coping (AvoCop). Group process skills refer to those that encourage group participation and enhance group cohesiveness. Such skills have been demonstrated to be central to effective therapy, almost irrespective of the theoretical perspective from which the therapy is conducted (e.g. Yalom, 1975; Beech and Fordham, 1997; Schaap et al, 1993). It is argued that taking an overview of the group process, rather than becoming immersed in it, develops such skills. Also, responding to what is observed in a proactive and integrated manner, no matter how difficult the issue may be, results in a high score on this dimension. This would be counter to avoidance coping.

Finally, the Personal Coping item on the treatment manager rating scale was significantly predictive of DetCop. The emergence of a predictive relationship between these two variables is encouraging. DetCop has been consistently identified in this research as desirable in relation to therapist well-being. As with the other findings in this study, that coping style may be observed, as

well as ascertained by self-report to enable most appropriate targeting of support resources.

In order to establish any validity to the hypotheses presented above, regarding the predictive nature of treatment manager ratings and the psychological processes involved in adapting to work as an SOTP therapist, further research is required. But it is encouraging that preliminary investigations into this area have enabled identification not only of features that may be reliable indicators of psychological distress, but also of the processes involved in causing it.

5.5 Conclusions

The longitudinal investigation into facilitator well-being, whilst limited by the erratic behaviour of the control group, has nonetheless provided the first insight into the nature of the psychological processes that may occur as a result of adaptation to working therapeutically with sex offenders. Although at this stage, the hypotheses regarding these processes need to be tentative, the findings provide an empirical foundation on which to base further research.

Based on the current findings, observations regarding psychological adaptation can only be applied to therapists in the first 12 months of their work with sex offenders. A longer follow-up period would be required to examine the nature of responding among therapists with some longevity in the field and to identify any changes that may occur as a result of experience. This would also involve following up individuals who self-deselect or who are deemed by treatment managers to be unsuited to SOTP work.

The predictive validity of the treatment manager ratings requires robust examination. Inter-rater and test-retest reliability of the ratings need to be established before firm conclusions can be drawn about their predictive nature. Even so, at this stage, identification of a potential method of objective assessment of facilitator well-being is encouraging and should be developed.

To date, the provision of information to therapists about the possible effects of their work has taken the form of likely symptoms and the percentage of people likely to experience them. No discrimination has been made regarding who

might be at particular risk or why or when. Continued investigation into the long-term psychological adaptation of therapists to their work would provide therapists with valuable information about the general nature of the adaptation process and so enable informed responses to psychological change that might otherwise be unexpected. It would also enhance the ability of managers to respond appropriately to the support needs of therapists at different stages of their careers and to target resources accordingly.

Chapter Six

A Qualitative Longitudinal Investigation into the Impact of Working Therapeutically with Sex Offenders

6.1 Introduction

Anecdotally, individuals undertaking therapeutic work with sex offenders have described fundamental changes in their perception of the world that they attribute directly to their experience of their work. Few therapists report remaining unchanged by their experience of delivering sex offender treatment, and some have been so overwhelmingly affected that clinical diagnoses of Post Traumatic Stress Disorder (PTSD) have resulted. However, despite the growing literature regarding the negative outcomes of working with sex offenders that might be considered symptomatic of challenges to an individual's fundamental assumptions about the world, conclusions about the processes involved remain *ad hoc* and atheoretical.

There is an extensive and varied literature focusing on the ways in which individuals make sense of their experience. For example, Parkes (1975) referred to the "assumptive world", Bowlby (1969, 1973) to "working models" and Marris (1975) to "structures of meaning" to describe how people construe their reality. Janoff-Bulman (1992) highlighted that although different terms have been used, there was congruence in the descriptions of a single underlying phenomena, a conceptual system developed over time, providing a framework in which individuals developed expectations about themselves and the world. She described this system, sometimes referred to as schemas (Piaget, 1971), as a "set of assumptions or internal representations that reflect and guide our interactions in the world and generally enable us to function effectively" (p.5). For a comprehensive review of the schema literature see Beck (1995).

McCann and Pearlman (1990), researching the impact that working with trauma survivors had on therapists, hypothesised that trauma disrupted schemas, especially in relation to safety, dependency, trust, power, esteem and intimacy. They argued that the extent to which disruptions to schemas were subtle or shocking depended on the dissonance created by the material presented to

therapists in the course of their work, as well as their existing schematic framework. Adaptation, they suggested, required integrating or transforming experiences, a process that might result in potentially lasting alterations in their own cognitive schema.

Paton and Smith (1996), preferring a more cognitive behavioural to psychodynamic approach, argued that theories offering an appropriate framework for the study of work-related trauma were those that emphasised appraisal/information processing bias for reactivity. They cited the work of Horowitz (1976), whose information processing model suggested that traumatic experiences overwhelmed the cognitive information processing system, resulting in a period of dysfunction as the individual attempted to incorporate the atypical trauma data into their operational schema. The negative behavioural symptoms reported by sex offender treatment providers are characteristic of these periods of dysfunction.

Beck (1996) argued that the ways in which schema affect information processing, being outside of conscious awareness, are therefore very difficult to measure through self-report. However, identifying schema might enable the development of an individual's capacity to process atypical information, reducing the likelihood that exceptional work-related events would overload the information processing systems (Paton and Smith, 1996). Paton and Smith also proposed that increasing the sophistication of an individual's schematic base through training and intervention would result in them being better able to assimilate traumatic events. Though for that to be possible, the schemas through which an individual made sense of his or her world needed first to be identified, and methods through which this could be done are scarce.

One established method of eliciting an individual's beliefs about their world is derived from Personal Construct Theory (PCT - Kelly, 1955). While it is beyond the scope of this thesis to provide a review of PCT (the interested reader is referred to Kelly, 1955; Bannister and Fransella, 1986), a summary of the fundamental principles provides a context for the assessment methodology used in this study. PCT is widely considered one of the most thoroughly explicated theories of personality (Dalton and Dunnett, 1992). It is underpinned by the philosophy of Constructive Alternativism, the premise of which is that

individuals have alternative constructs available to them with which they can construe themselves and their world. A second core element of the theory is the metaphor of person-as-scientist, which proposes that every individual engages in the generation and testing of hypotheses in order that they can make predictions about their world. Successful predictions are then incorporated into the individuals psychological system. The third premise is the reflexivity principle, which refers to the applicability of PCT to *everyone* - in other words, that all individuals operate psychologically, whether they do so effectively or not. The fourth and final main component of PCT is the structure of the theory itself.

Kelly's work is underpinned by a fundamental postulate, supported by 11 corollaries. The fundamental postulate states that a person's processes are psychologically channelled (or '*channelized*') by the ways in which he or she anticipates events. Kelly carefully explicated each word he used in the postulate to ensure that it was recognised as referring to the individual as a whole *(person),* that from a psychological perspective the individual was understood to be continually in motion *(processes),* that the person's processes were considered *psychologically* as opposed to, say, sociologically, that the processes were seen to operate through a network of pathways *(channelized),* that both the predictive and motivational elements of the theory were incorporated *(anticipates),* and that the person was ultimately trying to anticipate real events, rather than anticipate for the sake of it.

Janoff-Bulman (1992) noted that although Kelly's work was based on a system of dichotomised constructs, rather than general belief systems referred to in the schema literature, his emphasis on the importance of understanding people's individual formulations of their world was consistent with schema theory. Importantly, PCT brought with it a method for eliciting an individual's beliefs based entirely on the individual's meaning and not constrained by the rigid formulation of psychometrics.

The Repertory Grid (RG) was designed as a therapeutic tool to explore an individual's repertoire of constructs and to apply values to the relationships between those constructs (Fransella and Dalton, 1990). Based on Kelly's (1955) assertion that a person's construct system was composed of a finite number of

dichotomous constructs, the RG provided a systematic method for eliciting these, as well as an opportunity for considering change in those constructs over time, to which a unitary value could be ascribed (see section 6.1.1 for a description of this method).

Furthermore, Kelly identified constructs of transition, consistent with the symptomatology identified among sex offender treatment providers. For example, he described anxiety as the awareness that the events confronting an individual lay outside the range of convenience of the existing construct system, leaving the person quite unprepared to deal with the event, with anxiety developing as a consequence. Dalton and Dunnett (1992) proposed that how the individual went about dealing with the anxiety depended upon the nature of the structure of his or her construct system. If the structure was very 'tight' (leading to unvarying predictions being made) it was likely that existing constructs would continue to be applied to the event in the hope that something would work. In PCT terms, the continued application of constructs that meet with invalidation is defined a disorder. Conversely, someone with a more flexible system might be able to take current constructs and see if they could be adapted to deal with the presenting situation, thereby extending the range of convenience of the construct system.

Considering this one example in the context of sex offender treatment provision, it can be seen that PCT provides a framework by which the change described by therapists may be more thoroughly investigated on an individual level. Therapists commonly describe anxiety, particularly at the early stages of their therapeutic career (e.g. Farrenkopf, 1992). If this is symptomatic of a process of adaptation, as implied by the example above, recognising how working with sex offenders might impact people at an individual level, and understanding how an individual operates within their construct system, has the potential to provide the basis for training, preparation and intervention that reflect individual need.

The study reported in this chapter employed repertory grids as a method for investigating change over time at an individual level, and was entirely exploratory in nature. The purpose was three-fold: to see if it was possible to identify some of the changes in construal reported by therapists, through use of

the RG; to investigate the merits of RG assessment as a way of understanding impact on facilitators of their work at an individual level and to consider the relationships between results from limited psychometric assessment and RG assessment.

6.1.1 The Repertory Grid

As previously mentioned, the repertory grid provides a systematic method for eliciting an individual's personal constructs. Every grid consists of four basic components (Jankowicz, 2004): the topic; the elements; the constructs; and the ratings. Constructs are the units of description and analysis and are bipolar, in other words, they always represent a contrast, and the contrast needs to be made explicit before the meaning of the whole construct can be ascertained. The constructs constitute the personal belief system of the individual. According to PCT, "people have constructs about anything and everything" (Jankowicz, 2004; p.12), therefore a grid is always conducted about a particular topic. This results in just those constructs used to make sense of that particular realm of discourse being elicited by the grid. In this instance, the topic for study was adaptation to working therapeutically with sex offenders. This was done by prescribing elements to which experienced therapists reported a change in sensitivity that they attributed to SOTP provision (see section 6.2.1.1 for the procedure used to identify appropriate elements). Ratings of elements on constructs resulted in the grid, which provided a precise statement about the way in which the individual thought about, gave meaning to, and *construed* the topic in question.

6.2 Method

6.2.1 Procedure

Study participants were recruited from trainees attending a national SOTP facilitator-training course run in January 2003. On the first day of the course all forty-five trainees received a presentation regarding the purposes of the research, the relevance of current study, and the methodology used to elicit constructs. A decision was taken between the researcher and the course organiser that all trainees would participate in the session, but that only those trainees willing to

participate in the research would submit their data for inclusion. Therefore, trainees were made fully aware that consent for involvement in the research was implicit in the return of data.

Trainees were given a 20-minute presentation on repertory grid elicitation (see Appendix R). For the remainder of the session (90 minutes) all trainees worked in pairs and threes to elicit constructs from each other pertaining to prescribed elements (see section 6.2.1.1). All trainees then completed a structured grid (see Appendix S) and rated their constructs on a six-point scale, as recommended by Jancowicz (2004). A high score indicated the element was rated towards the positive end of the construct, and a low score towards the negative end. For ease of rating, participants were instructed to record the positive pole of the construct on the left of their grid and the negative pole on the right. It should be noted that this diverged slightly from recommended practice, which indicates the emergent pole should be recorded on the left and the implicit pole on the right. This is to overcome the possibility that the two poles of the construct might not necessarily represent a positive or negative aspect. In this instance, participants were asked to put on the left, the pole that represented how they themselves would most like to be.

Trainees willing to participate in the study were then asked to complete the short battery of psychometric assessments (described in Section 6.2.3) and provide demographic information (as collected in previous elements of this research). Participants were given 24 hours for completion of the psychometric assessments when the researcher returned to collect the data from participants by hand.

Twenty-eight trainees agreed to participate in the research. Six months after the original testing period, those 28 participants were contacted and asked to re-rate their original constructs against the prescribed elements, and complete the same battery of psychometric assessments. In addition, participants were asked to state how many sessions of sex offender treatment they had delivered, whether there had been a change in their personal circumstances, and whether they had experienced any events in the previous six months that they had found distressing. Seventeen participants responded. For the analysis of grids, a decision was then taken only to include individuals who had elicited five or more constructs, on the basis that greater accuracy of understanding was likely to be

achieved (Jones, 2003). This resulted in a total of ten participants' data being included in the final study.

6.2.1.1 The Elements

When elements are prescribed by a researcher (or clinician), they are done so on the basis of knowledge and the reason for eliciting a repertory grid (Jancowicz, 2004). The purpose of this study was to consider ways in which new therapists' constructs might change as a consequence of working with sex offenders. For this reason it was concluded that the most appropriate elements were likely to be those that experienced therapists considered emotionally evocative, i.e. situations to which they reported changed emotional sensitivity that they attributed to their therapeutic experience.

Sixteen such situations, generated by therapists at one treatment site, were recorded and circulated to all active therapists in HMP Prison Service via Treatment Managers at 26 treatment sites. Respondents were asked to record the extent to which they felt more sensitive about each situation on a four-point scale (where 1 indicated "no more sensitive" and 4 indicated "much more sensitive"). The mean rating for each situation is presented in Table 6.1.

Table 6.1 Mean ratings of situations for use as prescribed elements

Situation		Mean	SD
1	Being alone in a house and hearing a loud noise	1.72	1.03
2	*Not being able to switch off from work*	*2.14*	*0.94*
3	*Seeing a man in the park watching a child*	*3.10*	*0.93*
4	Being on the receiving end of an angry group member	1.69	0.85
5	Feeling like you've got your life well balanced	1.89	0.89
6	Playing rough and tumble with a child	1.90	1.03
7	*A colleague being derogatory*	*2.16*	*1.02*
8	*Being supported by colleagues*	*2.35*	*0.95*
9	*Seeing a child alone and distressed*	*2.68*	*1.11*
10	*Your treatment style being commended*	*2.21*	*0.90*
11	Experiencing an intrusive image in a sexually intimate moment	1.84	0.88
12	*Seeing a group member change for the better*	*2.75*	*0.89*
13	*Being told by your partner that you have mood swings*	*2.03*	*1.00*
14	Increasing your alcohol consumption	1.55	0.85
15	*Feeling as if other professionals value your opinion*	*2.22*	*0.93*
16	*Feeling mentally and physically exhausted*	*2.62*	*0.89*

Respondents were not asked to make a distinction between the positive or negative direction of the change, only that they attributed the change to their therapeutic experience. Responses were anonymous and no demographic information was collected. One hundred and seventeen returns were received. The ten situations with the highest means, suggesting the greatest change in sensitivity, were chosen as the prescribed elements. These are presented in italics in Table 6.1 above.

6.2.2 *Participants*

The final 10 participants comprised eight females and two males, with a mean age of 29.00 (SD 6.82) and mean time in Service of 24.3 months (SD 26.15). Three respondents were prison officers, three were psychological assistants, two were psychologists, one a probation officer, and one categorised as "other". Three of the ten respondents reported an experience they had found traumatic in the six months prior to first assessment, and four between the first and second assessment.

6.2.3 *Apparatus*

In addition to repertory grid and demographic data, a number of psychometric measures were also employed. The rationale for this was to provide an opportunity to examine the relationships between repertory grid data, i.e., personal derived psychological data, and that which could be elicited by psychometric assessment. For this reason three scales were chosen that, it was hypothesised, were most closely aligned to the topic of the grid.

The Attitude Towards Sex Offenders Scale (ATS - Hague, 1995). This 36 item scale was devised specifically to examine the impact of training and experience on new therapists' attitudes to sex offenders. Hogue found that positive changes on the scale immediately post-training were maintained at six months follow-up. The premise was that positive changes in attitudes to sex offenders, as measured by the ATS, should be reflected in positive ratings of constructs on the elements used in this study (see Appendix S).

The revised Emotion Control Questionnaire (ECQ - Roger & Najarian, 1989; Roger et al, 2000). The revised ECQ, comprising Rumination (R) and Emotional Inhibition (EI) provides a comprehensive assessment of emotional style. It was predicted that emotional style should be reflected in the constructs elicited and the extent of change in constructs over the testing period. Particularly, it was hypothesised that high R scorers would rate the elements and constructs more negatively over time.

The Positive Emotional Sensitivity Sub-Scale of the Emotional Sensitivity Scale (PES - Guarino et al, 2001). This sub-scale, measuring emotional sensitivity to situations, was predicted to be related to the extent of change in ratings of the elements, with individuals high on this scale exhibiting the greatest change.

6.3 Case presentation and analysis

Methods for scoring grids are numerous (for a thorough description see Jancowicz, 2004). Consideration was given to principal components analysis, but this method was not advised given the low level of variance in ratings, so it was decided to keep the analysis as simple as possible by considering mean differences in ratings of elements and constructs at the two testing periods. The key advantage of this method of analysis was the ease with which visual comparisons between the two testing periods could be made. However, this method also resulted in some loss of detail provided by the raw data. For example, a reversal in the way an element was scored on a construct would provide critical information about an individual's construal, but the mean score at the two testing periods might remain relatively unchanged. In instances such as this, reference was made to the raw data, although the raw data were not presented.

The overall analysis focused primarily on changes in mean element scores i.e. how situations to which experienced individuals reported changed sensitivity were scored differently as a result of experience among new therapists. Changes in construct scores reflected individual style in the nature of construing and were therefore much harder to draw conclusions about without discussion with the client. Nonetheless, it was considered interesting to comment on them in the light of changes in element ratings and psychometric assessment of emotional style.

Following guidance provided by Jancowicz (2004) regarding descriptive analysis of repertory grids, each case was discussed as follows:

1. A description of the initial grid in terms of ratings, the relationship of the elements to each other, and a summary of the nature of the constructs
2. Consideration of the ratings of the elements
    a. Did the ratings of the elements change over time? If so in favour of which end of the construct?
    b. Did those changes result in a change in the relationship of the elements to each other? In what way?
    c. Did the changes in the ratings of elements relate in any way to changes of psychometric assessment of attitudes to sex offenders (ATS scale)
3. Consideration of the ratings of constructs
    a. Did the way in which constructs were rated change?
    b. Was there any apparent relationship between these and changes in psychometric assessment of emotional style (ECQ and PES scores).

Additionally, a brief description of each case was provided, incorporating demographic details relating to gender, age, time in the prison service, the experience of trauma prior to initial assessment and during the assessment period, and the number of sessions run since the initial assessment period. These factors were considered most pertinent to the examination of potential change in personal construction of the experience of working with sex offenders, particularly traumatic experience and number of sessions run.

The provision of this structure systematised the qualitative analysis, and also constrained what might have become an unending series of hypotheses and questions regarding the nature of individual construing. This was considered particularly important as the nature of the study meant that interpretations of changes in construct scores were at the discretion of the interpreter, and not subject to the rigour or constraints associated with statistical analysis.
For reference, the ten elements used in the study are presented again in Table 6.2. below.

Table 6.2 The Ten Elements

No.	Element
1	Not being able to switch off from work
2	Seeing a man in the park watching a child
3	A colleague being derogatory
4	Seeing a child alone and distressed
5	Your treatment style being commended
6	Seeing a group member change for the better
7	Being supported by colleagues
8	Being told by your partner that you have mood swings
9	Feeling as if others value your opinion
10	Feeling mentally and physically exhausted

6.4 Results

6.4.1 Case One

Case One was a 30-year old female who had worked in the Prison Service for five months. She had not experienced trauma in the six months prior to the research or in the six months between testing periods. She had facilitated seven sessions of SOTP between the first and second assessment periods. Her data are presented in Table 6.3.

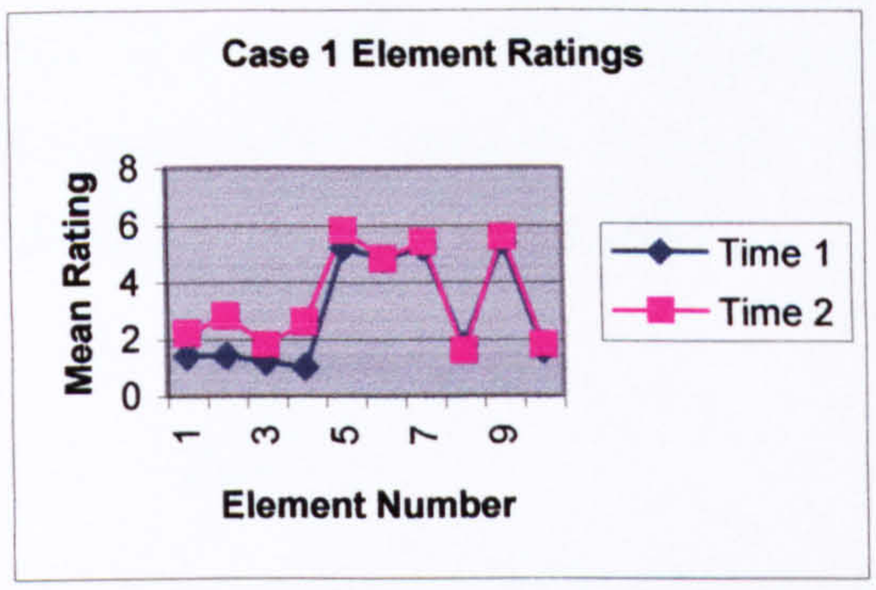
Case Discussion

Case One produced five affective constructs, illustrating a primarily emotional response to the elements. It is likely that some, such as Respected versus Not Valued and Empowered versus Unable to Cope, represent Core Constructs, i.e. those that are considered to govern the individual's maintenance processes and are central to identity (Winter, 1992). However, this would need verification with the individual.

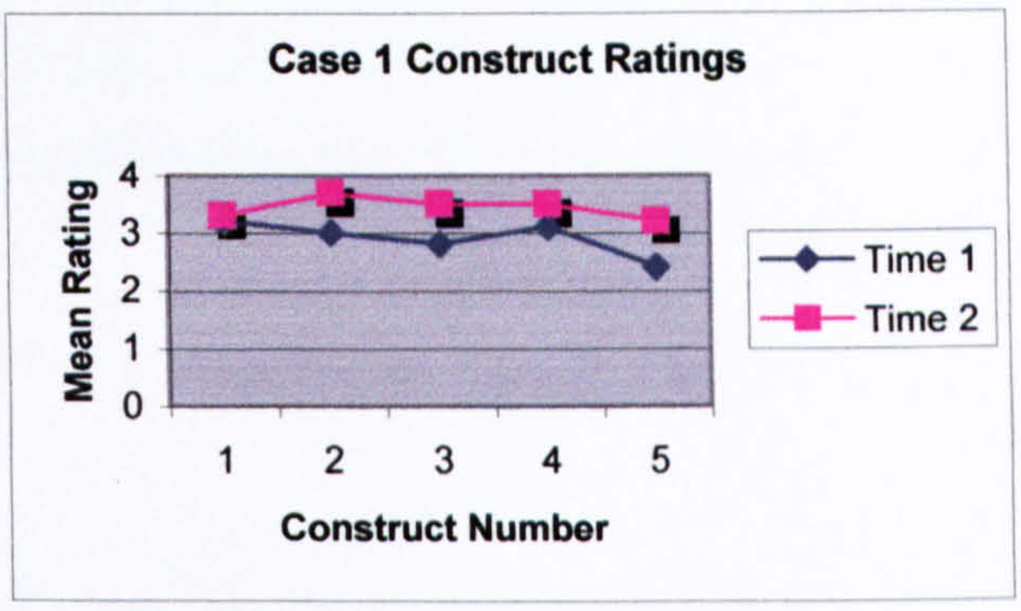
Table 6.3 Case 1 Repertory Grid and Psychometric Data

No.	Construct	Scale	Series 1	Series 2
1	Confident - Unhappy	PES	10	9
2	Respected - Not valued	EI	1	1
3	Happy with self - Unloved	RUM	6	6
4	Empowered - Unable to cope	ATS	74	81
5	Cared for - Alone			

Mean Element Ratings at Time 1 and Time 2



Mean Construct Ratings at Time 1 and Time 2



PES=Positive Emotional Sensitivity; EI=Emotional Inhibition; R=Rumination; ATS= Attitudes to Sex Offenders

The ratings were noticeably polarised at Time 1, with scores of one or two, or five and six, resulting in two clear clusters. Highly rated elements included five, six, seven and nine, all of which pertained to positive collegial interactions, while the remaining six elements were rated more negatively.

In terms of element ratings, at Time 2 there appeared to be more flexibility in the application of the rating scale, reflected in changes in the mean scores. The most substantial change was evident in ratings of elements two and four, both of which involved children and both potentially suggesting risk to the child. The more positive ratings of these elements on all but one construct, might suggest that increased awareness of the behaviour of sexual offenders, through training and the delivery of treatment, demystified the behaviour for this therapist, to the point where potentially emotive situations were not viewed negatively. This is also reflected in a less distinct clustering of the elements at Time 2, indicating experience lessened the likelihood of construal of situations at the extreme poles of the constructs.

For this respondent, little change was seen on the elements relating to professional issues, such as elements five, seven and nine, perhaps indicative of the stability of the confidence construct that showed the least change of all five constructs.

The increase in positive construal was accompanied by an increase in positive attitudes to offenders assessed by the ATS, providing support for the suggestion above, that experience lessened negative views of sensitive situations. All five constructs elicited from Case One were rated more highly six months after training, suggesting that involvement in SOTP had generally been a positive experience. No change in R and EI, and a one-point change in PES suggest no disruption to emotional style.

6.4.2 Case Two

Case Two was a 24-year old female who had worked in the Prison Service for nine months prior to SOTP training. She had not experienced any trauma in the six months prior to commencement of the research, but did report experiencing a traumatic event over the six months in which the research was conducted. She had facilitated eight SOTP sessions between the first and second testing period.

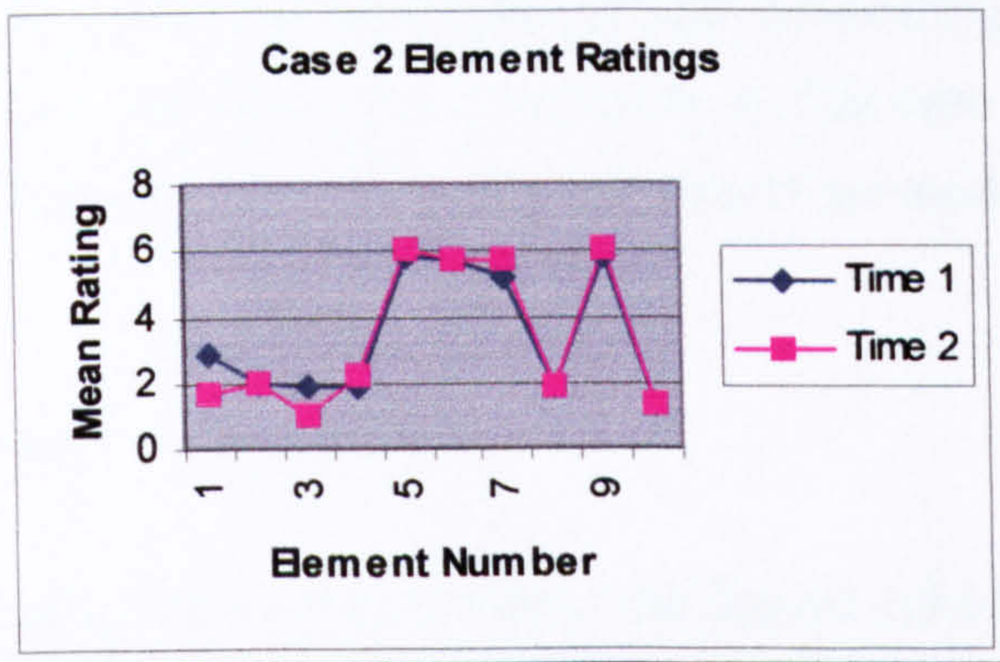
Case Discussion

Case Two provided six constructs, three of which, Uplifted, Contented and Happy, appeared to be closely related affective constructs, while the remaining three, Valued, Respected and Rewarded, appeared to represent more core type constructs (see Table 6-4). Examination of the initial grid indicated more polarised ratings of the elements using core type constructs, with more flexible use of the rating scale using the affective constructs. This meant that the elements were not clearly grouped, although those relating to collegial issues were rated more highly at both testing periods.

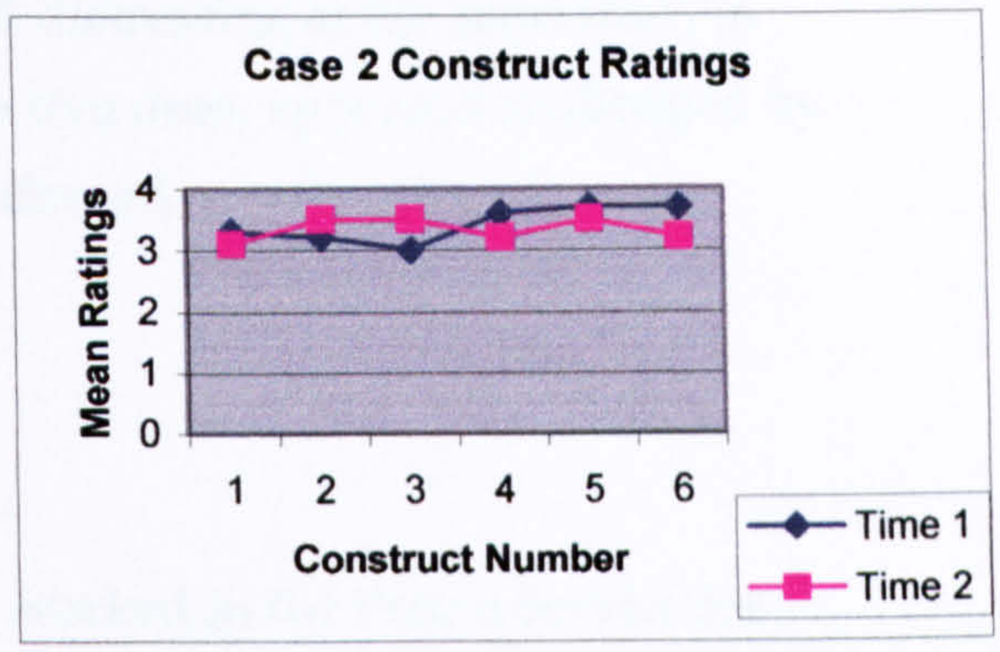
Table 6.4 Case 2 Repertory Grid and Psychometric Data

No.	Construct	Scale	Series 1	Series 2
1	Valued - Drained	PES	10	7
2	Respected - Undervalued	EI	11	10
3	Rewarded – Not respected	RUM	9	8
4	Uplifted – Stressed	ATS	63	60
5	Content - Depressed			

Mean Element Ratings at Time 1 and Time 2



Mean Construct Ratings at Time 1 and Time 2



PES=Positive Emotional Sensitivity; EI=Emotional Inhibition; R=Rumination; ATS= Attitudes to Sex Offenders

The way in which the elements were rated demonstrated the clear demarcation between the two groups of constructs at the first and second testing period and is illustrated in Figure 6.2.1. The core construct group were rated marginally higher than the affective constructs at the second testing period, a reversal of the situation at the initial assessment. This meant that although element ratings did change over time, the changes were not immediately apparent in the mean scores. For example, the mean rating of element two (seeing a man in the park watching a child) did not change, although it was on this element that that the biggest shift in ratings occurred. The element had previously been scored at the lowest point on the scale on the core type constructs and on the mid range on the affective constructs. This reversed at the second testing period, suggesting the element elicited more affective concern but was less of a challenge to the core constructs. It would be reasonable to hypothesis that this resulted from SOTP training and facilitation experience.

The clear change in the poles at which the two groups of constructs were rated might suggest that Case Two experienced a somewhat negative response in emotional terms to her SOTP experience whilst also showing a shift to the more positive end of the pole on core constructs in the same context. This change was accompanied by a slight decrease in Positive Emotional Sensitivity and a less positive attitude to offenders, possibly suggestive of a coping response.

The changes shown by Case Two support the anecdotal reports that sex offender treatment provision can be both rewarding and distressing at the same time, in the sense that some constructs, in this case affective ones, appeared challenged by the process, while other constructs seemed confirmed or strengthened.

6.4.3 Case Three

Case Three was a 23-year old female who had worked in the Prison Service for five months prior to SOTP training. She had not experienced any trauma in the six months prior to, or six months during the research, and she had not facilitated any SOTP sessions between the two testing periods.

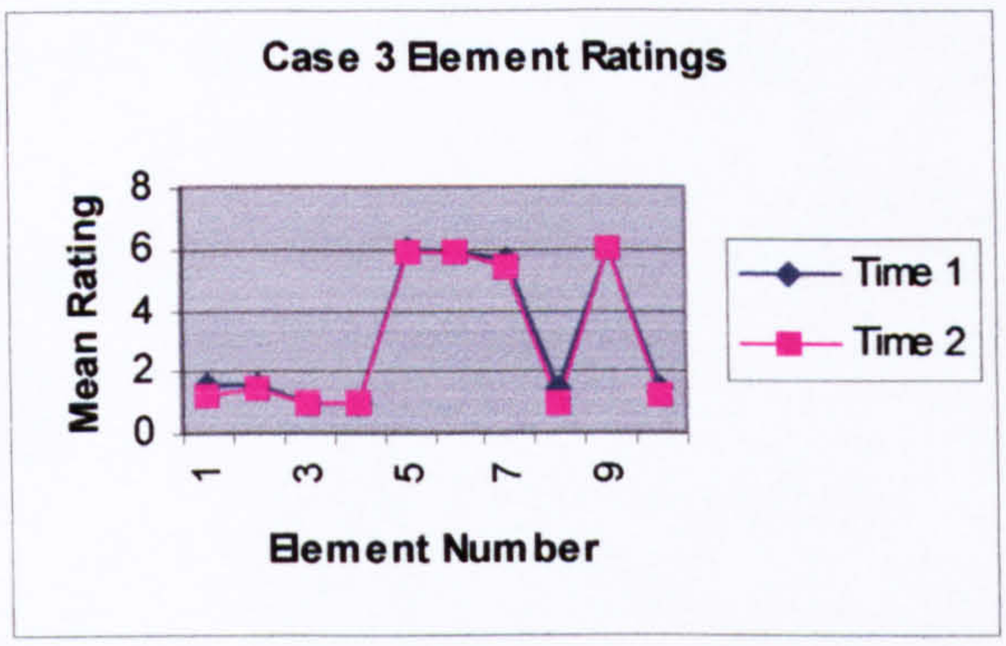
Case Discussion

Examination of the initial grid indicated five, probably core, constructs on which elements were clearly demarcated. Table 6.5 indicates that elements were rated at either extreme of the construct poles at both testing periods, demonstrating little change in relation to the ways in which the elements were perceived. The relationships between the elements were very similar to those observed in the previous two cases, with those concerning collegial support and external acknowledgement of a job well done being rated at the more positive ends of the construct poles.

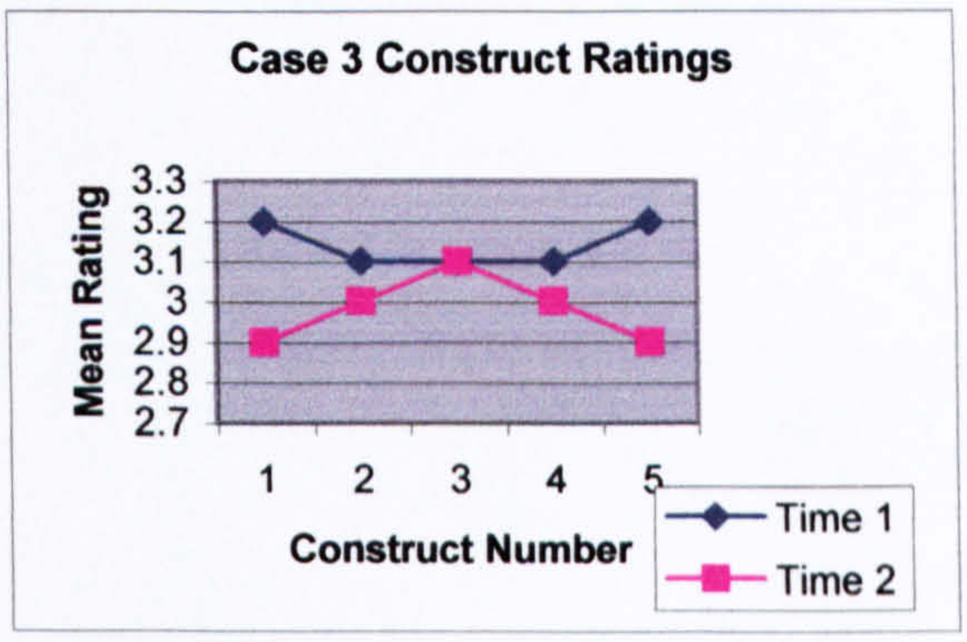
Table 6.5 Case 3 Repertory Grid and Psychometric Data

No.	Construct	Scale	Series 1	Series 2
1	Valued - Unsupported	PES	14	12
2	Confident – Self-doubt	EI	0	1
3	Rewarding – Concerning	RUM	3	2
4	Satisfying – Worrying	ATS	85	90
5	Sense of Achievement - Stressed			

Mean Element Ratings at Time 1 and Time 2



Mean Construct Ratings at Time 1 and Time 2



PES=Positive Emotional Sensitivity; EI=Emotional Inhibition; R=Rumination; ATS= Attitudes to Sex Offenders

That the ratings of the elements did not change over time might be indicative of no practical experience of delivering treatment between the first and second testing period. As has been mentioned elsewhere in this thesis, however realistic training might be, there is no substitute for direct experience of treatment provision to the offenders themselves. Such experience would be predicted to have the most influence on construal. However, there was a slight increase in positive attitudes to offenders, measured by the ATS, which was likely to be a function of the training experience.

Four of the five constructs elicited by Case Three were rated towards the more negative end on the poles at the second testing period, especially 'Feeling Valued vs Feeling Unsupported' and 'A Sense of Achievement vs Stressed'. It would be interesting to ascertain if this resulted from not having had the opportunity to put training into practice.

As with Case Two, a slight drop in PES score accompanied a drop in the ratings of the core constructs, but very little change was observed on the other two

emotional style measures.

6.4.4 Case Four

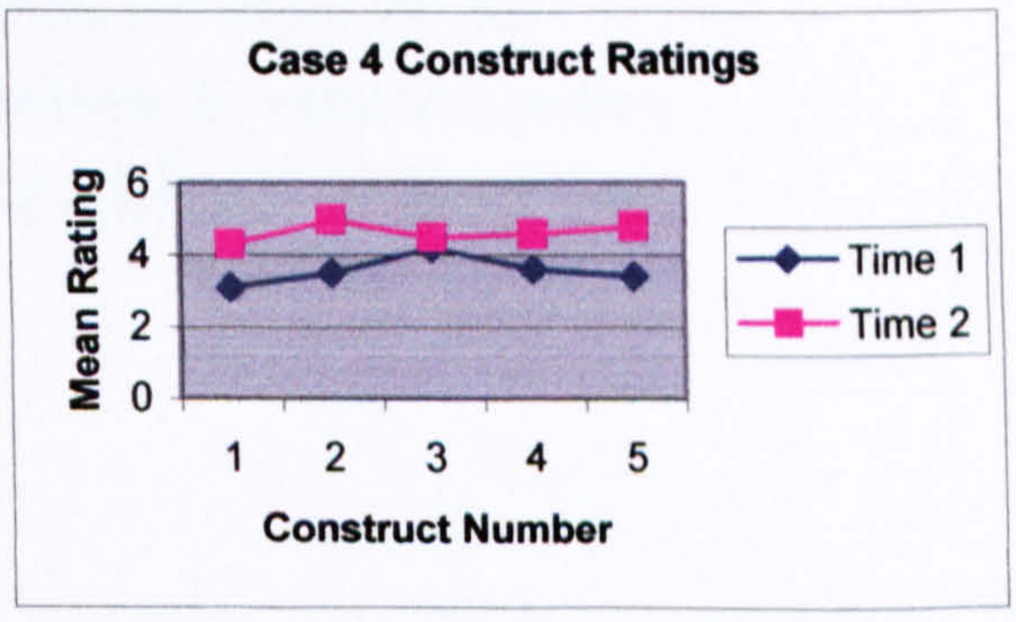
Case Four was a 23-year old female with six months experience in the Prison Service prior to SOTP training. She reported having experienced a traumatic event both in the six months prior to training and in the six months between testing periods. She had delivered 36 sessions of SOTP by the second testing period, the most of all participants.

Table 6.6 Case 4 Repertory Grid and Psychometric Data

No.	Construct	Scale	Series 1	Series 2
1	Honest – Untrustworthy	PES	10	7
2	Friendly – Isolated	EI	1	2
3	Understanding – Dismissive	RUM	0	2
4	Patient – Ignorant	ATS	64	72
5	Confident – Submissive			

Mean Element Ratings at Time 1 and Time 2

Mean Construct Ratings at Time 1 and Time 2



PES=Positive Emotional Sensitivity; EI=Emotional Inhibition; R=Rumination; ATS= Attitudes to Sex Offenders

Case Discussion

Case Four provided five essentially behavioural constructs, although 'Honesty vs Untrustworthy' might be indicative of a core construct. In terms of ratings, the whole range of the scale was utilised, resulting in a less pronounced demarcation between the elements than had been evident in previous cases (see Table 6.6).

This might have been a function of the nature of the constructs, in that 'friendly', 'understanding', 'patient' and 'confident' all suggested behavioural skills, as opposed to emotional responses, so might be more generally applicable.

By the second testing period, six of the elements were rated more positively, but the ratings did not make a marked difference to the relationship between the elements with the exception of Element Two, referring to seeing a man in a park watching a child. This element was rated considerably more positively at the second testing period, suggesting that the experience of treatment provision resulted in a more positive behavioural response, and aligning this element more closely with support from colleagues and having opinions valued. A higher score on the ATS accompanied the positive changes in ratings of the elements at the second testing period.

At the second testing period, all five constructs were rated towards the more positive end of the pole. Given the behavioural nature of the constructs this may reflect development in therapeutic skills as result of delivering treatment. For example, describing higher levels of patience, confidence and friendliness in response to the elements would suggest the therapeutic experience had enhanced those constructs. Interestingly, a drop in PES score accompanied the enhancements, although PES is essentially a measure of emotional, rather behavioural responding and a clear relationship might not be immediately apparent.

6.4.5 Case Five

Case Five was a 46-year old female with two months experience in the Prison Service prior to SOTP training. She did not report experiencing a traumatic event in the six months prior to initial assessment, but did report such an experience in the six months between assessment periods. She had not delivered any SOTP sessions.

Case Discussion

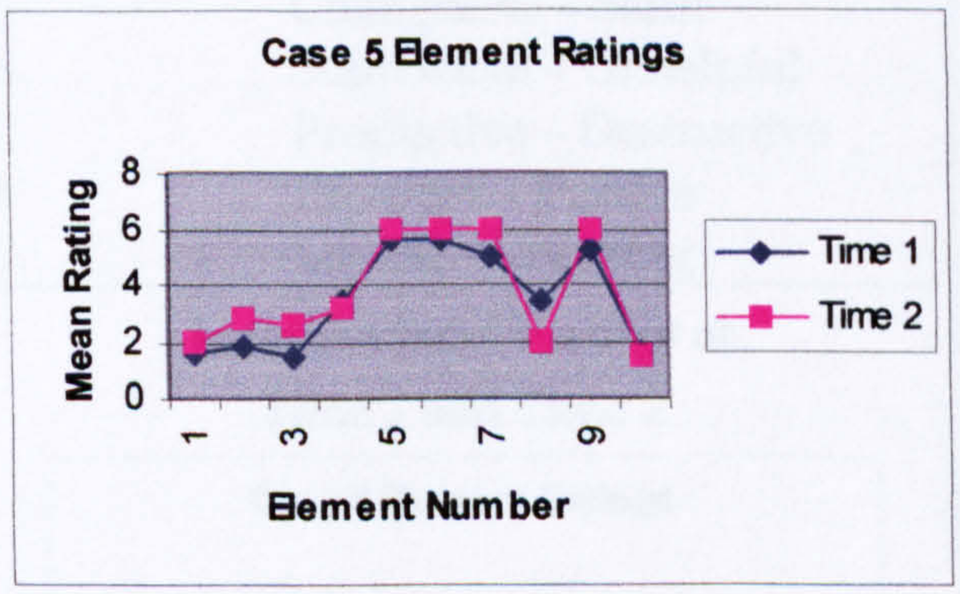
The elements appeared to produce a combination of affective and core constructs for Case Five. As with cases one to three, there was a clear relationship between the elements relating to colleagues and external validation of good work, but the grouping of these elements from others was slightly less distinct than had been seen in previous cases. This suggested a more fluid movement between the two poles of the constructs.

By the second testing period, with one exception, the elements were rated the same or more positively. Unlike cases One and Four, where more positive ratings of elements were accompanied by a noticeable increase in ATS score, for Case Five, the ATS score remained similar (dropped by one point).

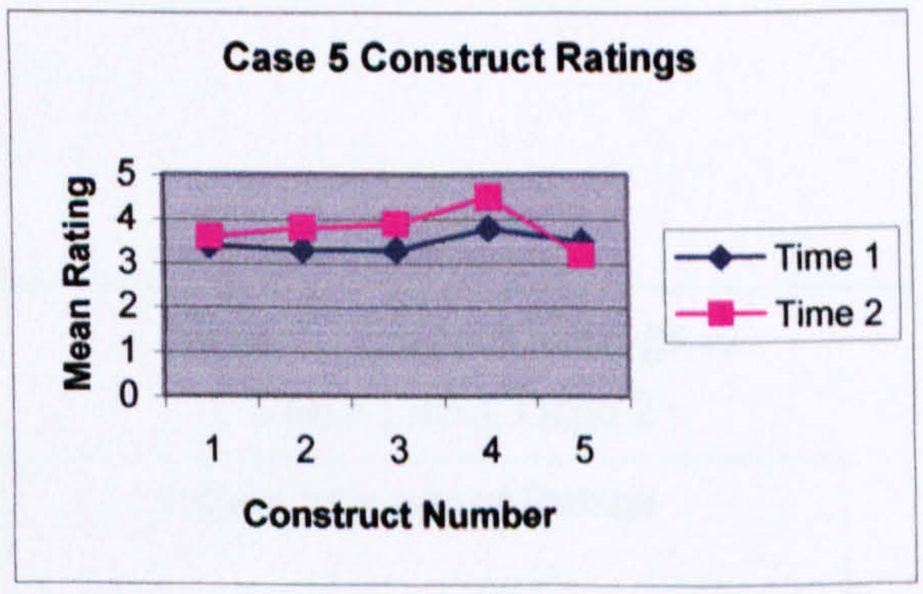
Table 6.7 Case 5 Repertory Grid and Psychometric Data

No.	Construct	Scale	Series 1	Series 2
1	Confident – Weak	PES	9	14
2	Achieve – Ineffective	EI	1	0
3	Optimistic - Depressed	RUM	1	4
4	Choices – Fixed	ATS	59	58
5	Worthwhile - Anxious			

Mean Element Ratings at Time 1 and Time 2



Mean Construct Ratings at Time 1 and Time 2



PES=Positive Emotional Sensitivity; EI=Emotional Inhibition; R=Rumination; ATS= Attitudes to Sex Offenders

In terms of constructs, there was a slight movement towards the positive end of the pole at the second testing period on three of the five constructs, but no discernable pattern emerged. There was also a slight increase in PES and R scores at the second testing period, though there is no clear association between

construct and psychometric changes.

Case Five was the eldest of the ten participants in the study, and it might be that, as was hypothesised in Chapter Two (section 2.5), maturity equated in general to the development of more functional coping strategies and a broader context into which SOTP experience could be assimilated, resulting in less clear evidence of adaptation. This is speculative and would require further investigation with the participant.

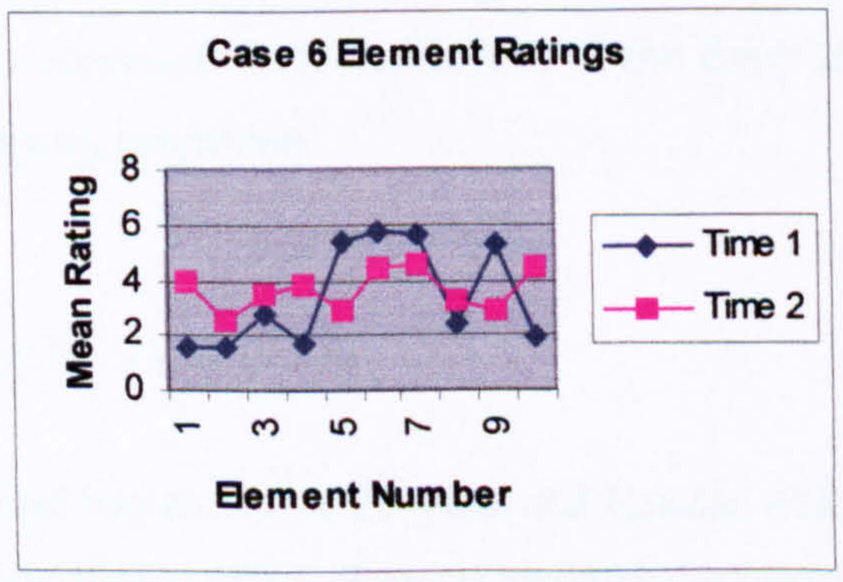
6.4.6 Case Six

Case Six was a 30-year old female with one week's experience in the Prison Service prior to SOTP training. She did not report any traumatic experiences in the six months prior to training or the six months between testing periods, and had not facilitated any SOTP Sessions between testing periods. Data are presented in Table 6.8.

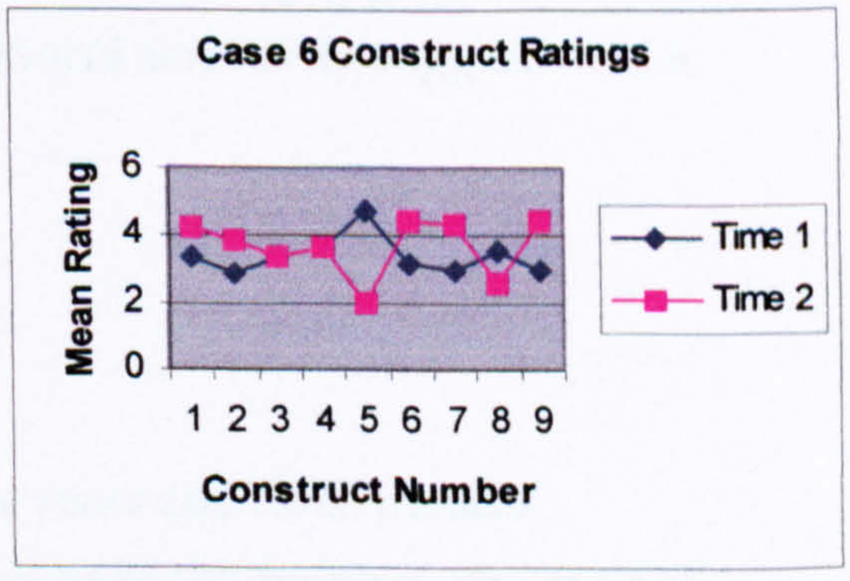
Table 6.8 Case 6 Repertory Grid and Psychometric Data

No.	Construct	Scale	Series 1	Series 2
1	Coping – Struggle	PES	7	3
2	Stability – Chaos	EI	0	1
3	Safe – At risk	RUM	4	4
4	Control – Powerful	ATS	79	78
5	Changeable – Static			
6	Supportive – Unhelpful			
7	Productive – Destructive			
8	Proactive - Passive			
9	Loving - Uncaring			

Mean Element Ratings at Time 1 and Time 2



Mean Construct Ratings at Time 1 and Time 2



PES=Positive Emotional Sensitivity; EI=Emotional Inhibition; R=Rumination; ATS= Attitudes to Sex Offenders

Case Discussion

Case Six elicited nine constructs from the elements, comprising a mix of core, behavioural and affective constructs. At the first testing period there was a distinct pattern in the relationships between the elements, evidenced by ratings at extreme ends of the poles. Specifically, and similarly to previous cases, elements relating to colleagues and external validation were rated closely together. But by the second testing period, the pattern had changed considerably and all the elements were rated utilising a greater range of the rating scale. This resulted from a change in the direction of the ratings at the second testing period, with the four elements concerned with colleagues and external validation all rated less positively. Interestingly, however, elements more concerned with a child at risk, such as seeing a man in the park watching a child and seeing a child alone and distressed were rated more positively, particularly on the behavioural constructs, showing a similar pattern to that identified in Case Four. The changes were not accompanied by a change in ATS score.

Construct ratings also changed considerably between testing periods, with most of the behavioural constructs ('Coping', 'Supportive' and 'Productive'), rated more highly the second time around. 'Proactive' and 'Changeable' were rated more negatively. A drop in PES score accompanied these changes.

Interestingly, Case Six had only been in the Prison Service one week prior to commencement of training. It is likely that the changes observed in the Repertory Grids were as much a function of adapting to a new role as to SOTP, even more pertinent, given that no SOTP sessions were run between testing periods.

The less systematic changes in construct and element scoring might be indicative of constructs in transition, and the drop in emotional sensitivity suggestive of a coping response.

6.4.7 Case Seven

Case Seven was a 25-year old female with three years and three months experience of working in the Prison Service prior to SOTP training. She did not report experiencing a traumatic event in the six months prior to training but did

in the six months between testing periods. By the second testing period she had facilitated six sessions of SOTP. Data are presented in Table 6.9.

Case Discussion

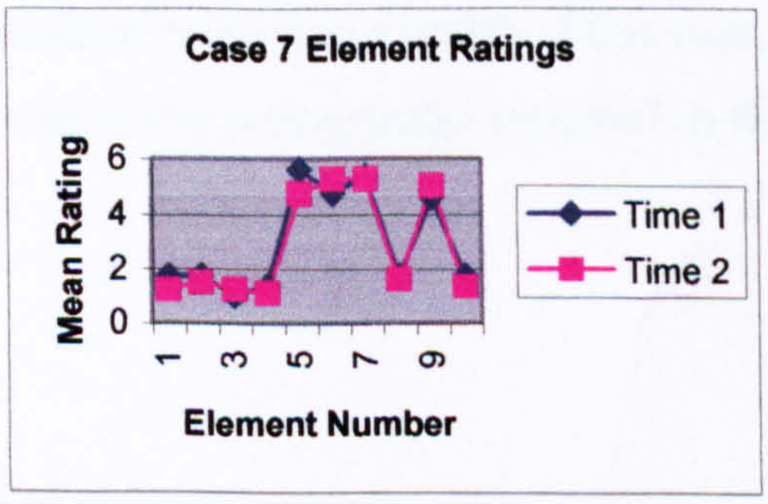
Case Seven elicited eight essentially core and affective constructs. Examination of the elements indicated they were generally scored at contrasting ends of the rating scale and that the elements relating to support and external validation were rated similarly to each other, and more highly than the remaining elements, repeating a pattern identified previously.

There was very little change in the ratings of the elements between testing periods, which may in part reflect the length of previous Prison Service experience prior to SOTP training, i.e. the elements may not have been as novel to this participant compared with less experienced trainees. Further, there was little change in the poles at which the constructs were rated, suggesting some stability and perhaps less need for the accommodation of new experience.

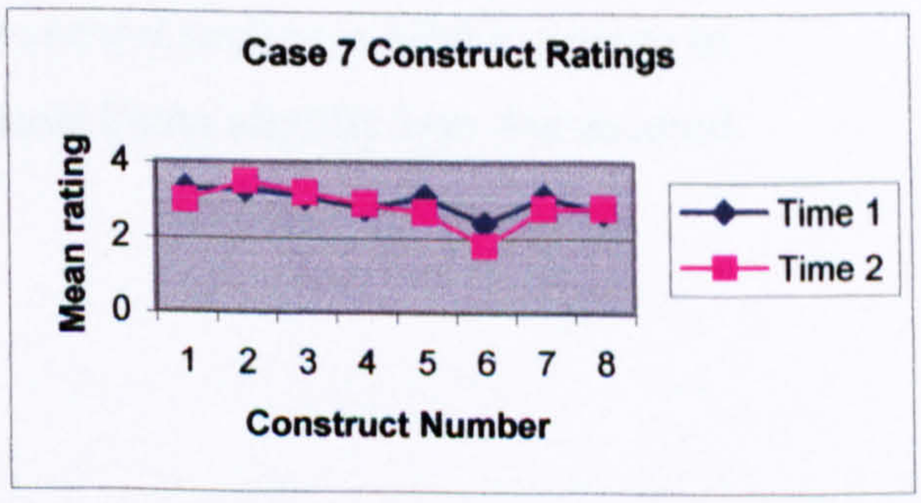
Table 6.9 Case 7 Repertory Grid and Psychometric Data

No.	Construct	Scale	Series 1	Series 2
1	Appreciated – Taken for granted	PES	12	13
2	Self-worth – Hopeless	EI	2	5
3	Positive – Undermined	RUM	0	1
4	Uplifted – Depressed	ATS	58	63
5	Job satisfaction – Helpless			
6	Feel cared for – Suspicion			
7	Positive – Anxiety			
8	Encouraged - Suspicion			

Mean Element Ratings at Time 1 and Time 2



Mean Construct Ratings at Time 1 and Time 2



PES=Positive Emotional Sensitivity; EI=Emotional Inhibition; R=Rumination; ATS= Attitudes to Sex Offenders

In terms of psychometric scores, results for Case Seven showed a slight increase in emotional inhibition (EI) and a slightly more positive attitude to offenders six months after training. The former reflects the finding in Chapter Five regarding increases in EI in the first year of facilitating, although it should be noted that the score remained low. It is interesting to speculate on the association of emotional inhibition and the slight shift on the constructs of 'Job Satisfaction vs Helpless', 'Feel Cared For vs Suspicion' and 'Positive vs Anxiety' towards the more negative end of the poles.

Case Seven had considerably more experience in the Prison Service than the cases presented previously and it is hypothesised that the relatively stable scoring of elements and constructs reflects this.

6.4.8 Case Eight

Case Eight was a thirty-year old female with four years and eight months experience in the Prison Service prior to SOTP training. She reported having experienced a traumatic event in the six months prior to training but not in the six months between testing periods. By the second testing period she had facilitated 38 sessions of SOTP. Data are presented in Table 6.10.

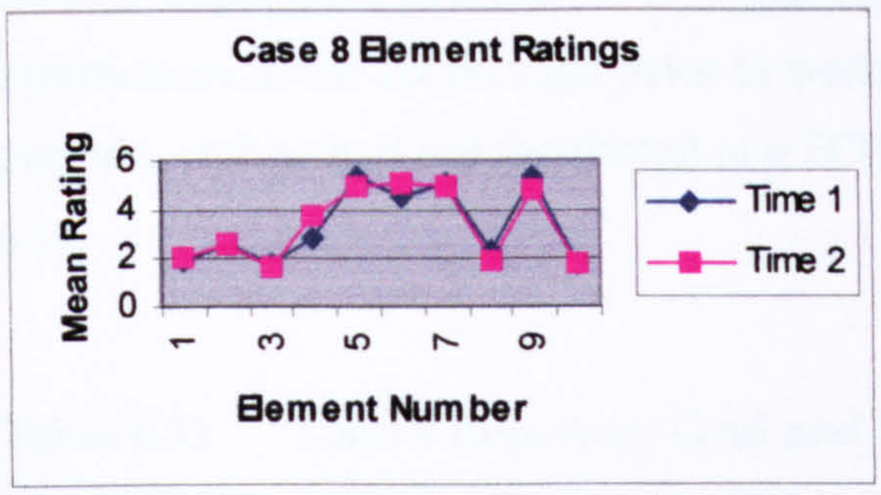
Case Discussion

Case Eight elicited 10 mostly core and affective constructs, although it was clear that some constructs, such as 'Mature vs Childish' and 'Included vs Excluded' were not particularly inference-rich. The pattern of ratings of the elements was similar to that seen in previous cases, with those relating to support and external validation rated more highly. However, by the second testing period a change in the use of the rating scales resulted in the elements being slightly less demarcated.

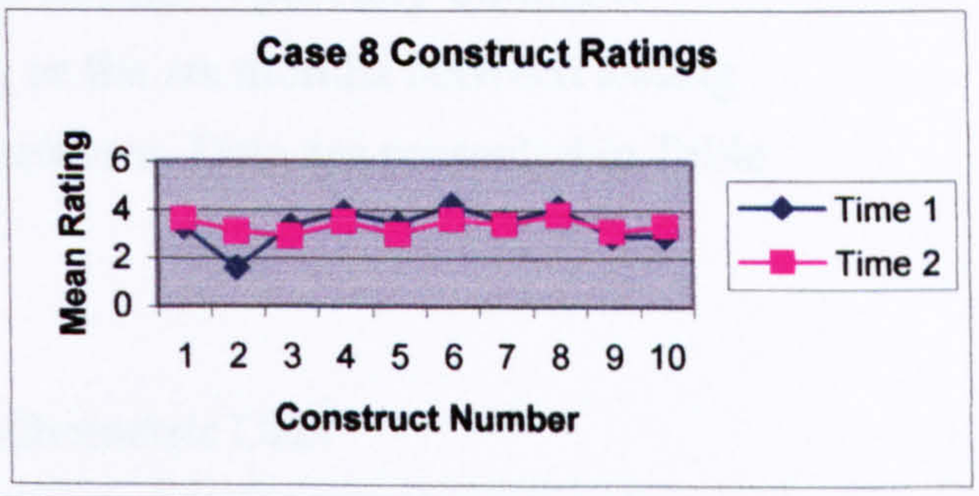
Table 6.10 Case 8 Repertory Grid and Psychometric Data

No.	Construct	Scale	Series 1	Series 2
1	Fulfilled – Disheartened	PES	11	11
2	Support – Stress	EI	10	13
3	Warm – Cautious	RUM	14	15
4	Proactive – Defensive	ATS	58	63
5	Trust – Suspicion			
6	Empowered – Powerless			
7	Included – Excluded			
8	Mature – Childish			
9	Relaxed – Frustrated			
10	Open - Critical			

Mean Element Ratings at Time 1 and Time 2



Mean Construct Ratings at Time 1 and Time 2



PES=Positive Emotional Sensitivity; EI=Emotional Inhibition; R=Rumination; ATS= Attitudes to Sex Offenders

Although not obvious from the data, the biggest change in element ratings occurred on element two 'seeing a man in the park watching a child'. There was a shift towards the more negative end of two constructs, 'Proactive vs Defensive' and 'Empowered vs Powerless' and a move to the positive end of the rating scale on constructs such as 'Fulfilled vs Disheartened' and 'Included vs Excluded'. Further exploration of changes in construct ratings yielded a complex pattern of movement between the poles of the constructs for Case Eight, although it should be noted that the changes were subtle. It can be seen from the ratings of the constructs that at the second testing period five constructs were rated comparatively more negatively and four more positively, suggesting a move towards the more Fulfilled, Supported, Relaxed and Open end of the relevant constructs, but a move towards the Cautious, Defensive, Suspicious, Powerless and Childish on others. Without further discussion with the individual, it would not be possible to draw reliable conclusions regarding why this pattern emerged. But in terms of investigating individual experience of SOTP facilitation, the results from this case, together with those from Case Two, highlight the paradox

that has been referred to throughout this thesis regarding therapists' reports of high levels of job satisfaction and simultaneous experience of deleterious changes.

Interestingly, Case Eight also demonstrated an increase in EI at the second testing period, together with a more positive attitude to offenders. As with Case Seven, further investigation of the relationship between EI and the move to more negative construct poles would be useful.

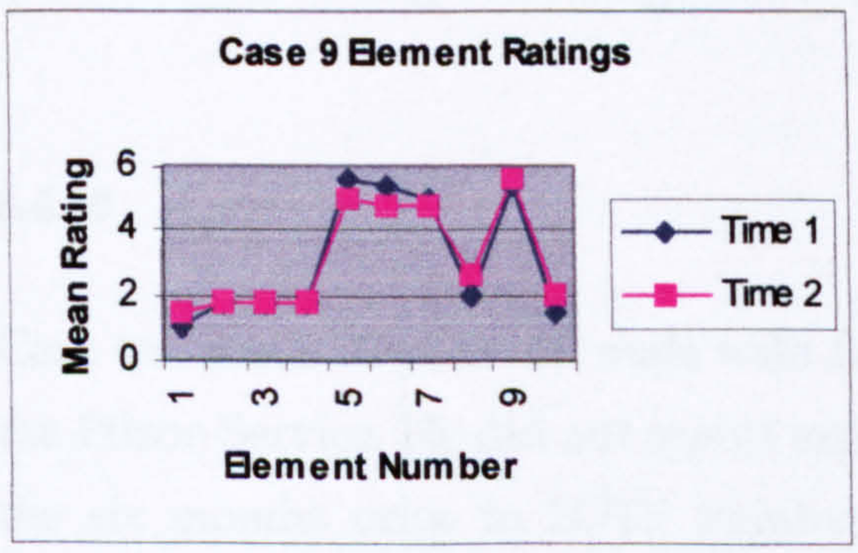
6.4.9 Case Nine

Case Nine was a 27-year old male with four years and eight months Prison Service experience prior to SOTP Training. He did not report any traumatic experiences in the six months prior to training or the six months between testing periods, and he had not facilitated any SOTP sessions. Data are presented in Table 6.11.

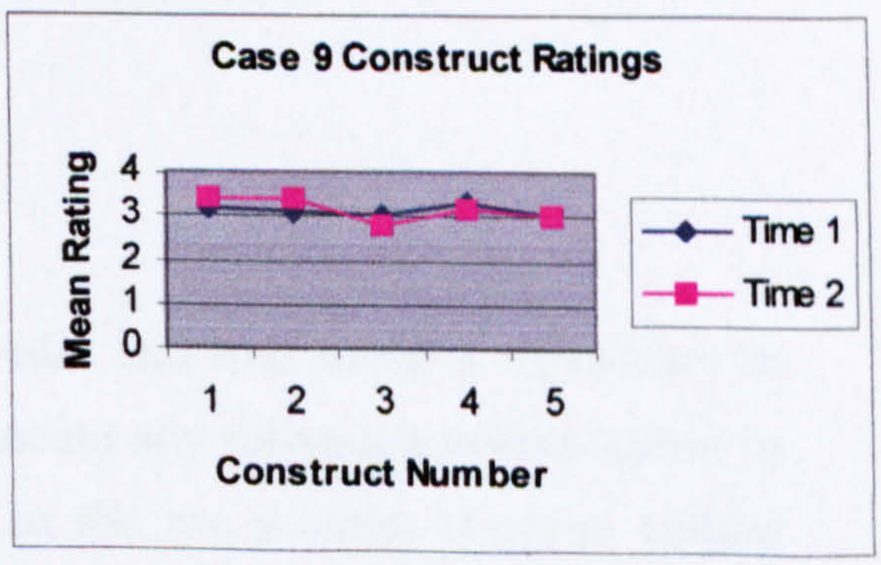
Table 6.11 Case 9 Repertory Grid and Psychometric Data

No.	Construct	Scale	Series 1	Series 2
1	Feeling valued – Alone	PES	10	8
2	Capable – Unwanted	EI	6	5
3	Happy – Confused	RUM	4	2
4	Motivated – Not coping	ATS	62	62
5	Important - Weak			

Mean Element Ratings at Time 1 and Time 2



Mean Construct Ratings at Time 1 and Time 2



PES=Positive Emotional Sensitivity; EI=Emotional Inhibition; R=Rumination; ATS= Attitudes to Sex Offenders

Case Discussion

Case Nine elicited five constructs that appeared fairly central to his identity. These were rated on the elements in a similar pattern seen previously with sever other cases, Le. elements related to support and external recognition rated towards the more positive pole of the constructs and the other elements rated towards the more negative end of the pole.

As has been seen with other cases with longer Prison Service experience, there was very little change in the way the elements were rated at both testing period_ although a slight drop was evident in the mean ratings of elements five, six and seven (support and external recognition) by the second testing period.

Examination of the raw data did not reveal any anomalies in the element ratings and consideration of the psychometric data showed minimal changes that appeared unrelated to personal construal.

It is interesting to note that Case Nine shared a similar profile, in terms of lack of change, to Case Seven and a common variable was time in the Prison Service. Time in service was implicated in Chapter Two as an important variable in adaptation to sex offender treatment provision, and although age proved to be the statistically predictive variable, the current results suggest that experience of prisons and prisoners should remain an area focus in terms of adaptation to therapeutic work with sex offenders. This becomes more pertinent in the context of Case Six, who, with only one week's experience in the Prison Service, showed quite dramatic changes in rating of elements and constructs.

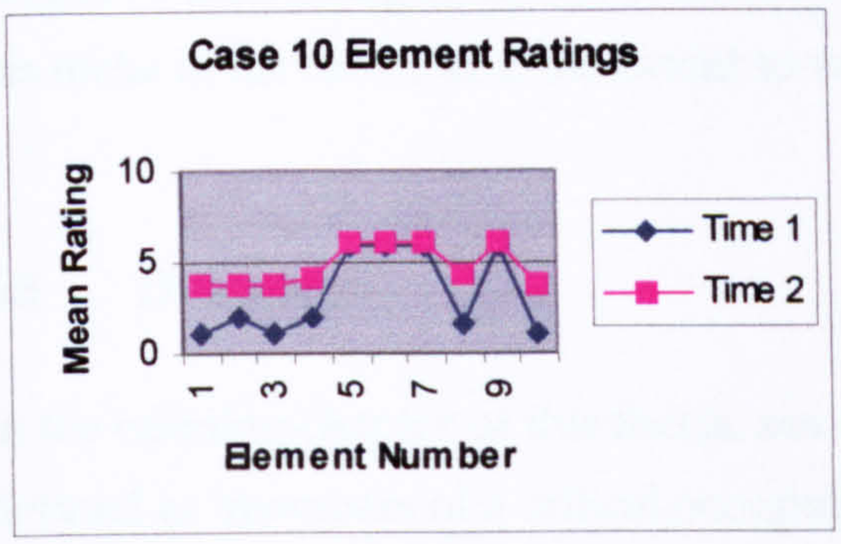
6.4.10 Case Ten

Case ten was a 32-year old male with five years and four months experience in the Prison Service. He did not report experiencing any traumatic events, either in the six months prior to SOTP training or in the six months between testing periods. He had facilitated 12 SOTP sessions by the second testing period. Data are presented in Table 6.12.

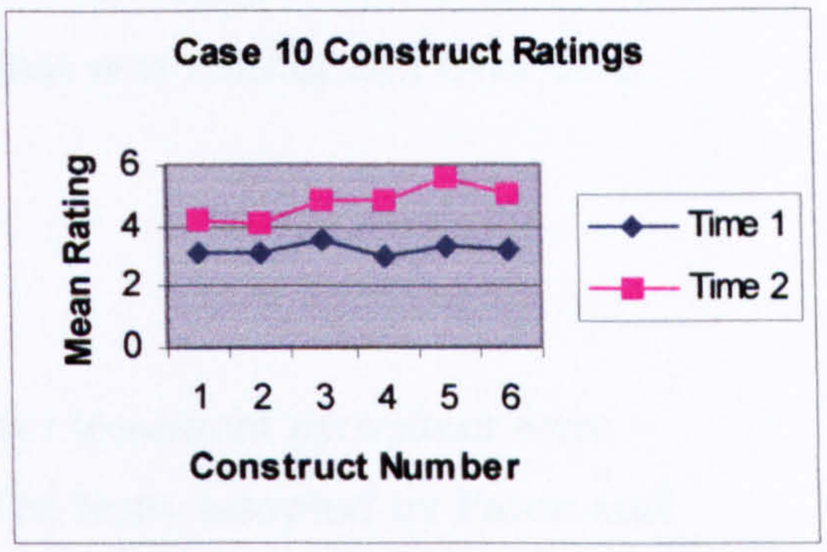
Table 6.12 Case 10 Repertory Grid and Psychometric Data

No.	Construct	Scale	Series 1	Series 2
1	Achievement – Failing	PES	10	11
2	Being proud – Being upset	EI	1	3
3	In control – Restricted	RUM	0	0
4	Freedom – Less choice	ATS	72	75
5	Supported – Alone			
6	Effort – Not Bothered			

Mean Element Ratings at Time 1 and Time 2



Mean Construct Ratings at Time 1 and Time 2



PES=Positive Emotional Sensitivity; EI=Emotional Inhibition; R=Rumination; ATS= Attitudes to Sex Offenders

Case Discussion

Case Ten provided six essentially core constructs on which the elements were rated at the first testing period, similarly to previous cases, i.e. Support and External Validation elements rated towards the positive ends of the construct poles and the other elements towards the more negative end. Interestingly, Case Ten utilised the full range of the rating scale at the first testing period, but at the second testing period all elements were rated towards the positive end of the constructs, making the relationships between the elements far less distinct.

From consideration of the data, it would not be unreasonable to hypothesise that facilitating SOTP had been a wholly positive experience for Case Ten, with no apparent ambivalence in the way the experience had been construed.
Significantly, Case Ten had a number of years experience of the Prison Service prior to facilitating treatment, but the key difference between this and the two cases with similar levels of experience was the number of treatment sessions

delivered. It is important to exercise caution when attributing change of this magnitude to one event or experience, and validation would need to be sought from the individual. However, an understanding of the rewards of working therapeutically with sex offenders is equally as important as an understanding of the deleterious effect, and it is suggested that the profile of construal presented here might provide a usual platform from which to develop that understanding at an individual level.

The psychometric data from Case Ten do not indicate substantial changes, with scores in EI and R already low, and attitudes to sex offenders relatively stable. It would be interesting to ascertain the extent to which Case Ten felt he had found his niche in his career and the extent to which that was maintained over time.

6.5 Discussion

In the opening chapter of this thesis, sex offender treatment providers were defined as 'members of a critical occupation'. The term, adopted by Paton and Violanti (1996), describes individuals, who in the course of their work, may encounter traumatic events or material that, under certain circumstances, might exert critical pressure on their psychological well-being. How such pressure impacts on an individual's psychological infrastructure, and why some individuals may be more susceptible to it than others, remains little understood.

The purpose of the current study was a tentative exploration of the ways in which an individual's psychological processes may be affected by the experience of facilitating sex offender treatment through the use of Repertory Grids (RGs). Despite the very clear limitations regarding the application of the RG technique, the results have provided important insights with respect to the three research questions posited at the end of Section 6.1. The first of these considered the use of RG data to identify changes in construal among therapists as a result of their SOTP experience. The second considered the merits of RG assessment as a way of conceptualising impact at the individual level, and the third was concerned with the relationship between psychometric and RG data. The following discussion will address these three areas in turn, and will conclude with recommendations for design improvements and further research.

The findings presented in Section 6.3 supported the use of RGs to identify superficial changes in construal of scenarios among new facilitators, to which experienced facilitators reported increased sensitivity. This conclusion was based on changes in the way constructs were rated between the two testing periods. Such changes in the ways in which existing constructs are used is known as 'slot rattling', and in therapeutic terms is considered to represent a relatively shallow level of change (Jancowicz, 2004). Nonetheless, in the face of invalidation of positive constructions, such changes could have a demonstrable impact on behaviour (Houston, 1998). In most of the ten cases presented, changes were observable in terms of which end of the construct poles the elements were rated. In some cases elements were rated more positively at the second testing period and in others more negatively. These changes were observable both within and between participants. It would be hypothesised that a marked shift towards the negative end of a construct or constructs would result in observable behaviour change and reports of negative impact such as that described in Chapter One. However, this would require validation through further research.

The extent to which changes in construal were positive or negative is most usefully addressed in the context of the second research question regarding impact at an individual level. Research investigating the psychosocial impact on facilitators of working therapeutically with sex offenders has consistently identified a proportion of therapists reporting deleterious effects (Edmunds, 1997; Ellerby, 1998; Turner, 1992). The proportion is generally between one- fifth and one-quarter of the sample, with effects ranging from mild anxiety to clinical diagnoses of Post Traumatic Stress Disorder. Paradoxically, the same and other studies also report large percentages of therapists who consider working with sex offenders to be the most rewarding work they have undertaken. Clearly then there are a number of individuals for whom therapeutic work with sex offenders is an ambivalent experience and existing research has done little to advance the understanding of why this might the case. Psychometric investigation has enabled the identification of trends in early psychological adaptation, as well as the importance of emotional style in relation to healthy adaptation: However, such investigation is constrained by the nature of the measures used and does not enable scrutiny at the individual level. The findings from the current study were particularly revealing regarding the psychological processes that may underlie

the apparent satisfaction/distress interaction.

For example, it has generally been assumed and expected that the nature of the clients and the material they present are causal in therapist distress, leading commentators such as Ryan and Lane (1991) to conclude that fear of known may be worse than fear of the unknown for sex offender treatment providers. However, evidence from the current study contradicts that assertion. For example, Cases One, Five, Six and Ten all rated elements related to vulnerable children more positively at the second testing period, suggesting a far from fearful experience. Indeed, understanding of sex offending and experience of the perpetrators appeared to result in more positive construal for these facilitators, highlighting one potential positive aspect of the work for them. But at the same time, beliefs about one's colleagues and expectations surrounding support may be fundamentally challenged, as illustrated by Case Six, highlighting not only positive and negative impact on construal, but also the very individual nature of that impact.

Negative impact may result from a number of processes, including negative 'slot rattling', SOTP being outside the range of convenience for an individual's existing construct system, SOTP experience requiring constructs beyond the individual's repertoire, or representative of constructs in transition. Only evidence for the former of these processes was available from this study and was most clearly demonstrated by Cases Three and Six, both of whom showed noticeable declines on at least two constructs by the second testing period.

Invalidation of established ways of construing, evidenced perhaps by negative 'slot-rattling', could result in the manifestation of constructs of transition, which are often unpleasant (Dalton and Dunnett, 1992). Threat, for example, was described by Kelly (1995) as the awareness of an imminent comprehensive change in one's core structures. In SOTP terms, a new therapist, who does well in training and has his/her constructs regarding competence confirmed, may feel particularly threatened by, for example, encountering a resistant sex offender who is not amenable to any therapeutic technique to engage in the therapeutic process.

In PCT terms, the healthy response would be to accept that the encounter as

beyond his/her experience and reorganise his/her construct system accordingly. However, the therapist may have a particularly rigid construct system and attempt to dismiss the behaviour of the offender or attempt to avoid the individual altogether in order not to have their construct system challenged. Such behaviours are often referred to in the therapist impact literature as indicative of deleterious outcome for therapists. Combining this experience with, say, the of endorsement of constructs relating to self-worth resulting from fellow professionals valuing the therapist's opinion, it becomes clearer why sex offender treatment provision can be simultaneously a positive and negative experience for therapists.

In relation to RG ratings and psychometric data, little evidence of any relationships was apparent, although a trend between construct ratings and the measures of PES is worth noting. In five of the ten cases, changes in the direction in which constructs were rated were accompanied by concomitant changes in scores on PES, e.g., if construct scores went up at the second testing period, so did PES scores. It might be that the lack of any threat to an individual's construct system enables more emotional openness, while demand on the system results in a reduction in sensitivity as a coping response, though this can only be speculated upon at this point.

The lack of more distinct relationships between RG and psychometric data is hypothesised to be a function of the test-retest interval. It is suggested that over 12 months and longer, clearer relationships would emerge. This is partly based in the findings of the previous chapter, where changes in psychometric scores were more marked over 12 months than 6 months. It is also likely that changes in construal would be clearer over a longer period, as a result of greater experience.

Beyond the research questions posed at the start of this chapter, an interesting pattern emerged regarding the ways in which the elements were rated. In PCT terms, the elements are generally seen as vehicles through which constructs could be elicited, and unless they had a particular therapeutic relevance may not be commented on further. But in SOTP terms the elements employed in this study were chosen because of their resonance with experienced facilitators and so are worthy of comment. In eight of the ten cases, elements relating to support of colleagues and external validation of a job well done were rated consistently

higher than the other elements at both testing periods. The importance of this relates to the implications of the effect on individuals' construal of their SOTP work when such elements are absent or reversed.

Organisational factors are consistently cited as integral to employees' well-being, and are often considered more stressful than operational ones (Hart et al, 1995). The finding here supports previous assertions made in this thesis, that it is individuals' construal of these issues and not the issues themselves that affect well-being, and this is likely to be central to psychological health. For example, if external endorsement impacts substantially on positive construal, it follows that lack of endorsement, or indeed overt hostility from colleagues, is likely to put considerable demand on an individual's construct system. This might account for organisational issues being considered so critical by some therapists, and leads to consideration of the role of perspective taking, identified in Chapter Three as inversely related to levels of Organisational Dissatisfaction. For example, is perspective taking indicative of a more loosely structured construct system or are individuals with high ratings on perspective taking less likely to rate such elements so highly? This, in turn, poses interesting questions regarding preparation of therapists to work with sex offenders, not just in terms of the material and individuals they may encounter, but also in terms of organisational issues.

With regard to the relationship between psychometric assessment and PCT, it is interesting to speculate how particular measures might correlate with styles of construing. For example, do tight construers, those whose view of life is organised rigidly, experience greater levels of rumination in the face of challenges to their construct system? Do individuals high on detachment experience less threat in the face of such demand? Is emotional sensitivity dependent on the extent or level of demand? These questions and others are important to the investigation of ongoing adaptation and well-being of therapists and should form the basis of future research.

Investigating therapist impact within a PCT framework supports the use of the term 'critical occupation' to describe the role of sex offender treatment providers, in that the ways in which critical pressure may be exerted on an individual's psychological well-being become more clearly identifiable and more readily

explicated. The use of Repertory Grids as an assessment of change at the individual level has provided fundamental insights into facilitators' construal of their SOTP experience, generating new hypotheses about the nature of the impact of sex offender treatment provision on psychological well-being, as well as identifying areas for further research. It is to this area that attention will now be turned.

This study was tightly constrained owing to its exploratory nature, making avenues for further research and the ongoing use of RG methodology plentiful. The areas outlined below are not presented in any particular order of priority and all should be examined in order to validate and develop the current findings.

Firstly, the method by which the participants' constructs were elicited, whilst expedient, was far from ideal. Indeed, it was creditable that trainee facilitators with no experience of construct elicitation were able to produce such a rich pool of data. Future research should involve either experienced PCT practitioners in grid elicitation or more extensive training of research participants.

In this context, the use of prescribed elements needs to be considered. It is standard and acceptable procedure to provide elements for research or therapeutic purposes, but this inevitably leads to limitations in terms of the nature of the constructs that are likely to be elicited. For example, in the current study, constructs surrounding family and other non-work related interpersonal relationships were not directly tapped. However, allowing participants to identify their own elements means areas of research interest may be omitted. A compromise would be to combine both approaches for future research.

In order to consider change at a level deeper than that identified by 'slot-rattling', participants in future research should be encouraged to add new constructs and elements at subsequent testing periods. Although this makes considering change over time more complicated, there are recommended methods of analysis (Jancowicz, 2004). The advantages include a far more comprehensive assessment of change, including the introduction of new constructs, redefining the meaning and relative importance of existing constructs and redefining the hierarchy of the construct system (Winter, 1992).

Incorporating the changes recommended so far would also enable a more sophisticated analysis of the grids than was possible in the current study. A number of software packages exist which are based on Principal Components Analysis and allow for a number of different statistical procedures to be applied to the data. These include: analysis of the correlations between constructs; identifying psychological relationships between constructs; element sums of squares, indicating how meaningful each element is to the client; distance between elements, indicating how similarly the elements are construed in relation to each other; and the percentage of variance accounted for by each component. This latter analysis is particularly useful in terms of highlighting tightly organised constructs systems as well as providing a measure of cognitive complexity (Houston, 1998). In terms of changes in construal as a result of sex offender treatment provision, such analyses have clear advantages.

A further area for investigation is the potential relationship between group differences, as established through the use of psychometric assessment, and individual differences, identified within a PCT framework. This was alluded to earlier in this discussion in terms of styles of construing and scores on particular psychometric scales. The practicalities of applying the techniques of PCT to facilitators as a matter of course are considerable, although to be able to respond to every individual's experience of treatment provision would be highly desirable. An alternative would be to be able to predict construal styles based on psychometric measures and respond accordingly. For example, if it were established that people high on Rumination (R) were likely to be tight construers, individual work with high R scorers within a PCT framework could be used preventatively. This also has the potential to inform organisational responses to the management of therapeutic distress among facilitators, given what was learnt about the importance of organisational recognition highlighted earlier.

For these same reasons, it would also be interesting to investigate the predictive value of behavioural observations, such as the Treatment Manager Ratings employed in Chapter Five, in relationship to personal construction of SOTP work.

Although the argument is reasonable that any obvious challenges to an individual's psychological infrastructure, identified through behavioural or emotional distress, could be addressed via the established channels of counselling

and supervision, PCT and Repertory Grids might provide a critical dimension. Specifically, identifying precisely where and how an individual's psychological infrastructure is challenged by sex offender treatment provision should enable more personally relevant and focussed intervention and support.

In conclusion, despite the methodological limitations of this study, the findings have stimulated a number of potential avenues for new research into an area that is perceived as highly complementary to the psychometric approach taken throughout this thesis. The study of individual change described here may prove particularly enlightening in terms of targeted use of psychometric assessment, a more expedient method of assessment with large groups of individuals, as well as informing organisational strategies for the management and support of sex offender treatment providers.

Chapter Seven

The Moderating Effect of the Organisation on Facilitator WellBeing

7.1 Introduction

Over the past 50 years, stress has become a household word, used as the dominant term for uniting concepts such as conflict, trauma, anomie, depression and emotional distress (Lazarus, 1999). Indeed, such is its usage that some academics argue it is now meaningless, or does not exist at all. However, there is plenty of empirical evidence linking distress, including poor psychosocial work environments, with subsequent mental and physical ill-health (Bosma, Marmot, Hemingway, Brunner and Stansfield, 1997; Kuper and Marmot, 2003, 1997) and it remains the most popular and commonly used term to describe this experience. The Health and Safety Executive (HSE) defines stress as "the adverse reaction people have to excessive pressure or other types of demand placed on them". Weiner (1989) suggested that the degree of stress experienced was a function of the demands on the individual and the internal and external resources available to cope with those demands.

Like many others in the literature, the HSE definition of stress fails to take adequate account of individual differences in responding to stress, and can be taken to imply that stress is inherent in certain jobs or events. By contrast, Roger (2002) defines it as a preoccupation with emotional upset in response to events or situations, so in a work context, stress is a function of an individual's tendency to ruminate after the event about issues such as the perceived failure of the organisation to meet their needs. This might take the form of poor collegial support, or at a systems level, poor managerial training or unstructured promotion routes. Although it is clear that there are organisational features that are more or less likely to provoke rumination, Roger's approach places stress within the domain of internal resources available to cope with demands.

In the context of sex offender treatment provision and the model presented in Chapter One of this thesis, the organisation is therefore considered a dynamic

variable, on the grounds that organisational features may be subject to rapid change, for example, from the introduction of a new manager, to, in the case of public services, changes in political agendas. Such changes may resonate throughout the organisational infrastructure and impact at an individual or cultural level.

So it follows that work-related stress should be conceptualised and studied as a multifaceted problem involving personal (internal) characteristics, situational factors and the organisational and cultural context (external factors) in which the stress occurs (Pines et al, 1981). Nevertheless, the interaction of these factors in identifying or determining a stress response by any particular individual in a particular set of circumstances is recognised as complex.

Stress is clearly multi-faceted and complex, but there are some grounds - pragmatic, conceptual, methodological and humanitarian - for continuing to study psychological ill-health specifically as a consequence of work generated stress (Briner, 1997). Research commissioned by the Health and Safety Executive (HSE), reported on the HSE website (www.hse.gov.uk/stress) and due for publication in 2003, indicated that about half a million people experienced work-related stress at a level they believed was making them ill; up to 5 million people in the UK felt "very" or "extremely" stressed by their work; and work-related stress cost society between £3.7 billion and £3.8 billion every year (1995/96 prices). Brown and Blount (1999) argue that, pragmatically, failure to take account of worker stress may constitute a breach of duty of care, and cite the case of Walker v. Northumberland County Council (1995) I All ER 737 as an emphatic reminder of this duty. Mr Walker, a social worker, successfully sued his former employer for failing to take reasonable precautions to avoid him suffering a health endangering workload (Porteous, 1997), because the court indicated that risk of psychiatric damage was included within the ambit of the employer's duty of care.

Such is the concern arising from cases like this, that the government recently released draft management standards aimed at reducing work-related stress (Head, 2003), and although currently at the pilot stage, the HSE plans to issue the standards, probably as an Approved Code of Practice, by 2004. The standards, based largely on research from the 'Whitehall II Study (Head et al,

2002; Stansfield et al, 2000), refer to six key areas in which employers need to be able to demonstrate employee endorsement. These include: *demands* (at least 85% of employees indicate they are able to cope with the demands of their job); *control* (at least 85% of employees indicate they are able to have a say about the way they do their work); *support* (at least 85% of employees indicate that they receive adequate information and support from their colleagues and superiors); *relationships* (at least 65% of employees indicate they are not subjected to unacceptable behaviours (e.g. bullying at work)); *role* (at least 65% of employees indicate that they understand their role and responsibilities); and *change* (at least 65% of employees indicate that the organisation engages staff frequently when undergoing change).

The higher cut-off points for demands, control and support reflect the more robust empirical evidence linking them to health. In the Whitehall II study, high job demands were linked with poor mental health and increased risk of coronary heart disease, low control at work was associated with increased risk of poor mental health, increased risk of sick absence and increased incidence of coronary heart disease, and good levels of social support were found to be protective of mental health and reduced spells of sick absence (Head, 2003).

While the standards described above are for general application, there is little doubt that there are some professions, referred to as 'critical occupations' (Paton, 1996) in the introduction to this thesis, to which such standards are highly applicable, and that repeated exposure to graphic details of sexual abuse of children and adults, either recounted by sexually deviant individuals or ascertained through victim statements, identifies working therapeutically with sex offenders as such an occupation.

Official records regarding the psychological and physical health of facilitators, such as recorded sickness absence, decline in mental health or increase in coronary heart disease have not been kept, but in the past five years, three stress related cases have been brought against the Prison Service by SOTP therapists who worked as facilitators between 1991 and 1995. Central to the claimants cases was that insufficient priority was accorded to the programmes and that those involved had insufficient time to prepare themselves for the courses; there was insufficient time for debriefing following sessions; there was

insufficient supervision of facilitators in the programme so that the pressure under which such tutors were operating was not properly evaluated. All three cases were settled out of court, without acceptance of liability. Media reporting indicated that the therapists involved were diagnosed with Post Traumatic Stress Disorder arising directly from their work with sex offenders, and a failure by the organisation to provide appropriate support and supervision. There are many more anecdotal reports of individuals traumatised by their SOTP experience, but the prevalence remains unknown.

Despite the evidence from these cases, the view taken in this thesis is consistent with that described earlier - that stress is a complex issue, and to conceptualise a particular job or organisation as stressful of itself is erroneous and misleading. Regarding stress as an inevitable part of a job negatively structures workers' expectations regarding potential emotional reactivity, fails to take account of the role of individual differences in that reactivity, and denies the individual the opportunity to take responsibility for themselves and their reactions. Indeed, Roger (2002) has argued that to consider stress as the property of a particular occupation or event is to resign oneself to a life with the condition. Instead, he proposed there to be a stressful way of responding, a function of what he called emotion response style. This perspective may help to explain one of the more consistent findings among researchers investigating the impact of providing psychological services, summarised by Kadambi and Truscott (2003, p.20), that "the majority of professionals are not suffering emotional or psychological distress in response to clinical work, and are coping well with the demands of their work in the face of workplace challenges and stressors specific to client populations" (Coster and Schwebel, 1997; Elliot and Guy, 1993; Follette et al, 1994; Shapiro et al, 2001; Thoreson, Miller and Krauskopf, 1989).

Although there is some empirical evidence in the SOTP literature that the organisational context in which treatment occurs impacts on therapists well-being (Ellerby, 1998; Turner, 1992; Myers, 1995), it is suggested that the organisation plays a moderating rather than a causal role. That is to say, individuals experiencing distress as a result of their SOTP roles, may have that experience exacerbated by a poor psychosocial work environment, but the distress is not caused by the environment.

To this end, the remainder of this section considers the literature regarding occupational stress amongst prison staff, including the limited research evidence relating to SOTP therapists, and the infrastructure introduced by HM Prison Service for the implementation of programmes, into which aspects of therapist support are incorporated. This will be followed by details of an investigation into the relationship between the organisational infrastructure, reported satisfaction with organisational support and the role of individual differences.

7.1.1 Occupational stress in prisons

In 1997, Cartwright and Cooper identified working in the Prison Service as the most stressful occupation of 104 surveyed, and the prevailing opinion among professionals and the lay public alike is that prisons are stressful environments in which to work (Schaufeli and Peeters, 2000). The recency of these conclusions indicates that researchers have yet to incorporate Pines et al's (1981) multifaceted conceptualisation of stress and this is reflected in the available literature, which focuses primarily on elements of the job and the organisation that are perceived as stressful (see Section 1.4.1.1 for a more thorough overview).

Most research into stress in prisons focuses on prison officers. Little attention is given to the range of other professions represented, such as psychologists, probation staff, administrative staff, health care specialists and so on. Also, much of the evidence for stress amongst prison officers comes from North American correctional officers, and given the substantial difference between British and American penal institutions, generalisations of the findings may not be reliable.

However, in a review of 43 empirical articles relating to occupational stress among correctional officers from nine different countries, Schaufeli and Peeters (2000) identified three British papers. These highlighted a range of stressors, including dealing with prisoners (Holgate and Clegg, 1991; Launay and Fielding, 1989; Lombardo, 1989), role ambiguity (Holgate and Clegg, 1991;

Lombardo, 1989), lack of involvement with decision-making (Holgate and Clegg, 1991; Lombardo, 1989), poor interaction with management (Launay and Fielding, 1989) and lack of a support network (Lombardo, 1989), themes that appeared to be common internationally.

It is suggested that the identification of stressors such as these (some of which are the hallmark of the role) by prison officers, indicates a mismatch between individuals' professional and coping skills and their role requirements, a conclusion that is partially supported by data from countries where prison officer selection criteria are more stringent and include psychometric assessment of applicants. For example, Greuter and Castelijns (1992), pointed to the low turnover rate of prison officers in the Netherlands (4-5% per annum), where more rigorous personnel selection procedures operate, in comparison with the United States (up to 38% turnover in some states (Corrections Compendium, 1996), where more emphasis is placed on physical rather than personality characteristics (Schaufeli and Peeters, 2000). Indeed Schaufeli and Peeters hypothesised that that job stress was more common among officers in the United States partially because they possessed fewer personal coping resources. Such inferences further support the imperative of considering individual differences when assessing stress reactions to a particular role, before concluding that the role causes stress.

7.1.2 Organisational factors and stress related to sex offender treatment provision

In relation to sex offender treatment providers, a number of organisational factors have been identified that are thought to affect therapists' psychological well-being. For example, practice setting has been implicated in higher levels of depersonalisation and lower levels of personal accomplishment among clinicians practising in institutional settings in comparison with their community based counterparts (Ellerby, 1998), a finding replicated in the general psychotherapy literature (Farber and Heifetz, 1981). Inconsistencies in the criminal justice system and punitive attitudes of non-therapeutic colleagues (Farrenkopf, 1992), the inhumanity of prison environments (Freeman Longo, 1997) and the system's inability to protect potential victims (Ryan and Lane, 1991) have also been cited as sources of stress to therapists.

But by the far the most attention has been given to peer and social support from colleagues. For example, support from other therapists was cited as crucial by 88% of respondents in Jackson et al's (1997) study, while only 20% of that sample considered support from family, friends or other criminal justice representatives as important. Kadambi and Truscott (2001) identified professional peers and co-workers as a highly valued support resource, and Ennis and Horne (2003) reported that *perception* of peer support was a significant predictor of lower levels of psychological distress and PTSD related symptoms. Formal supervision has also been identified as an essential form of support (Jackson et al, 1997), providing a forum for the exploration of both personal and professional issues arising out of sex offender treatment provision.

Social support as a potential moderator of the impact of stress has been extensively researched. Forbes and Roger (1999) highlighted the beneficial effects of social support, which have been demonstrated for general health and well-being (Cobb, 1976; Cohen and Willis, 1985; Thoits, 1985) as well as for facilitating adaptation to and adjustment to change (Cobb, 1976; Sarason, 1981). Overall, however, the results have been equivocal, both in the general social support literature and that relating to the effects of social support on work stress and health. For example, Sandler and Barrera (1984) reported that high levels of social support might have negative consequences in mental health settings, and Fiore, Becker and Coppel (1983), in a comparison of the effects of the positive and negative interactions on health, found negative interactions to outweigh the beneficial effects of social support. Billings and Moos (1982b) reported gender differences in the stress-buffering effects of social support on physical and psychological health, with effects consistently evident for males but not females, and Orpen (1982), in a survey of black and white clerical workers in South Africa, found consistent buffering effects for black but not white employees.

Some studies based on prison personnel have indicated that peer support increased rather than reduced correctional officers' levels of job stress (Grossi and Berg, 1991; Morrison et al, 1992), and Peeters et al (1995) study of Dutch correctional officers showed that social support did not lead unconditionally to

a positive effect. Findings such as these support Digman and West's (1988) contention, that although support from co-workers and supervisors has been identified frequently as both a preventative mechanism and a remedy for burnout (Cherniss, 1980; Maslach, 1976; Pines and Maslach, 1978), there is actually little empirical evidence available to support this.

Research conducted early in the genesis of sex offender treatment in HM Prison Service reported that facilitators did not experience sufficient support from the establishments in which they facilitated programmes (Turner 1992; Myers 1995), and perceived a lack of understanding from colleagues about the nature of the programme with which they were involved (Mann, 1995). Responding to this concern, Attrill (1995), adapting Ajzen and Fishbein's (1980) Theory of Reasoned Action, set out to identify specific behaviours considered supportive of SOTP, and to investigate what might influence non-SOTP staff to perform those behaviours.

Her results suggested that the provision of support was far from straightforward, confirming the equivocal findings described above. Importantly, therapists perceived different behaviours by different groups of staff as being supportive. For example, supportive behaviour by co-therapists included covering shifts to enable completion of SOTP work and being willing to discuss how group sessions had gone. However, specialist staff were considered supportive by demonstrating a willingness to share specialist knowledge, managerial staff were considered supportive by easing the operational complexities of running treatment programmes and publicly backing the programme, and senior managers were considered supportive by attending meetings and SOTP related training. Non-SOTP colleagues' supportive behaviour included asking therapists for help with sex offenders interested in undergoing treatment and asking about SOTP in a way that suggested genuine interest. Support was rated most highly when received from co-therapists and direct managers, substantiating the findings of Jackson et al (1997).

7.1.3 Summary

The continued study of psychological ill-health in relation to work-generated stress has pragmatic and humanitarian value, although it is clear from the research evidence that conceptual differences abound. Despite a call for a multifaceted approach, incorporating personal, situational, organisational and cultural factors, researchers continue to emphasise the stressful nature of particular jobs, roles or organisations.

The relevance of social support in moderating work-related stress has been extensively researched and the results have been equivocal. It is argued that this is likely to be due the complexities associated with the provision of such support, both in terms of individual differences in the need for, use of and acceptance of social support, as well as where the support is coming from. This seems to be particularly relevant to sex offender treatment providers.

7.1.4 The accreditation and audit processes

Accreditation was originally perceived as a method of facilitating organisational development, but has increasingly become associated with regulating and promoting quality (Scrivens, 1997). In terms of offending behaviour programmes, an advisory non-departmental body, consisting of international experts in the criminal justice field, exists to give accreditation. Known as the Correctional Services Accreditation Panel (CSAP), it works to "ensure that sufficiently rigorous standards of design and implementation are in place to enable programmes to have a measurable effect on reducing reconvictions" (Blud, 2003; p.65). This is achieved by a two-stage process, firstly ensuring that programmes meet the criteria identified through meta-analytic review regarding effectiveness in reducing re-offending (see section 7.1.4.1), and secondly by ensuring programmes are delivered in such a way that programme and treatment integrity are maintained. This is achieved through a process of auditing the programme at the site at which it is implemented (see section 7.1.4.2).

Whilst it is clear that the accreditation and audit processes are primarily concerned with programme effectiveness in terms of reducing reconviction, it

is argued that this cannot be achieved without considering the role of the treatment providers. The following two sections consider these processes with particular emphasis on the lack of attention paid to the well-being of therapists.

7.1.4.1 Accreditation

A comprehensive framework of accreditation has guided the development of programmes running in HM Prison Service (Blud, 2003), and the SOTP Core Programme was one of the first to be awarded accredited status in 1996. The accreditation process is a formal mechanism by which offending behaviour programmes are assessed, by an independent panel of experts, for their adherence to principles drawn from the What Works research (McGuire, 1995).

These principles were operationalised into 11 criteria (Home Office, 2000) to ensure that: 1) the programme is based on an explicit model of programme function, backed by research evidence, 2) the programme targets criminogenic need, 3) the methods used to target these needs are ones to which the offenders are responsive, 4) the methods used are consistently effective, 5) the programme is skills orientated, 6) the programme addresses a range of criminogenic targets in an integrated and mutually reinforcing way, 7) the delivery of the programme, in terms of dose, relates to the needs of the offenders, 8) programme delivery is such that it engages and motivates the offender, 9) there is a comprehensive throughcare procedure, ensuring progress in prison is reinforced in the community, 10) there is ongoing monitoring of the programme, and 11) there is ongoing evaluation of the effectiveness of the programme (for a comprehensive review of the criteria see Lipton et al, 2000).

It is pertinent that in the context of offending behaviour treatment programmes in general, and SOTP in particular, only one of the criteria refers to the well-being of staff delivering programmes. This falls within the criteria for 'ongoing evaluation' of the programme, and indicates that the effect that involvement in the programme has on staff should be evaluated. It is argued that given each criteria is measured on a three-point scale (2 = criterion fully

met, 1 = criterion partially met and 0 = criterion not met), and that within the ongoing evaluation criterion there are five areas to consider (including the substantial area of the impact of the programme on reconviction), there is insufficient emphasis placed on the psychological responses of staff to the experience of running SOTP to comprehensively address the issue of quality programme delivery.

7.1.4.2 Audit

Each year, prison establishments running sex offender treatment programmes are audited by staff from Offending Behaviour Programmes Unit (OBPU), the department responsible for implementation of SOTP and other programmes, against a wide range of criteria. The purpose of the audit is to "maintain and improve standards of implementation, and thus ensure that programmes have the best possible chance of reducing re-offending" (SOTP Audit Document 2002-03). However the criticism levelled at the accreditation process regarding the well-being of treatment providers may also extend to some degree to the audit criteria against which the ongoing monitoring criterion is assessed.

The audit criteria are divided into three areas, A) Programme management, B) Treatment Management, and C) Resettlement. Each criterion is measured on a four-point scale, with guidance provided in most cases about the standards to be achieved for the award of a particular score. Some criteria, however, are scored at the discretion of the CSAP. Within the Programme management section of the audit document, six of the 23 criteria cover organisational matters associated with staff well-being, including SOTP awareness training for non-therapeutic staff, supportive behaviours by non-therapeutic staff, planning and debrief times for therapists pre-and post-session, provision of counselling sessions for therapists, and adherence to the pre-training selection process for new therapists. Within the Treatment Management section, three of the 22 criteria refer to therapist issues, including the provision of supervision and the prevention of over-exposure to facilitating treatment.

These criteria clearly go some way to addressing the issues raised earlier in this chapter regarding, for example, support of therapists through appropriate

selection of staff for the role, and the provision of time for debriefing, planning and supervision. Indeed the audit criteria go considerably further than the accreditation criteria to address therapist well-being, but the arbitrary nature of several of the criteria suggest an intuitive response based either on clinical concern or limited research data, rather than a targeted response based on robust empirical evidence. For example, the provision of a counselling service for therapists, and mandatory attendance by therapists at a set number of counselling sessions per programme indicates a compassionate organisational response to reported therapist distress. The provision of counselling is organised locally by each individual establishment, and appointments of counsellors are not prescribed. The only two criteria set by OBPU are that counsellors are members of a recognised professional body and that they are sympathetic to the cognitive behavioural perspective. Therefore the theoretical perspective from which counselling is provided may change from establishment to establishment.

In a review of different interventions employed to reduce the risk of PTSD following a traumatic event, Richards (1994) found little support for traditional intervention methods such as counselling, psychological debriefing, psychodynamic treatment or cognitive behavioural therapy. Indeed he commented that, "the literature describing counselling and treatment for PTSD is characterised by a profusion of case studies and descriptions of therapy but there is a paucity of carefully evaluated treatment studies. Controlled studies are still rarer" (p.54).

One study comparing the effect of three different treatments - exposure, Stress Inoculation Training (SIT) and non-directive counselling (Rothbaum et al, 1992), found that while all three treatments reduced non-specific distress such as depression and anxiety, PTSD symptoms were not treated successfully by supportive counselling. This supports the view extended by Duckworth and Charlesworth (1988), that counselling is only of general use.

Given that sex offender therapists in HM Prison Service have been clinically diagnosed with PTSD, and the concern expressed that the mandatory nature of counselling may ultimately prove more harmful than helpful (Freeman-Longo, 1997), counselling may not prove to be the most effective way of preventing or

reducing the prevalence of psychological distress.

Within the Programme Management section of the audit document, other criteria refer to the development of a supportive residential environment through: 1) the attendance of managers at SOTP awareness training; 2) the provision of awareness training for non-SOTP prison staff; and 3) examples of SOTP supportive behaviours by staff, as reported by therapists. Planning and debrief times are also specified.

While it is clear that criteria such as these have been incorporated on the basis of some empirical evidence (e.g. Attrill, 1995; Turner, 1992), the assessment of the criteria is essentially quantitative, relies on self-reported information collected on one occasion each year, and fails to account for the complexities surrounding peer and organisational support outlined earlier in this chapter.

7.1.5 Summary

The accreditation and audit processes exist to ensure that offending behaviour programmes are designed and delivered in such a way that a reduction in re-offending is achievable. While attention is given to the selection and training of staff facilitating the programmes, the psychological effects on therapists of delivering treatment has been largely ignored by these processes. It is argued that failure to monitor comprehensively the psychological well-being of treatment providers may well compromise treatment integrity, especially given the evidence presented throughout this thesis regarding therapist features required for effective interventions and the role these may play in dysfunctional adaptation of therapists to their work (see for example sections 3.1.2 and 5.4).

7.1.6 The present study

The study presented in the following sections was designed to investigate therapists' reported satisfaction with organisational support provided in the context of the audit infrastructure, thereby also examining the effectiveness of the audit criteria in meeting their support needs. It was hypothesised that high

levels of reported satisfaction would relate to high programme and treatment management scores ascertained by audit inspection. Further, it was proposed that reported satisfaction would be a function of individual differences in need for, use of and acceptance of organisational support. Although it was not feasible to address this latter issue extensively, given the complexity of the areas highlighted in the Sections 7.1 to 7.1.2, measures of PT and coping style were incorporated into the design to enable a preliminary investigation of the area.

7.2 Method

7.2.1 Participants

One hundred and thirty five facilitators from 24 sites returned completed questionnaire sets (see section 7.2.2 for procedure regarding questionnaire distribution). Fifty-seven percent of respondents were female and 43% male, and the mean age was 38.64 (SD 10.43). The majority of the respondents were prison officers (36.3%), followed by psychologists (28.1%), probation officers (16.4%) and psychological assistants (13.3%), probation service officers (3.7%), administrative staff and chaplains (1.5%) and other (0.7%). A majority of facilitators were currently involved in delivering a programme (63.7%) and 15.6% of the sample classed themselves as ex-facilitators. Most respondents had run one programme (28.1%), 23% had run two programmes, 21.5% three programmes, 7.4% four programmes and 8.1% five programmes. The maximum number of programmes run was 20 (1 respondent). The mean number of sessions run by respondents was 228.75 (SD 217.79) and the mean length of time facilitating was 36.46 months (SD 27.08).

In addition to the information described above, respondents were also asked about any change in their use of alcohol and drugs since starting their therapeutic role, and whether or not they practiced a faith. No respondents admitted to class A drug use, 1.5% to occasional use of class B drugs and 5.1% to occasional to regular use of class C drugs. One respondent indicated an increase in drug use and six reported a decrease. Two did not comment.

In relation to alcohol intake, the mean unit consumption per week was 11 (SD 11.73). Almost an equal number of respondents reported an increase or decrease in consumption (9% and 9.7% respectively) with 80.7% reporting no change.

A majority of the sample did not practice a faith (72.4%), 20.1% practiced occasionally, 1.5% fairly regularly and 6% regularly.

Given the small number of participants disclosing drug use or change in their alcohol consumption, these data were excluded from the analyses.

7.2.2 *Apparatus*

7.2.2.1 Psychometric measures

Participants completed four psychometric measures in addition to the demographic questions. The number and scope of the measures were restricted for two reasons. At this stage in the research a large number of Prison Service facilitators had been approached a number of times for inclusion in different studies and the restricted nature of the available population meant participant fatigue was an important consideration. Secondly, it was considered that a higher response rate was likely to be achieved by keeping the time necessary to respond to a minimum. The four measures used are described below with a rationale for their inclusion.

Organisational Dissatisfaction (OD) subscale of the ADA. This subscale is the only specific measure of organisational issues specific to sex offender treatment providers and has direct relevance to an investigation considering the relationship between the organisational infrastructure designed to support facilitators and their perceptions of that support.

The Compassion Satisfaction (CompSat) subscale of the Compassion Fatigue Satisfaction Self-Test (CFSST - Figley, 1995). The CompSat subscale of the CFSST assesses the positive aspects of working in a 'helping profession', both on a personal and organisation level. It has previously been shown to be negatively

correlated with the OD subscale of the ADA (see Section 3.3.1) and is included in this study to allow positive dimensions of organisational matters to be assessed.

Perspective Taking (PT) subscale of the Interpersonal Reactivity Index (IRI - Davies,1980). In a previous element of this research, (see section 3.3.2) PT was significantly negatively correlated with OD, suggesting that PT influenced the extent to which therapists experienced satisfaction with the organisation. This finding was discussed in the context of attribution of blame and was considered important in terms of the distress experienced by facilitators. A further examination of this finding was considered important and an investigation into the organisation as a moderator of distress provided a good opportunity to do this.

Detached Coping (DetCop) subscale of the revised Coping Styles Questionnaire (CSQ - Roger et al, 1993; *Roger,* 1996). DetCop assesses the extent to which an individual feels independent of a potentially stressful event and the emotion associated with it. In an organisational context it is argued that ability to be detached from organisational issues is likely to enhance healthy adaptation to the work.

7.2.2.2 Audit Data

Offending Behaviour Programmes Unit at HM Prison Service Headquarters provided data from four years of audits, from 1998 to 2002, from all SOTP sites in HM Prison Service. The data were summarised as total scores in the two relevant areas of Programme Management (PM) and Treatment Management (TM). A small amount of qualitative data was also provided, detailing comments made by the CSAP regarding the Programme Management criteria for the year 2001-2002.

It should be noted that over the four years for which data were supplied, a number of changes were made to the audit criteria, meaning comparisons between years was not possible.

7.2.3 *Procedure*

In order to maximise the sample, treatment managers at all 27 sites running SOTP were sent a minimum of 10 and a maximum of 30 sets of questionnaires (depending on the size of the site) and asked to distribute them to all currently active and any available ex-facilitators at the establishment. The covering letter encouraged treatment managers to photocopy the questionnaires if required. Each questionnaire pack contained a letter explaining the purpose of the research and ensuring anonymity, together with a demographic survey (See Appendix C) and the four scales described in section 6.2.2.1. Freepost envelopes were supplied for the return of completed questionnaires.

7.2.4 *Statistical analyses*

In the first instance, relationships amongst the psychometric scales and the demographic data were considered. The psychometric data were then aggregated to enable examination of the relationships between establishment audit scores and therapists' self-reported organisational satisfaction, analysed by year. More sophisticated statistical analyses were precluded owing to the nature of the audit data. Specifically, the criteria that related overtly to staff support were subsumed within other programme and treatment management criteria, and the data provided was insufficient to extract detail at the individual criterion level. Further, although there were criteria clearly directly related to staff support issues, it would have been an arbitrary decision to extract only those to the exclusion of others that may have had a perceived bearing on support.

7.3 Results

Correlations between the demographic and psychometric variables were run and a number of statistically significant relationships emerged (see Table 7.1). These were between age and OD ($r = 0.19$, $p<o.05$), age and DetCop ($r = 0.21$, $p<o.05$), and frequency of religious practice with CompSat ($r = 0.20$, $p<o.05$). Additionally, current status as a facilitator (respondents currently involved in *delivering* a programme versus those between programmes and ex-facilitators)

correlated positively with CompSat (r = 0.18, p<o.05) and PT (r = 0.27, p<0.001) and negatively with OD (r = -0.30, p<0.001), though being an ex-facilitator correlated significantly positively with OD (r = 0.22, p<0.01).

Table 7.1 also shows the correlations between the psychometric measures. The results indicated a statistically significant negative correlation between OD and PT (r = -0.24, p<0.01) and OD and CompSat (r = -0.17, p<o.05), and positive correlations between PT and CompSat (r = 0.24, p<0.01) and CompSat and DetCop (r = 0.39, p<0.001).

Table 7.1 Correlations between demographic and psychometric variables

	1	2	3	4	5	6	7	8.	9.	10.
1. Gender	1.00									
2. Age	-.23**	1.00								
3. Months as facilitator	-.29**	.42**	1.00							
4. No. of sessions run	-.30**	.34**	.88**	1.00						
5. Active	.06	-.17	.02	.07	1.00					
6. Ex-facilitator	-.12	.28**	.10	.08	-.57**	1.00				
7. Practice a faith	.01	.13	-.07	-.10	.03	.13	1.00			
8. OD	-.20*	.19*	.16	.15	-.30**	.22**	.02	1.00		
9. CompSat	.06	.06	-.03	.01	.18*	-.16	.20*	-.17*	1.00	
10. PT	.10	-.04	-.04	-.03	.27**	.02	.10	-.24*	.24*	1.00
11. DetCop	-.17	.21*	.15	.11	.07	.10	-.01	-.16	.39**	.16

** p<0.01 ; p< 0.05; OD=Organisational Dissatisfaction; CompSat=Compassion Satisfaction; PT=Perspective Taking; DetCop=Detached Coping

Psychometric scores were then aggregated by establishment (n=24) and correlated with each of the two audit scores provided for each of the four years (see Table 7.2). For the years 1998-99 and 1999-2000, no significant relationships were found. For the Year 2000-2001, the Treatment Management score correlated significantly positively with DetCop (r = 0.47, p<0.05). For the year 2001-2002 the Treatment Management score correlated significantly positively with PT (r = 0.49, p<0.05).

Table 7.2 Correlations between merged psychometric and audit scores

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1.OD	1.00										
2.CompSat	-.24	1.00									
3. PT	-.03	.16	1.00								
4.DetCop	-.25	.16	.22	1.00							
5.PM98/99	.05	-.29	.00	.08	1.00						
6.TM98/99	-.17	.01	.16	.05	.48*	1.00					
7. PM99/00	.00	-.13	.12	-.18	.35	.15	1.00				
8.TM99/00	.12	-.14	.12	.16	.26	.09	.61*	1.00			
9.PM00/01	.09	.00	-.29	.21	-.01	.00	.01	.19	1.00		
10. TM00/01	-.22	-.03	.25	.47*	.02	-.25	.25	.22	.15	1.00	
11. PM01/02	.16	-.27	.06	.05	.60*	.39	.24	-.10	.02	-.07	1.00
12.TM01/02	-.07	.21	.49*	.15	-.33	-.04	-.33	-.22	-.41*	.31	-.19

*p<0.05, **p<0.01; OD=Organisational Dissatisfaction; CompSat=Compassion Satisfaction; PT=Perspective Taking; DetCop=Detached Coping; PM=Programme Manager Score; TM=Treatment Manager Score

The implications of these findings are discussed in Section 7.4.

7.3.1 Subsidiary analysis

The unexpected relationship between age and OD warranted further investigation and given the relationship between OD and facilitator status as an ex-facilitator, a linear regression was run with OD as the dependent variable and age and status as an ex-facilitator as independent variables. Status as an ex-facilitator was significantly predictive of OD (β=0.18, $p<0.05$), but age was not (β =0.14, $p=0.12$).

The negative correlation between OD and PT replicated that found in the Scale Validation exercise reported in Chapter Three, section 3.4.3. To ascertain the strength of the relationship between these variables, a linear regression was conducted using OD as the dependent variable and PT, CompSat and DetCop as independent variables. PT was the only significant predictor (β= -0.20, $p<0.05$).

The results regarding current status as a facilitator and scores on OD, PT and CompSat also warranted further investigation, as it appeared from the current findings that involvement or not in the actual delivery of treatment was the

crucial issue, rather than whether therapists had quit treatment delivery altogether or were simply on a break between programmes. It was considered that the findings of further analyses would have a bearing on the conclusions presented in Chapter 4 (Section 4.7.1) regarding the well-being of ex-facilitators. To this end, a number of independent sample t-tests were run to look at differences between the two groups. Table 7.3 summarises the results.

Table 7.3 Summary table of t-tests comparing facilitator status on measures of Compassion Satisfaction, Perspective Taking and Organisational Dissatisfaction

	Currently running a programme	N	Mean	SD	t	p
CompSat	No	49	86.74	17.20	-2.05	0.04*
	Yes	85	92.55	14.96		
PT	No	48	15.31	3.16	-3.25	0.001**
	Yes	84	16.85	2.23		
OD	No	49	5.67	2.79	3.66	0.000**
	Yes	86	3.87	2.73		

* p<0.05;**p<0.001; CompSat = Compassion Satisfaction; PT = Perspective Taking; OD = Organisational Dissatisfaction

The results indicate that facilitators currently delivering treatment reported higher levels of CompSat, higher levels of PT and lower levels of OD compared with a group of respondents who were either not currently delivering treatment or were ex-facilitators. These findings are discussed below in Section 7.4.

7.4 Discussion

The purpose of this investigation was to consider the role of the organisation as a dynamic variable in the well-being of sex offender treatment providers, and this was undertaken explicitly in the context of the audit process, an organisationally imposed framework which includes criteria specifically focused on supporting therapists, and which itself is driven by an accreditation procedure designed to enhance the effectiveness of therapeutic interventions for offenders. The findings of the study suggest that the criteria aimed at ensuring therapists receive organisational support, as detailed in the audit

process, actually bear little relationship to measures assessing therapists' satisfaction with the organisation.

Before considering the relationships between measures of organisational satisfaction and the audit criteria, however, it is helpful to review the nature of the relationships between the psychometric and demographic variables collected. The correlations revealed a significant positive relationship between age and Organisational Dissatisfaction (OD) and age and Detached Coping (DetCop). These results, suggesting older respondents were more dissatisfied and more detached, have not been replicated elsewhere in this thesis. The relationship between age and OD was investigated further in relation to facilitator status. Regression analysis indicated that being an ex-facilitator was significantly predictive of OD, but age was not. This confirms the findings presented in Chapter 4 regarding ex-facilitators and OD.

The relationship between age and DetCop had not previously been investigated with a sample of a similar size in this research, but can perhaps be explained in a similar way to the age and Ruminative Vulnerability (RV) finding reported in Chapter 2 (Section 2.4.3). In that report, the significantly higher score of younger therapists on the RV measure was explained in relation to them having fewer or less established coping resources on which to draw in order to assimilate their experiences of working with sex offenders. The finding in the current study lends some support to that conclusion, suggesting that over time DetCop may well emerge as part of a process of adapting to therapeutic work with sex offenders.

The results concerning current status as a facilitator and scores on measures of CompSat, OD and PT are particularly interesting in the context of the findings in Chapter Four, regarding ex-facilitators and Negative Reactivity to Offenders (NRO) and OD. In Chapter Four (Section 4.7.1) ex-facilitators, i.e. those who were no longer involved in SOTP in any capacity, scored significantly more highly on NRO and OD. This was explained partly in terms of no longer having access to the therapeutic milieu in which practicing therapists are immersed, and also in terms of the suppression of negative emotional reactivity while facilitating. The current findings provide some further support for those findings, at least in relation to OD, but also indicate that it is not only

ex-facilitators who report different experiences to practicing facilitators, but also those who remain involved in treatment but not actively delivering.

It appears from the current findings that those involved in delivering treatment experience greater CompSat and less OD, and it is proposed that this is likely to be a function of the range of rewards of providing treatment services to sex offenders identified by Kadambi and Truscott (2003). The finding regarding PT may be slightly more complex. It is hypothesised that the higher levels of PT reported by currently practicing therapists could be evidence of skills practice, in that regular therapeutic interaction with offenders in SOTP groups requires therapists to adopt other-orientated responses more frequently than other aspects of Prison Service work in which non-delivering therapists would be engaged. However, causality cannot be assumed and it might also be the case that non-practicing and ex-facilitators have generally poorer PT skills, which might in part account for the current status. This, however, is considered unlikely.

Finally, in terms of demographic variables, those practicing a faith on a regular basis indicated greater levels of CompSat. This finding is supported by researchers such as Levin (2001), who suggests that frequent church attendees generally report higher levels of psychological well-being.

The correlations of the psychometric variables with each other follow similar patterns to those found in previous elements of this research (see Chapter 3, Sections 3.3.1.1 and 3.3.2.1). Of particular interest is the replicated finding regarding PT and OD and CompSat, suggesting that those with higher PT scores report greater CompSat and less OD (common to currently practising facilitators). High OD scorers generally endorse statements referring to perceived lack of support from colleagues and managers, and low CompSat scorers are less likely to report good relationships with co-workers. The relationship of PT with these areas suggests that being able to view matters, presumably in this case from a colleague or managers perspective, reduces the sense of dissatisfaction with perceived support from others. This introduces the notion of individual differences in perception of peer, social and managerial support, and, it is argued, begins to shed some light on the equivocal results

regarding the role of social support in the reduction of stress, highlighted in the introduction to this chapter.

The theme of peer support will be returned to in more detail in the context of results from the audit data, but to elucidate further on the importance of PT, there is considerable empirical evidence regarding high levels of job satisfaction among sex offender treatment providers, despite often deleterious psychological effects (Edmunds, 1997; Ellerby, 1998; Kadambi, 200; Kadambi and Truscott, 2003; Turner, 1992), and anecdotal evidence suggests that SOTP therapists can become absorbed in their work almost to the exclusion of other aspects of their role. It is hypothesised that this level of attachment might serve to reduce an individuals capacity to take the perspective of those not as committed to the treatment of sex offenders, resulting in therapists experiencing frustration with those who do not attribute the same value to the work as they do. It is argued that therapists who are able to take the perspective of managers and colleagues are more likely to recognise less overt expressions of support and to understand others' perhaps less enthusiastic responses to SOTP. It then makes sense that such therapists would experience greater CompSat in their role as treatment providers.

This conclusion is further supported by the relationship between CompSat and DetCop, which were significantly positively related, replicating an earlier finding in this research (see Chapter 3). Again, although causality cannot be assumed it seems likely that a level of detachment from the work, as opposed to being overly emotionally invested in it, enhances therapists levels of satisfaction in providing treatment to sex offenders. These findings support the conceptualisation of stress proposed by Roger (2002), that stress is not inherent in features of the organisation but a function of individual differences in stressful responding. Evidence from Chapter Six, examining individual construal of features relating to support and organisational recognition further substantiate this claim.

If this is the case, the role of PT and detachment could be viewed as critical moderators in achieving a balance between being overly committed to the therapeutic process on the one hand, thereby potentially increasing the risk of psychological distress, and becoming overly distanced on the other, thereby

reducing therapeutic effectiveness.

The failure to find any meaningful significant relationships between the two elements of the audit procedure (treatment management and programme management) and the psychometric measures used in this study, representing four consecutive years, raise some important questions about the value of the audit process in relation to therapists' well-being. While it is important to remember that the audit criteria are essentially designed to ensure treatment integrity is maintained, it has been argued previously that this cannot be achieved comprehensively if the well-being of therapists is a secondary consideration. It was also proposed in section 7.1.4.2 that methods for assessing audit criteria failed to accommodate the complexities of some of the issues covered, such as peer support and the provision of counselling. These concerns are supported by the current findings.

Two potential explanations may account for the findings, the first relating to methodological problems and the second to the applicability of the audit criteria to therapist support. Firstly, it is possible that the failure to find any relationship between the audit criteria and measures of organisational satisfaction was a function of the psychometric measures used in this study. This is considered unlikely, given the qualitative similarities between specific audit criteria and items in the scales used, but it is possible that the absence of any relationship was due to the way in which the audit criteria have been categorized into programme and treatment management, each area only containing a few items relating to staff support. It is suggested that factor analysing the criteria should establish groups of items more focussed on specific aspects of programme implementation (such as staff support), which in turn are more likely to correlate with relevant measures (see section 7.5).

In terms of the applicability of the audit criteria to satisfaction with support received, a number of areas require attention. Within the programme management section of the audit, three criteria relate to treatment being provided in a supportive environment, and are assessed through the number of managers attending training sessions, the number of staff awareness sessions provided within the establishment and therapists' own reports of supportive behaviours by others. Two of the psychometric measures are

specifically targeted at collegial and managerial support, so a strong relationship between the two areas would be predicted. It is suggested that the lack of a relationship is a function of over-generalised criteria that are crudely assessed. For example, the criteria fail to incorporate an assessment of a) how attendance at a training session translates into supportive behaviour, b) the types of behaviour performed by different grades of staff identified in Attrill's (1995) research, or c) individual differences among therapists in relation to perception of the support provided. Further, therapists' reports of supportive behaviours by colleagues and managers are likely to be biased by a range of other factors such as how recently supportive behaviours were experienced, availability of opportunities to mix with peers and managers, current level of involvement in treatment provision and personal circumstances (see Chapter Two, section 2.3.2.7), to name a few.

The programme management section of the audit document also incorporates criteria related to facilitator support through mandatory counselling. These state that facilitators should attend counselling to "protect them from trauma or burnout associated with the demands of treating sex offenders", that counselling should meet the needs of the facilitators and be provided in safe and appropriate surroundings, and that the aim of the sessions should be to reduce the likelihood of facilitators experiencing adverse personal affects. It is apparent from the current findings that these criteria are not related to facilitators' reported satisfaction with the organisation, even though it might be expected that provision of counselling is a supportive organisational action. But there is no empirical evidence to suggest that mandatory counselling is an appropriate organisational response and indeed the literature consistently indicates that far from all therapists experiencing traumatic reactions to their therapeutic work, the prevalence is between a fifth and a quarter of treatment providers. The anecdotal reports of resistance to mandatory counselling might well reflect therapists' opposition to the assumption that they will automatically experience psychological symptoms as a result of their therapeutic work and should, therefore, receive professional intervention to prevent them. The possibility is that rather than being perceived as supportive, the mandatory nature of counselling is considered intrusive, and alternative ways to reduce the risk of deleterious effects should be considered. This will be discussed further in Chapter Eight.

The Treatment Management (TM) section of the audit, which is primarily concerned with the quality of treatment delivery, includes three criteria related to therapist support, two of which refer to supervision and the third to preventing overexposure to treatment. In 2000-2001, DetCop correlated significantly positively with TM and in 2001-2002, PT correlated significantly positively. That these correlations are not repeated in other years may reflect changes in the audit criteria between the two years. Neither of the measures of organisational satisfaction correlated with TM scores in any year.

The criteria relating to supervision are primarily concerned with treatment delivery style and treatment integrity, but also refer to the individual needs of therapists in relation to their emotional health and support needs. The criterion related to over-exposure states that, "facilitators should not be put into a situation where they become damaged by over-exposure to sex offender treatment" and specifies a two-months break between programmes. Paradoxically, however, breaks between programmes to relieve pressure on facilitators actually appear to increase it, evidenced by higher OD scores among resting facilitators. The potential causes of this have been discussed previously, both in this chapter and in Section 4.7.1, and support the need to review the purpose of the audit criteria.

The relationship between TM scores, PT and Detachment, and facilitator well-being are interesting but tenuous, bearing in mind the 19 other criteria included in the section that do not have a direct bearing on the psychological health of therapists. Nonetheless, the implication that higher scores on detachment and PT might be associated with superior treatment management warrants further investigation, especially in the context of therapist skills and positive clinical change by offenders. It would be particularly pertinent to consider the issue of causality in this context, as this might have implications for the development of treatment managers. This issue will be addressed again in Chapter Eight of this thesis.

7.5 Conclusions and Recommendations

This study investigated the relationship between the organisational

infrastructure, (the SOTP audit process), therapist's reported satisfaction with organisational support, and individual differences. Interestingly, neither of the two measures assessing satisfaction with the organisation, OD and CompSat, correlated with the audit measures designed to assess support structures for therapists. The results *did* support previous findings regarding the relationship between PT and OD, and indicated a relationship between OD and CompSat. A relationship also emerged between CompSat and DetCop. Earlier findings regarding the OD of ex-facilitators were replicated, and in addition, the current study indicated that therapists currently on a break from delivering treatment could be incorporated with ex-facilitators in terms of their expressed dissatisfaction with the organisation.

The significance of individual differences in organisational satisfaction suggests that these factors may be more pertinent to psychological well-being of therapists than organisational ones *per se*, but as stated in the introduction to this chapter, the interaction between individual and organisational factors is recognised as complex.

In terms of the model presented in Chapter One, the current findings suggest that stable features such as PT and coping style are more critical to well-being than the organisation as a dynamic variable, though given the HSE research into work-related stress, and the humanitarian and pragmatic motivations for reducing it, the organisation clearly has a significant role in moderating stressful responding. In SOTP terms, this might be achieved optimally through the provision of training in psychological self-maintenance skills such as DetCop and PT. Retaining the organisation within the dynamic domain of the model therefore seems prudent.

Recommendations for therapist training, and for further research to clarify the role of the organisation in facilitator well-being are detailed in Chapter Eight.

Chapter Eight

Conclusions

8.1 Introduction

Within the past two decades the systematic provision of therapeutic services to sex offenders has become an increasingly specialized endeavour. Both within penal institutions and in the community, and nationally and internationally, efforts have been directed towards the development and delivery of effective interventions aimed at reducing the prevalence of sexual offending. HM Prison Service introduced a comprehensive strategy for the treatment of sex offenders in 1991. Since then, nearly 1500 individuals have been trained in programme delivery.

More recently, in addition to research focussing on treatment outcome, attention has been given to the impact of treatment provision on the psychological well-being of those charged with its facilitation. Reflecting, perhaps, a pervasive acceptance of detrimental effects, most researchers have identified a range of injurious psychological consequences for facilitators undertaking therapeutic work with sex offenders, ranging from mild anxiety to severe psychological morbidity. Since the inception of the Sex Offender Treatment Programme (SOTP), three claims of psychiatric injury have been brought within HM Prison Service by facilitators trained in the early 1990s.

Based partially on available research findings as well as clinical and operational experience, HM Prison Service instituted a series of mechanisms to support staff, including mandatory counselling, supervision and debrief time, and awareness training for non-SOTP staff. These factors all constitute part of a complex infrastructure designed to ensure the integrity of treatment.

However, scrutiny of the impact literature revealed a number of methodological and empirical shortcomings, resulting in sometimes misleading conclusions about psychological effects based on unreliable findings. In particular, the research focussed almost exclusively on establishing the nature and prevalence of psychological distress. This thesis did not seek to

replicate previous studies aimed at ascertaining the extent of the problem, but sought to address the methodological and empirical shortcomings of previous investigations. The intended outcome was to provide a more comprehensive understanding of the factors and processes implicated in the deleterious effects identified, enabling HM Prison Service to provide a more informed organisational response to the support needs of facilitators. To this end, a model was posited in the introduction to this thesis, accompanied by a number of research aims and these were addressed systematically in a series of studies presented in Chapters Two to Seven.

In the form of a summary of Chapters One to Seven, this final chapter provides an overview of those studies, followed by a general discussion integrating the findings from each in relation to the original aims. Recommendations for future research are then made. Finally, the operational implications for the delivery of sex offender treatment in HM Prison Service, in terms of therapist well-being and longevity in the field, are deliberated, and the thesis is then concluded.

8.2 Summary of the findings

Chapter One provided an overview of sex offender treatment in HM Prison Service, with particular emphasis on features of effective interventions, such as cognitive restructuring, modelling and positive reinforcement. In this context, the emerging literature regarding therapeutic style and group cohesiveness as agents of effective sex offender change was also described. Importantly, empathy was identified as a key skill, and its relevance in relation to facilitator well-being was returned to in later chapters.

Chapter One also reviewed the available literature relating to the impact on individuals of providing therapeutic services to sex offenders. Research findings, mostly emanating from North America and Canada, indicated a bleak psychological outlook for many facilitators. Studies consistently found between a fifth and a quarter of respondents experienced deleterious behavioural, cognitive, emotional and sexual effects. Symptoms were variously attributed to the content of the work, the nature of the client group, the setting

in which treatment took place, and the lack of organisational and social support. Only one study considered the role of individual differences in relation to the effects described.

The overall impact was predominantly conceptualised as burnout, although the terms Vicarious Trauma, Secondary Traumatic Stress and Compassion Fatigue had also been applied. Interestingly, the research also highlighted remarkably high levels of job satisfaction among facilitators, ranging from 75% to 96% of research participants.

Examination of the research revealed substantial methodological shortcomings, considered to render the findings and the consequent conclusions on which they were based, unreliable. For example, all the published studies were based on "snap-shot" methodology, which by definition could only represent the psychological health of therapists at a given point in time. But on the basis of such findings, researchers concluded that burnout was the predominant negative outcome for a substantial proportion of study participants. The research failed to identify the processes by which therapists arrived at a point of psychological ill-health, or the prognosis for recovery from their symptoms.

A major shortcoming was also evident in the way symptomatology had been measured. Most available research evidence was derived from poorly structured, *ad hoc* surveys, or general measures reflecting the researchers' perspective of the concept. For example, the Maslach Burnout Inventory (MBI - Maslach and Jackson, 1980) was widely employed to establish the frequency of burnout symptoms, often on the overtly stated assumption that burnout was an expected consequence of treatment provision.

Largely as a consequence of research design, the results from these studies were characterised by little more than lists of symptoms and their prevalence. The validity of such findings was further confounded by the fact they had been elicited solely from self-report methodology, without adequate regard for the inherent problems associated with reliance on that methodology alone. Even bearing in mind the advantages of self-report methodology when examining beliefs and attitudes, the lack of control group data in the published research

meant that comparisons with other mental health professionals were not possible. Without a context in which to set the effects described by sex offender treatment providers, it was not feasible to ascertain the comparative extent of the problem.

Concluding that the existing research failed to give an adequate explanation of the psychological processes implicated in both the deleterious and beneficial effects of treatment provision to sex offenders, an alternative conceptualisation of the problem was proposed. It was hypothesised that facilitators experienced a process of psychological adaptation, influenced by a range of variables that, in the interests of coherence, were categorised into a model based on the principles of risk prediction. Grouped as static, stable and dynamic variables, it was proposed that the model would enable investigation of the relative significance of each of the variables, changes in their relative importance over time, and ways in which they might interact to moderate outcomes. By measuring levels of psychological distress over time, it was intended that the model would enable the identification of areas in which particular strategies for alleviating distress might be targeted.

Chapter Two reported on the construction of the Assessment of Dynamic Adaptation (ADA). The aim was to generate a psychometrically valid and reliable assessment designed specifically to identify psychological outcome in relation to sex offender treatment provision, as represented in the model presented in Chapter One. The initial item pool was generated using the scenario technique pioneered at the University of York (e.g., Forbes and Roger, 1999). Thirty short vignettes, identified in the literature and by experienced facilitators as emotionally provocative as a consequence of working with sex offenders, were circulated to 30 facilitators in the Prison Service. Respondents were asked to indicate how they would think, feel and behave in each situation.

Responses yielded over 200 statements, which were reduced to 176 after repeated items were removed. Exploratory factor analysis of the preliminary scale resulted in a three-factor structure, comprised of a total of 61 items. Thirty-two items depicting a range of negative and hostile emotions loaded on the first factor, which was subsequently called Negative Reactivity to

Offenders (NRO). The second factor, containing 17 items and characterised by emotional vulnerability and ruminative thinking, was called Ruminative Vulnerability (RV). The third factor, called Organisational Dissatisfaction (OD), contained 12 items depicting organisational issues illustrative of lack of support or understanding from colleagues. All three factors were shown to be internally consistent and to have satisfactory retest reliability over 16 weeks inter-test interval.

In addition to exploratory factor analysis, the three-factor model of the ADA was tested using more rigorous confirmatory factor analysis. Using data returned from 165 community based sex offender treatment providers (16.5% of the original distribution), the analysis confirmed the fit of the exploratory three factor solution.

Consideration of demographic variables in relation to the three factors revealed some interesting findings regarding levels of negative impact measured by the ADA. For example, males showed significantly higher scores on NRO, while younger therapists experienced significantly higher levels of RV. Occupation was found not to affect levels on any of the three factors, when age was accounted for. Individuals who reported experiencing sexual abuse as a child showed no significant differences from the rest of the sample on any of the three factors. However, respondents reporting experience of sexual abuse as an adult showed significantly higher levels of both NRO and RV. Respondents who reported experiencing a traumatic event in the six months prior to their involvement in the research were found to experience significantly higher levels of OD.

Having constructed the new ADA to measure the impact of their work on sex offender treatment providers, Chapter Three examined the concurrent validity of the scale. Based on the key themes that emerged from the literature concerning psychological effect, the measures used for the concurrent validation were drawn from a model of emotional style proposed by Roger and colleagues (Roger, et al, 2000) to predict psychological health status. They included measures of Rumination (R), taken from the Emotion Control Questionnaire (Roger and Nesshoever, 1987; Roger and Najarian, 1989), Positive Emotional Sensitivity (PES) taken from the Emotional Sensitivity Scale

(Guarino, Roger and Olason, 2001), and Detached Coping (DetCop) style taken from the Coping Styles Questionnaire (Roger, Jarvis and Najarian, 1993; Roger, 1996). A measure of satisfaction with work was incorporated (Compassion Satisfaction (CompSat) subscale of the Compassion Fatigue/Satisfaction Self-Test - Figley, 1995), based on the evidence for high levels of role fulfilment reported by therapists, as well as an assessment of aspects of empathy measured by the Interpersonal Reactivity Index (IRI - Davis, 1980).

Within this context, the issue of empathy was addressed in greater detail, particularly the paradox surrounding its statistically significant association with therapist distress (Maramas, 2001; Moosman, 2002; Wertz, 2001), as well as its statistical relevance as a therapeutic skill in effecting better treatment (Marshall, et al, in press).

All three factors of the ADA correlated significantly with conceptually similar constructs. For example NRO correlated significantly positively with R and PES, and inversely with DetCop, but was not related to levels of satisfaction with work or empathic responding. RV was significantly positively correlated with R, PES and Personal Distress (PD) from the IRI, and negatively with DetCop and Compassion Satisfaction. OD correlated significantly positively with R, and negatively with DetCop, CompSat and Perspective Taking (from the IRI).

The findings were discussed in the context of emotional style and, where relevant, operational implications. The complexity of measuring individual differences was highlighted, and the inter-relationships amongst the variables were discussed with reference to a psychologically robust emotional style profile.

Chapter Four had two related aims: to provide a cross-sectional analysis of different occupational roles; and to examine the extent to which physiological response patterns corresponded to the self-report data. The purpose was to address previously identified shortcomings regarding the failure to compare sex offender treatment providers with similar professional groups, and the lack of objective assessment to corroborate self-reported distress. Facilitators involved in the delivery of treatment were, therefore, compared with ex-

facilitators and Prison Service staff who had never provided therapeutic interventions to sex offenders, and measures of blood pressure (BP) were taken to gauge participants' physiological reaction to material typically encountered by sex offender treatment providers.

Analyses of the data failed to identify any significant differences between the three groups in terms of physiological reactivity to the three scenarios representing typical material, and no significant differences were apparent within groups in terms of the three scenarios evoking differential physiological responses. It was suggested that the failure to identify differences between and within groups could be attributed to the relative insensitivity of the BP measures in registering subtle changes, or to the stimuli themselves. Sample size and the nature of the sample were also discussed.

Importantly, all three factors of the ADA proved to be significantly predictive of aspects of BP reactivity. Specifically, RV was negatively predictive of systolic BP to the scenario depicting a managerial issue (management scenario), OD was positively predictive of diastolic BP to the same scenario and NRO was predictive of heart rate to both that scenario and the scenario describing forensic evidence in a child abuse case (forensic scenario). In addition to the psychometric variables, experience of sexual abuse as an adult and experience of trauma in the preceding six months were also predictive of BP.

A range of scales was administered to all three groups to carry out psychometric assessment. These were the Rumination (R) and Emotional Inhibition (EI) subscales of the Emotion Control Questionnaire (ECQ - Roger and Nesshoever, 1987; Roger and Najarian, 1989); the Detached Coping (DetCop) sub-scale of the Coping Styles Questionnaire (CSQ - Roger, Jarvis and Najarian, 1993; Roger, 1996); and the positive Emotional Sensitivity (PES) sub-scale of the Emotional Sensitivity Scale (ESS - Guarino, Roger and Olason, 2001). The three factors of the ADA were administered to current facilitators and ex-facilitators only.

Analyses indicated that there were no significant differences between the three groups on measures of R, EI, DetCop or PES, and ex- and current facilitators'

scores on RV were virtually indistinguishable. But significant differences were apparent between the latter two groups on the measures of NRO and OD. The potential reasons for the differences were discussed and the implications for support of facilitators no longer delivering treatment, especially in terms of organisational effectiveness, were highlighted. It was concluded that the study provided evidence for the validity and applicability of the ADA, as well as identifying other variables implicated in psychological well-being.

Chapters Five and Six addressed the previously identified shortcoming of overreliance on retrospective data by introducing longitudinal elements into the research. Chapter Five focussed on psychometric assessment of newly appointed facilitators and also incorporated an alternative measure of objective assessment to that used in Chapter Four, namely behavioural observation of facilitators by experienced treatment managers. Chapter Six introduced a qualitative component into the research through use of methods drawn from the field of Personal Construct Psychology.

Chapter Five followed 28 newly appointed facilitators over 12 months, assessing them psychometrically at three testing periods. Although data were also collected from a control group of non-facilitator prison staff, the data proved unreliable and were discarded. Repeated measures analysis indicated significant changes on four of the 15 psychometric measures used (for a description of all measures see Section 5.2.2.1). There were significant increases in Rumination (R) and Emotional Inhibition (EI) and significant decreases in Empathic Concern (EC) and Compassion Satisfaction (CompSat). Although the three factors of the ADA were administered at the second and third testing period, no significant differences were apparent over the six months between testing.

The statistically significant changes in scores were explained as part of a process of adaptation to therapeutic service provision to sex offenders, with reference made to the development of 'helper stereotype' (Short, 1979), a lack of psychological self-maintenance skills to facilitate adjustment, and the importance of individual differences in influencing adaptation. Non-significant trends in score changes on the remaining measures were also discussed.

Treatment manager ratings of therapeutic skills, undertaken routinely in practice as a method of monitoring treatment integrity, were found to be predictive of some aspects of facilitators' psychological well-being. Two of the ratings in particular, Modelling and Positive Reinforcement, emerged as repeatedly predictive of a number of psychometric factors. In total, five of the seven ratings used were predictive of at least one aspect of well-being. Owing to the lack of evidence for the reliability of the ratings employed, caution was urged in interpreting these findings, but the results were nonetheless encouraging. In the light of the difficulties associated with reliance on self-reported well-being, objective ratings predictive of scores relating to emotional style may have particularly important operational implications.

Chapter Six considered the impact of working therapeutically with offenders from a more qualitative perspective. The aim was to investigate the widespread anecdotal evidence for changes in fundamental beliefs about the world that therapists attributed to their work. Using Repertory Grids, a technique drawn from Personal Construct Psychology to elicit an individual's beliefs about any given topic, data from ten new therapists, followed over their first six months of involvement in sex offender treatment, were presented and discussed. Although the analysis was constrained by the design of the study, emerging patterns were particularly revealing with regard to the psychological processes that might underlie the apparent distress/satisfaction interaction highlighted in so much of the existing literature.

The relationship between psychometric data and styles of personal construing was also discussed, and hypotheses posited regarding the extent to which the nature of construing could be predicted by psychometric assessment of emotional style. Recommendations were made for incorporating assessment at an individual level, both in further research and in practice.

Chapter Seven investigated the relationships between the organisational infrastructure designed to provide support to facilitators (the audit process), facilitators' reported satisfaction with organisational support, and individual differences. The study was a preliminary investigation into the organisation as a dynamic variable, seeking to assess both the effectiveness of the procedures currently in place to support therapists and the role of individual differences in

the perception of that support.

The findings failed to identify a relationship between the audit infrastructure and self-reported satisfaction with organisational support. This was attributed largely to the way in which audit data were collected, and recommendations for alternative analyses that would allow the relationship between the two areas to be examined more effectively are made later in this chapter.

Importantly, the previously reported relationship between levels of OD and Perspective Taking was replicated in this study, and together with the significant correlation between Compassion Satisfaction and Detached Coping, these findings confirmed the assertion that perceptions of support were a function of individual differences. These findings were discussed in the context of the development of psychological self-maintenance skills for facilitators.

The well-being of ex-facilitators, previously raised in Chapter Four, was highlighted again Chapter Seven, showing significantly higher levels of OD, a finding that also emerged among resting facilitators. This was discussed in the context of contagion effects (Paton, 1996) impacting on the wider organisation.

8.3 Discussion of the findings

Research on the effects of sex offender treatment facilitation has been restricted to the identification and prevalence of a range of often distressing psychological symptoms, which have been shown to affect between 20 and 25 percent of therapists. The findings suggest that such deleterious outcomes are, for a proportion of therapists, inherent in taking on the role. The findings from the current research challenge such conclusions and suggest a far more optimistic future for facilitators.

A central premise of the current research was that negative psychosocial outcomes associated with the provision of sex offender treatment was largely a function of individual differences. While the very particular challenges presented by the nature of the clients and the content of the work were

acknowledged, the conclusion that harmful outcomes were inherent in those features was not accepted. Nor, it was argued, did the available evidence support such a conclusion. However, in recognition that sex offender treatment provision had the potential to initiate stressful responding in some facilitators, the term "critical occupation" was applied to the role. Originally coined by Paton and Violanti (1996), the term reflects the fact that some occupations result in workers encountering events or situations that "under certain circumstances, exert critical impact on their psychological well-being" (p.vii). The results from the current research provide empirical evidence for the nature of some of those circumstances.

8.3.1 Stable, static and dynamic variables associated with psychological well-being

The construction and validation of a scale specific to the demands of sex offender treatment provision meant that for the first time a reliable assessment of psychological distress, or in critical occupation terms, levels of critical impact, could be assessed. It was beyond the scope of this thesis to develop norms for the ADA (see Section 8.4), which would have enabled more definitive conclusions to be reached regarding comparative levels of distress. Nevertheless, the differential pattern of correlations with the criterion variables presented in Chapter Three, and the relationship of the ADA factors with a variety of socio-demographic and dynamic variables, established throughout the research, meant that reliable conclusions could be drawn regarding levels of psychological impact. The first four research aims of the project - the development of a scale of impact and the identification of stable, static and dynamic factors associated with facilitators' psychological well-being - were therefore met, and are discussed below.

Stable factors, features of the individual considered potentially changeable but relatively stable, were assessed using a variety of psychometric measures of emotional style, interpersonal reactivity and satisfaction with work scales. Throughout the research, a number of stable variables proved to be significantly correlated with factors of the ADA. These associations provided evidence that levels of distress were clearly independent of the provision of sex offender treatment *per se*, and statistically significantly related to features of

emotional style and responsivity, among other things. Specifically, all three ADA factors shared a statistically significant positive relationship with Rumination and negative relationship with Detached Coping. High levels of Rumination have been empirically linked to indices of ill-health, including self reports of deteriorating health status (Roger, Najarian, and Jarvis, 1994), delayed heart rate recovery and elevated cortisol secretion following exposure to stressors (Roger and Jamieson, 1988; Roger and Najarian, 1998), and suppressed immune function (Tomsen, 2003). The repeated relationship of RV, NRO and OD with Rumination might then reasonably lead to the conclusion that facilitators high on these factors of the ADA are at greater risk of stress-related ill-health, and that health status is linked to this stable factor, as opposed to working therapeutically with sex offenders. Unfortunately, no organisational data were available regarding the health status of sex offender treatment providers, making such an association purely speculative.

Findings from Chapter Four, investigating the physiological reactivity of individuals to material typically encountered by sex offender treatment facilitators, provided some support for the association between stable variables and physiological indices of stressful responding. For example, NRO was significantly predictive of increased heart rate. This relationship was considered to reflect the nature of the NRO factor, characterised by the hostile and angry emotions associated with the fight element of the well-documented 'fight or flight' response.

Given the relationship between NRO and Rumination, prolonged or frequent elevations in heart rate would not be considered desirable from a number of perspectives. Primarily, facilitators delivering treatment three or four times a week, and involved in different elements of treatment provision at other times, would experience regular exposure to material that could stimulate such physiological arousal. Additionally, ex-facilitators, who demonstrated substantially higher levels of NRO than practicing facilitators, would appear to be at greater risk of heightened physiological reactivity in some contexts.

The potential, albeit indirect, for stable characteristics such as rumination and NRO to induce stress related ill-health indicates the need for vigilance at both the individual and organisational level, regarding psychological and physical

well-being and levels of performance. This latter point will be discussed in more detail later in this section. In terms of the relationship between NRO and heightened physiological arousal, further research is required before firm conclusions can be drawn and recommendations for this are made in Section 8.4.

The negative relationship between the three factors of the ADA and Detached Coping echoes the interaction between emotion control and coping styles reported by Roger, Jarvis and Najarian (1994). Detachment, defined by the feeling of being independent of a potentially stressful event and the emotion associated with it, is inversely related to rumination and is considered to be an adaptive and protective coping style. Indeed, empirical evidence (Roger and Hudson, 1995) indicates that training in detached coping significantly impacts on rates of sickness absence and self-reported levels of detachment in an operational setting.

In the context of sex offender treatment delivery, the negative relationship between detached coping and the ADA factors makes clinical and intuitive sense. The content of the work and nature of the client group have frequently been cited as sources of stress for facilitators, but if these factors were inherently stressful, all facilitators completing the ADA should obtain high scores on the three factors. That this is not the case, implies the intervention of moderator variables, and detached coping appears to be one of these. The ability to maintain a detached perspective on the potentially distressing circumstances often presented by sex offender treatment provision leads to a freedom from the negative emotion which characterises the three factors of the ADA and Rumination, all of which correlated negatively with Detached Coping.

Further evidence for the impact of a more detached perspective on SOTP-related distress came from the negative relationship between OD and Perspective Taking, which emerged in separate studies based on different samples. It was concluded that an ability to perceive the role of treatment provider in the context of the wider organisation, and from the perspective of peers, reduced the extent to which facilitators considered themselves unsupported and misunderstood by colleagues, thereby reducing distress.

Higher levels of PT were also associated with higher levels of Compassion Satisfaction, which in turn was significantly positively correlated with Detached Coping.

The ability to emotionally detach from potentially distressing situations and to take perspective make a significant difference to levels of distress and satisfaction. Both are considered skills that can be trained. The evidence from the current research indicates that in the context of stable factors associated with levels of psychological well-being, specific interventions to develop those skills is likely to result in a reduction in ADA scores and the distress associated with high scores (see Section 8.4.8).

NRO and RV, but not OD, correlated significantly positively with Positive Emotional Sensitivity (PES), an assessment of emotional orientation to others highly correlated with measures of empathy (Guarino, Roger and Olason, 2001). The issue of empathy being implicated in therapist distress (Maramas, 2001; Moosman, 2002; Wertz, 2001), whilst at the same time identified as a central facilitator skill for effective sex offender treatment (Marshal et al, in press) was discussed in some detail in Section 3.1.2, and emerged as a theme several times throughout the research.

In the longitudinal study reported in Chapter Five, Empathic Concern (EC), measured by the Interpersonal Reactivity Index (Davis, 1980) and defined as an affective component of empathy (Atkins and Steitz, 1999), declined significantly over the first 12 months of involvement in treatment provision. It was hypothesised that this reflected an adjustment in therapists' empathic responses to their clients as they attempted to minimise the dissonance created by empathising with clients and the distress this could induce. It was not possible to ascertain whether this decline was accompanied by a change in treatment effectiveness, an investigation beyond the scope of the study.

It was concluded that disparities in definition and measurement created some of the difficulty in disentangling the positive and negative aspects of empathy in sex offender treatment provision. Authors such as Cliffordson (2000) and Hogan (1969) defined cognitive empathy as imaginatively taking the role of another and accurately predicting thoughts, feelings and actions of that

individual as a consequence. The key aspect was an element of detachment. Emotional empathy, on the other hand, was defined as a vicarious emotional response to the perceived emotional experiences of others, resulting in the perceiver experiencing similar emotions (Mehrabian and Epstein, 1972; Scotland, 1969). It was hypothesised that the first of these definitions constituted empathy as a desirable therapist skill, while the latter was likely to be implicated in facilitator distress.

Further, the relationship between empathy and treatment effectiveness appears to have been based on client appraisals of therapists' style, and it is these appraisals that have been demonstrated to be most predictive of treatment outcome (Orlinsky, Grawe and Parks, 1994). In relation to therapist well-being, however, empathy was assessed through psychometric self-report. It is not difficult to see why disentangling the significance of empathy in treatment provision has proved to be a complex task.

This research did not set out to address the issue of empathy specifically, but together with other emerging literature, the significance of PES and EC to therapist well-being demands that further research is undertaken. Proposals for this are made in Section 8.4.

RV and OD were both significantly negatively related to Compassion Satisfaction, suggesting that therapists could not experience high levels of satisfaction with their role as a treatment provider while experiencing high levels of RV or OD. Nonetheless, the distress/satisfaction paradox highlighted throughout this thesis, indicated that distress and rewards related to sex offender treatment provision were not necessarily mutually exclusive, although the interaction between the two areas was little understood. Some preliminary hypotheses regarding these processes were stimulated by the longitudinal research and will be discussed in that context later in this section.

In addition to stable features related to ADA factor scores, a number of static and dynamic variables were also identified. In particular, age emerged as a crucial variable, with young facilitators producing higher RV scores. Age was often, though not always, associated with amount of experience working with sex offenders, and although age transpired as the predictive variable for RV,

time in service was also related to higher scores. It was hypothesised that younger, or less established facilitators had a less sophisticated experiential framework into which they could assimilate their experience of sex offender treatment, resulting in the need for more extensive psychological adjustment. It was also posited that younger facilitators might have fewer or less well established coping resources with which to manage their new experiences.

Interestingly, qualitative data elicited in Chapter Six regarding changes in personal belief systems as a consequence of sex offender treatment provision, indicated that the youngest and least experienced facilitators demonstrated the clearest change in the ways in which their beliefs were rated over a six months period. At an individual level, this provides some corroboration for the conclusions drawn regarding the impact of age and experience. The implications for the recruitment of new sex offender treatment providers into HM Prison Service are important, especially given the high demand for new staff and more extensive availability of newly qualified or inexperienced staff to take up post.

Gender also proved to be an important static variable in relation to NRO scores, particularly within the Prison Service, with male facilitators' scores being significantly higher on this factor. It was suggested that this was a function of what Levant (1995) described as restricted emotionality, with emotional expression most commonly characterised by anger and hostility. But the finding was not replicated in the community sample described in Chapter Two, suggesting that high NRO scores among male facilitators in the Prison Service might have been a function of the organisational culture in which treatment was delivered. Particularly, it was proposed that the harsh and inherently masculine culture pervading most prisons prevented acknowledgement of emotional reactivity as a consequence of work related factors. Paton (1996) asserted that lack of organisational recognition of work-related trauma prevents traumatic reactivity being acknowledged for what it is - a normal response by normal people to abnormal events. Organisational issues will be discussed in more detail later in this section.

Among the remaining static variables examined, experience of sexual abuse as an adult was associated with significantly elevated scores on NRO and RV, but

experience of abuse as a child did not effect ADA scores. Little is understood about the impact of their own experiences of abuse when facilitators undertake therapeutic interventions with sex offenders, but in general, concern has been raised about the effects of childhood sexual abuse. It was proposed that high NRO and RV scores were likely to be a function of the recency of the abusive experience, in comparison with abuse as a child, indicating less time to assimilate or make sense of the experience. Lew (1993) made the distinction between surviving sexual abuse and recovering from it. It was hypothesised that elevated NRO and RV scores were perhaps indicative of active use of survival strategies, rather than reflective of recovery.

Without further research, the findings regarding facilitators' experience of abuse should be treated with caution, but they do raise issues around disclosure of these experiences in order that those charged with facilitators' supervision and management can respond appropriately.

In terms of dynamic factors, which may change rapidly or without warning, the experience of an event considered traumatic in the previous six months emerged as significantly related to OD. It was hypothesised that this was a reflection of the amount of time individuals spent in the work environment and the expectation or need for support during this time not necessarily being met. Winnibust, Buunk and Marcelissen (1988) argued that lack of adequate support under conditions of high stress would result in emotional strain in addition to the original trauma, which might well be reflected in higher OD scores. However, individual differences in the perception of support and the attribution of blame had not been elucidated in previous research indicating that organisational issues often resulted in more stress than operational ones (Hart, Wearing and Headey, 1995). Consequently, caution was recommended.

8.3.1.1 The organisation as a dynamic variable

The organisational infrastructure in which sex offender treatment was delivered was investigated in its own right as a dynamic variable, on the grounds that organisational features may be subject to fast or unexpected change. Its inclusion in a discrete study reflected the complexity surrounding organisational research, although the investigation was restricted to the

infrastructure in which sex offender treatment was delivered (the audit process) rather than the wider Prison Service.

The failure to find any significant relationship between reported well-being and the audit process was considered primarily to be a function of the way audit data were collected, but might also have resulted from the critical role of individual differences in the perception of organisational support. This latter conclusion was strengthened by the relationship between OD and PT and Detached Coping and Compassion Satisfaction, indicating that perspective taking and a detached coping style were both implicated in lower levels of dissatisfaction with the organisation.

Further support for the importance of individual differences came from the qualitative study reported in Chapter Six. It was noted there that most participants' personal constructs were rated consistently more positively on elements (scenarios) concerned with the external validation of the facilitators' work and collegial support, suggesting that well-being was strongly related with personal construal of such elements, rather than the elements themselves. It was hypothesised that if, for example, external validation of a job well done was not forthcoming, or indeed replaced with overt hostility, an individual's construct system would be fundamentally challenged, resulting in behavioural evidence of constructs in transition such as anxiety or hostility.

Drawing together the range of stable, static and dynamic variables associated with the newly constructed ADA provided the first empirical evidence to support the assertion that the psychological well-being of sex offender treatment providers was independent of treatment provision, and was moderated by a range of variables that were a function of the individual facilitator. To this end, the first four research aims were met.

8.3.2 Psychological well-being as an on-going process of adaptation

Having identified the variables implicated in well-being, a further research aim was to consider whether deleterious symptoms were a fixed outcome or indicative of stages in a process of psychological adaptation. Evidence from the

two longitudinal studies supported the hypothesis that facilitators experienced a dynamic process of adjustment, demonstrated by increased scores on Rumination and Emotional Inhibition, and decreased scores on Empathic Concern and Compassion Satisfaction, accompanied by changes in ratings of personal constructs elicited in response to the experience of treatment provision. In relation to psychometric assessment, the findings suggested what might be described as a psychologically uncomfortable adjustment, in that the observed changes were indicative of a decline in well-being.

However, qualitative assessment of individual belief systems shed important light on what might otherwise have been discouraging results. The use of the Repertory Grid technique, drawn for the field of Personal Construct Psychology (Kelly, 1955), indicated that at an individual level, changes in construal of treatment related scenarios were both negative and positive. Given the very individual nature of personal constructs, it would not have been possible to ascertain such changes through the use of psychometric measures alone. The results showed that on a general scale adaptation appeared, in the first 12 months at least, to result in deleterious outcomes, but that there were positive consequences too. Furthermore, the Repertory Grid findings suggested that the satisfaction/distress paradox, highlighted previously, probably resulted from changes in both directions on bipolar dimensions, a critical finding in terms of recognising adaptation at an individual level.

The time period over which facilitators were assessed did not allow for reliable conclusions to be drawn about the permanence of the changes observed. However, it was clear that facilitators did experience psychological adjustments and evidence comparing new facilitators with more experienced colleagues (Steed and Bicknell, 2001) would indicate that the process was ongoing. Continued follow-up would enable identification of patterns of adjustment that may be indicative of negative or positive psychological outcome in the longer term, as well as allowing for the evaluation of interventions aimed at developing therapists' psychological self-maintenance skills. It would also be necessary to take account of the static and dynamic variables previously identified, in terms of their relationship to psychometric measures and distress levels over time.

8.3.3 *Objective assessment of well-being*

An important element of the research was to address the over-reliance of previous research on self-report methodology. Two different techniques were considered, the first involving use of physiological assessment in the form of blood pressure (BP) monitoring and the second, the use of independent behavioural ratings by experienced treatment managers. As was discussed previously, the relationship between BP reactivity and psychometric scores indicated that BP monitoring might be useful in supplementing self-report data, although weaknesses in the experimental design and concerns about the sensitivity of BP monitoring emphasised the need for caution.

Behavioural observations of facilitators by treatment managers (TMs) yielded more robust and potentially very useful indicators of facilitator well-being. The results showed that five of seven behaviours observed and rated by TMs were predictive of psychometric scores of well-being, including levels of rumination, coping style, and empathy. Two of the behaviours, modelling and positive reinforcement, were described in the introduction to this thesis as central to effective facilitation, and form part of a fundamental skills set required by facilitators. Their statistically significant association with levels of psychological well-being of treatment providers could enable TMs to supplement self-reported well-being with routinely collected, objective information. The advantages of this relate particularly to the small number of treatment providers who appear to experience great rewards from delivering treatment while at the same time suffering from a range of deleterious effects (see, for example, Turner, 1992).

8.3.4 *Sex offender treatment providers in comparison with similar professionals*

The literature review presented in Chapter One highlighted the lack of comparison between the psychological well-being of sex offender treatment providers compared with similar occupational groups. Data from the cross-sectional study reported in Chapter Four, and the longitudinal research presented in Chapter Six were intended to address this, with relation to

potential differences in physiological and psychological reactivity respectively.

Unfortunately, owing to the nature of the data collected in the longitudinal study and methodological problems highlighted in the collection of physiological data, it was not possible to make reliable comparisons between groups. Neither was it possible to establish causal factors implicated in the psychological reactivity of treatment providers over time, as there were no reliable data with which to make comparisons.

Therefore, the research aim to identify differences between treatment providers and other professionals remains outstanding. This is addressed in Section 8.4.

8.4 Recommendations for future research and practice

By defining the provision of therapeutic services to sex offenders as a critical occupation, and by disputing the view of the role as inherently stressful, the current research has challenged many previously held assumptions about deleterious psychological outcomes for sex offender treatment facilitators. A range of static, stable and dynamic variables have been shown to have a statistically significant impact on well-being, providing a foundation upon which further research can be conducted.

The recommendations outlined below are not intended to be prescriptive or definitive, but to encapsulate the key findings of this thesis that may prove useful in guiding future research.

8.4.1 Assessment of facilitators' psychological well-being

The ADA provided the first measure of psychological well-being specific to sex offender treatment providers, and proved to be psychometrically robust. But perusal of the items suggests a predominantly negative slant to the scale, precluding direct assessment of the positive aspects of the role. Since the construction of the scale, Kadambi and Truscott (2003a), through research undertaken in Canada, identified a range of rewards perceived by therapists to

be associated directly with treatment provision. Collaborative work is underway to reconstruct the ADA, incorporating the work of these authors. Although it might reasonably be assumed that low scores on the current ADA represent positive outcomes, the aim is to provide a more balanced assessment of well-being. Cross-cultural validation of the scale is also intended, as well as the development of norms against which well-being can reliably be assessed.

It is recommended that both BP monitoring and other psychophysiological procedures should be pursued as objective methods to support self-reports of well-being. Despite the limitations of BP measurement outlined in Chapter Four, it remains the least intrusive and most economic technique. Alternatives to its application in this research should be considered, such as continuous rather than interval measurement, ideally in real-time, such as during the delivery of treatment sessions. The use of virtual technology, such as computer-simulated scenarios with which research participants interact to stimulate physiological arousal, should also be considered to allow more reliable comparisons with non-treatment providers.

Measurement of either urinary or salivary cortisol secretion may provide a more robust assessment of physiological reactivity in response to treatment provision. The application of this method in conjunction with BP monitoring would ensure comprehensive data with which to compare self-reported well-being and is recommended in addition to changes in the use of BP monitoring.

Larger, more diverse participant pools are also recommended, incorporating non-prison personnel where possible. This would help overcome the potential desensitisation amongst prison staff to the details of violent and sexual offending that may have rendered the groups used in Chapter Four indistinguishable.

The value of Treatment Manager Ratings (TMRs) as predictors of facilitators' psychological health proved promising, but further work is needed to validate the items used, particularly in terms of inter-rater reliability. Once this has been established, it is recommended that the predictive value of items should be re-evaluated.

8.4.2 The process of dynamic adaptation

The findings from the current research highlighted a process of adaptation undergone by therapists in their first year of facilitating sex offender treatment. However, it was clear from the significant differences between facilitators who had either resigned from treatment provision or were on a break from delivering treatment, and current facilitators, that this process was ongoing, even beyond active delivery of treatment. Further, owing to the unreliable data gathered from a control group of non-facilitators, it was not clear to what extent this process was different from that undergone by other prison staff.

An extensive longitudinal investigation is recommended, in order to establish the nature of the process of adaptation for the duration of a facilitator's career and beyond. The investigation should include control groups of non-therapeutic staff and facilitators of other cognitive behavioural interventions. Properly controlled research designs would provide more reliable data about the impact of sex offender treatment provision than has thus far been obtained.

Based on the findings regarding ex-facilitators, it is also recommended that individuals who resign from treatment delivery for any reason should remain within the study for a period beyond their resignation. Specific insights could then be provided into the adaptation of facilitators when they are no longer part of the therapeutic structure, as well as enable appropriate support mechanisms to be put in place.

The results from such a comprehensive investigation would allow the descriptive model presented in Chapter One to be developed into an overtly predictive model. In turn, a clearer understanding of the temporal relationships amongst the stable, static and dynamic variables would be provided, enabling an informed response by the organisation to the varying support needs of therapists.

8.4.3 Empathy

The paradox presented by empathy, as critical to effective intervention whilst at the same time empirically linked with deleterious psychological outcome for treatment providers, requires systematic and detailed investigation.

Owing to the divergent approaches to the assessment of empathy, it has been difficult to determine whether researchers are measuring the same general concept, or different components of that concept. For example, distinctions have been drawn between cognitive and emotional empathy, and in Chapter Three it was hypothesised that the former might be associated with effective interventions while the latter may be implicated in therapist distress. This was a speculative conclusion, and the potential for empathic (and, by implication, effective) therapists to be at greater psychological risk has implications for individual therapists, both in continuing to work in the field and continuing to be effective.

A more precise determination of the role of empathy in the effectiveness and well-being of therapists is therefore fundamental to the development of appropriate training, and the findings from this thesis have shown that detached coping and perspective taking as moderators of distress should play a central role here. Research on empathy also has clear implications for treatment delivery, and hence the success of sex offender treatment in reducing recidivism.

8.4.4 The relationship between personal constructs and psychometric assessments amongst sex offender treatment providers

Chapter Six presented an exploratory study into the use of Repertory Grids as a method for investigating change over time in an individual's beliefs, as a consequence of working with sex offenders. The results were enlightening with regard to the psychological processes that might underlie the consistent findings of simultaneous reward and distress resulting from treatment provision.

However, the study was tightly constrained owing to its exploratory nature,

and a number of recommendations were made for further research. These included the investigation of links between psychometric measures of emotional style and types of individual construal. For example, it was postulated that 'tight' construers - those who were less able to accommodate challenges to belief system - would be more likely to ruminate, while individuals with a detached coping style would be less likely to exhibit behaviours indicative of threat to their construct system. Furthermore, the use of repertory grids over the longer term and in a more flexible manner was considered beneficial in identifying change at a deeper psychological level.

The Repertory Grid method, and techniques from the field of Personal Construct Psychology provide a formal and detailed framework for investigating facilitator well-being at an explicitly individual level. In addition, strategies for working with individuals in adapting to change are also described, indicating that results from research may be supported by individual interventions where necessary.

8.4.5 Socio-demographic variables

A number of socio-demographic variables were statistically significantly related to ADA scores, including age, gender and experience of sexual abuse as an adult, although the strength and pattern of the obtained correlations varied depending on the sample from which the data were drawn. Further research is required, particularly with regard to distress attributable to facilitators' experience of abuse as an adult, where the samples were too small to provide reliable findings. Much of the existing literature makes assumptions about the deleterious effects of childhood sexual abuse on therapist psychological health, but the current evidence does not appear to support it. Little is understood about the effects that an individual's own experience of sexual abuse might have on the psychological processes underlying well-being, but it is argued that opportunities for the disclosure of abuse and the provision of appropriate support for therapists should contribute to the reduction of psychological risk.

8.4.6 The SOTP audit criteria

Chapter Seven considered the role of the organisation in moderating SOTP-related distress. No relationship was found between measures of reported satisfaction with the organisation and the infrastructure designed to support therapists represented by the audit criteria. This might have been a result of the way in which the audit data were collected, with criteria specifically related to support embedded within more general criteria.

It is recommended that the audit criteria be researched with a view to ascertaining their relevance to support needs. One possible approach would be to subject responses to the audit criteria to a factor analysis, to establish whether the criteria could be grouped in a meaningful way. Should a factor related to staff support emerge, this could be validated against measures of perceived support such as those used in this thesis. The validated factor structure might then form a basis for establishing a separate staff support audit, incorporating a far more comprehensive needs assessment than is currently available. Attrill's research from 1995 on the types of staff behaviours that therapists considered supportive could be made more explicit, and assessed more frequently. This would help overcome the difficulties, outlined in Chapter Six (Section 6.4), of implementing managerial and staff awareness of training without regard to how this training translates into operational practice, and would show how recent experience of supportive behaviours might influence reporting. Data from a longitudinal investigation might also result in the incorporation of additional criteria, reflecting changing needs over time.

It is argued that the development of a separate staff support audit would not only demonstrate overt commitment to sex offender treatment providers, itself an important element of organisational support, but would also adhere to the draft management standards outlined in Chapter Six (Section 6.1), to be introduced by the Health and Safety Executive (HSE), aimed at reducing work-related stress.

8.4.7 Individual differences and therapists' support

Even though Chapter Seven failed to identify a relationship between measures of reported satisfaction and the audit system, the results did indicate that individual differences in perspective taking and detached coping influenced levels of reported satisfaction. Therefore, although complex, it is recommended that future research should address the issue of individual differences in perceptions of organisational and peer support. In addition to PT and Detached Coping, other measures not employed in this thesis but theoretically relevant to perceptions and use of available support should also be investigated. For example, emotional inhibition, fear of disclosure and attributional style might all impact on the extent to which individuals perceive and make use of the formal support available. This should be viewed in the context of the evidence that emotional expression can serve to attenuate physiological arousal associated with stress (Mendolia and Kleck, 1993). These issues are particularly pertinent in an institutional setting where, as alluded to throughout this thesis, the culture is not always conducive to emotional expression.

8.4.8 Methods of supporting therapists

Although this thesis did not investigate the effectiveness of the support procedures in place for sex offender treatment providers, the findings discussed above suggest that existing measures are not meeting need. Specifically, the lack of empirical evidence regarding the effectiveness of counselling, combined with the relatively low incidence of deleterious psychological effects (between one-fifth and one-quarter), suggests that the provision of counselling should be reviewed. In particular, the psychological and economic implications of mandatory counselling for all therapists should be thoroughly investigated in comparison with empirically-validated alternative support strategies.

For example, as part of a comprehensive stress management programme developed by Roger (2002), training in detached coping has been shown to significantly reduce stress-related sickness absence and to increase adaptive coping skills (Roger, 2002; Roger and Hudson, 1995a). Programmes such as

this, which emphasise the role of perspective taking in managing emotional reactivity, should impact significantly on OD scores and other measures of treatment provision, and should also provide training in the development of facilitators' psychological self-maintenance skills.

In addition to preventative approaches to training, direct intervention in the form of counselling should be considered. One of the problems of a counselling service is the reluctance amongst staff to disclose trauma to a counsellor, particularly when peer-counselling is used. However, an alternative is trauma disclosure (for reviews see Pennebaker, 1997, 2000; Smyth, 1998), a procedure whereby individuals record in writing their thoughts and feelings about a traumatic life event. Trauma disclosure has been shown to have a salutary effect on health (Greenberg and Stone, 1992; King, 2001; Pennebaker, Kielcolt-Glaser and Glaser, 1988) and enhance positive self perception, resulting in more resilient self-concept (Hemenover, 2003; King, 2001; Pennebaker and Keough, 1999). Resilience is a psychological characteristic predicting "good outcomes in spite of serious threats to adaptation" (Masten, 2001, p.228) and trauma disclosure could prove particularly beneficial to sex offender treatment providers.

8.5 Operational recommendations for HM Prison Service

Although a considerable amount of further research has been recommended, the findings from this thesis provide a strong empirical foundation for future work on the way therapists are supported. Any changes that are made should be designed to incorporate new research findings as they become available, and to this end it is recommended that psychometric and socio-demographic assessment of all new facilitators is routinely undertaken to establish a comprehensive database. It is not advised that psychometric assessments be used for selection purposes this should remain the province of competency-based skills assessment - but rather to form part of an overall profile that informs training and support needs of individual facilitators. The scales used in such data-gathering should include indices of emotional style, coping styles and interpersonal reactivity, and measures of job satisfaction should also be incorporated. Consultation with experienced practitioners in the field may

yield additional measures that would be beneficial to ongoing research, as well as other personal variables that may be implicated in well-being.

Once the ADA has been revised, it is recommended that this be used routinely at prescribed intervals throughout a facilitator's career and beyond. This will provide a gauge of well-being at any given time, as well as assisting in developing norms for the scale. Changes in personal circumstances should also be noted and other psychometric assessments administered if necessary. The intervals between assessments will need to be carefully planned. Administering them too frequently could result in practice effects but too lengthy a period would defeat the purpose of ongoing assessment, and an inter-test of 12 months is suggested.

When research into physiological reactivity is completed, regular assessments may also include a physiological element in support of self-reported well-being. In this case it is recommended that occupational health staff be consulted.

There are many benefits of regular psychological health assessments for facilitators. At an individual level, the identification of personal support needs, accompanied by opportunities to address them, challenges the current approach to facilitator support that has clinical and intuitive value but no empirical substantiation. There are additional economic benefits to targeting support resources appropriately, as well as pragmatic advantages in terms of assuring concordance with HSE guidelines.

It is further recommended that the support needs of ex-facilitators and those currently on a break from treatment delivery should be incorporated into future audits. The evidence from the current research indicates that not only are ex- and non-delivering therapists more organisationally dissatisfied that their practicing peers, ex-facilitators also exhibit higher levels of Negative Reactivity to Offenders (see Chapter 4, section 4.6.2). That therapists leave the therapeutic infrastructure feeling unsupported and hostile to offenders may well result in what Paton (1996) refers to as contagion effects, impacting on the wider organisation and the surrounding community.

In relation to the audit process it is recommended that in addition to the audit research outlined in Section 8.4.6 current and ex-facilitators be surveyed regarding their immediate and long-term support needs. Survey results could then support empirical evidence to produce a comprehensive support infrastructure that is evaluated by the audit process. This would be in addition to the identification of individual support need discussed above and would inform the content and implementation of an overarching support strategy.

In terms of the development of facilitators' psychological self-maintenance skills, it is advised that training be implemented alongside the national training in therapeutic skills. Existing as well as new therapists should be targeted, and where appropriate ex-facilitators. Any interventions used should be thoroughly evaluated in relation to their impact on facilitator well-being, effects on facilitator effectiveness and on general organisational performance. To this end, factors such as turnover and sickness-absence among facilitators should be monitored, as well as external observation of performance, together with appropriate psychometric tools.

8.6 Conclusion

The systematic implementation of therapeutic interventions with sex offenders was based on strong empirical evidence that cognitive behavioural treatment was effective in reducing recidivism. In the early stages however, the impact on the psychological well-being of those charged with treatment facilitation was not recognised. As treatment protocols have developed and therapeutic intervention with sex offenders became more widespread, some deleterious psychological effects have been identified for facilitators that until now have been almost pervasively accepted as inevitable consequences for a proportion of those involved.

The findings from the current research challenge previous assumptions regarding adverse psychological impact. Instead they indicate the possibility of an optimistic psychological future for individuals who chose to embark on what a vast majority of facilitators consider the most rewarding and satisfying of critical occupations.

If it is agreed that the future of effective sex offender treatment is contingent on the psychological well-being of the treatment providers (Freeman-Longo, 1997) then ongoing research in the area, and the implementation of support strategies based on empirical evidence, should ensure that HM Prison Service not only has the largest multi-site sex offender treatment programme in the world, but also the most successful.

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Appendix A

SOTP Scenarios

INSTRUCTIONS

Listed below are scenarios that may be encountered by SOTP facilitators, either in their groups, in their prison, or in their personal lives. Please read each scenario and respond to the three questions:

1) What do you think?
2) How do you feel?
3) What do you do?

It is important that you only give your *personal* reactions, not what you should or ought to do professionally. Also, it would be helpful if you could consider what you might think, feel, and do immediately, as well as in the longer term. If there is a scenario that you have not encountered before, try to imagine how you might respond in that situation.

Thank you.

1. During a group session, one of the group members begins describing his 6 years old female victim as very knowledgeable about sexual intercourse
2. Your treatment manager has scheduled you to run a group with another facilitator you know you would find it difficult to work with
3. A group member insists that his victim did not experience long term damage from his abuse of her, as she is now grown up and has a family of her own
4. A neighbour asks if you could run their 10 and 8 year old children to school
5. At the end of a group, one group member who is still high risk, insists he will never offend again
6. During a role play session the group member being put into role becomes very distressed, crying and curling up in a ball on the floor
7. You currently run 4 SOTP sessions a week and have been asked to increase to 6 in order to meet end of year accreditation targets
8. A non-Prison Service friend asks you to baby sit their two children, as their original babysitter has let them down. It will involve bathing the children and putting them to bed
9. During an intimate moment with your partner, you start getting intrusive thoughts about an offender on your group
10. A group member is on the third session of his offence account, and despite all yours and your co-facilitators efforts, still insists that his 12 year old victim asked him if she could suck his penis
11. You learn that there has been a series of attempted abductions of children in your neighbourhood

12. You wake up in the middle of the night and find yourself thinking about one of the group members in your group and how you might challenge his distorted thinking. This is not the first time your sleep has been disturbed in this way
13. After a particularly draining session, your line manager asks you to undertake an urgent task right away
14. An offender who is convicted of raping three prostitutes says that all women are slags and deserves what comes to them
15. You hear from a friend that someone you know of has been charged with sexual offences against children
16. In a crowded shopping centre you see a young child about 4 years old, obviously lost and distressed
17. An offender who did very poorly on a Core Programme on which you tutored has come to the end of his sentence is released
18. Whilst a group member is giving his rape offence account, you notice another group member staring intently at your female co-facilitator
19. As part of your group preparation you have been reading victim statements. You have read three and as you are leaving for lunch another member of staff comments that SOTP is not "real work"
20. You are alone in your house and have been writing up session notes about a rapist who posed as a window cleaner. Someone knocks at the door
21. For the second time you have been withdrawn from refresher training due to pressure of work in your team.
22. During supervision you have been given feedback about your tutoring which you feel is overly critical
23. You hear a rumour that the Governor is thinking of cutting SOTP from the regime
24. A member of your group describes a childhood, where he was locked in cupboards and made to lick the kitchen floor clean. He was also systematically sexually abused by a series of "uncles". This is corroborated by external sources. He has committed a large number of offences against boys ranging from 4 to 16 years, and says it is his right
25. Your prison receives a poor audit report
26. By the Relapse Prevention block it is clear that 2 of the group have made so little progress that drawing up a comprehensive Relapse Prevention plan would be very difficult. You think they should leave the group but your treatment manager says you must persist
27. On an afternoon stroll with family/friends you pass a playground. There is a man, seemingly alone, sitting watching the children
28. You walk onto a wing that doesn't run SOTP and another member of staff whispers "nonce lover" under their breath
29. You are due to have a counselling session and really feel you need it. 10 minutes before it's due to start the prison has an emergency lock down and your session is cancelled
30. A group member you think did very well on his Core Programme has been found with hard-core pornography in his cell

Appendix B

Original Scale consisting of 176 items

SOTP
Core Programme
Impact Scale

Below you will find a series of statements relating to how working with sex offenders has impacted on peoples lives. Some of the statements relate directly to running groups and others are more general statements. Each statement requires a "Mostly True" or "Mostly False" response. For example:

I feel responsible for lowering the risk of sex offenders	***Mostly True***	***Mostly False***

If this statement is "Mostly True" of you, please underline or circle "Mostly True" as shown. If it is "Mostly False", underline or circle "Mostly False".

Please answer all the statements. If you are uncertain about how a statement relates to you, circle the response that is nearest to your ideal answer. Please do not leave any statement unanswered.

Thank you very much for your time.

	ITEM	**Mostly True**	**Mostly False**
1.	I feel confident that I can recognise distorted thinking in sex offenders	*Mostly True*	*Mostly False*
2.	I feel angry when sex offenders describe children in a sexual way	*Mostly True*	*Mostly False*
3.	I believe sex offenders try to pull the wool over your eyes	*Mostly True*	*Mostly False*
4.	Sex offenders make excuses about their offending because they are selfish and don't care about anyone but themselves	*Mostly True*	*Mostly False*
5.	I feel nervous when I have to challenge the way a sex offender sees his behaviour	*Mostly True*	*Mostly False*
6.	I feel guilty if I think I know better than my colleagues	*Mostly True*	*Mostly False*
7.	When a sex offender describes a child as knowing about sex, I start to think about how the child must have felt during the abuse	*Mostly True*	*Mostly False*
8.	If a sex offender gets distressed I worry that I may have pushed him too far	*Mostly True*	*Mostly False*
9.	I try to make time to think before I confront a sex offender about his offence	*Mostly True*	*Mostly False*

10.	When a sex offender tries to excuse his abuse of a child I relate his comments to children I know to realise how absurd it sounds	*Mostly True*	*Mostly False*
11.	I feel important knowing that I play a key role in the success of SOTP	*Mostly True*	*Mostly False*
12.	I make my feelings known when I am unhappy about management decisions	*Mostly True*	*Mostly False*
13.	I try hard not to let my feelings show when sex offenders talk about their offences	*Mostly True*	*Mostly False*
14.	If I hear about a sex offence being committed I worry that it might be someone I've treated	*Mostly True*	*Mostly False*
15.	Sometimes I lack confidence in the skills of my colleagues	*Mostly True*	*Mostly False*
16.	If I had to look after someone else's children I would feel vulnerable	*Mostly True*	*Mostly False*
17.	I feel calm when I challenge a sex offender	*Mostly True*	*Mostly False*
18.	I get frustrated if a sex offender cannot rework his distorted thinking	*Mostly True*	*Mostly False*
19.	If I see a sex offender staring at a female colleague my first thought would be that he is getting aroused	*Mostly True*	*Mostly False*
20.	I spend a long time evaluating my performance as an SOTP facilitator	*Mostly True*	*Mostly False*
21.	If a sex offender describes a child as knowledgeable about sex, I think it is because he genuinely believes it	*Mostly True*	*Mostly False*
22.	Telling someone else how bad sex offenders are makes me feel better	*Mostly True*	*Mostly False*
23.	When a sex offender denies harm he should be made to feel how his victim felt	*Mostly True*	*Mostly False*
24.	I feel awkward about working with some colleagues	*Mostly True*	*Mostly False*
25.	I feel angry towards sex offenders who deny they have damaged their victims	*Mostly True*	*Mostly False*
26.	When a sex offender says the right things I do not believe he is sincere	*Mostly True*	*Mostly False*
27.	I worry that I am arrogant about my ability to work with sex offenders	*Mostly True*	*Mostly False*
28.	I doubt my ability to work with sex offenders	*Mostly True*	*Mostly False*
29.	I get fixated on getting the reply I want in a group	*Mostly True*	*Mostly False*
30.	If a sex offender insists he will never offend again I think I've failed	*Mostly True*	*Mostly False*
31.	I am accepting of the decisions of managers	*Mostly True*	*Mostly False*
32.	Even if a sex offender remains high risk after treatment I think I have given it my best shot	*Mostly True*	*Mostly False*
33.	I would refuse to take on more work than I had originally agreed to	*Mostly True*	*Mostly False*
34.	I feel frustrated that I can't express my true feelings about sex offenders	*Mostly True*	*Mostly False*

35.	I feel anxious that someone I have reported positively about might re-offend	*Mostly True*	*Mostly False*
36.	I feel excited by the challenge presented when sex offenders try to justify their behaviour	*Mostly True*	*Mostly False*
37.	Increasing the number of sessions per week is always about achieving numerical targets and not about effective treatment	*Mostly True*	*Mostly False*
38.	I do not feel sympathetic to sex offenders when they are distressed	*Mostly True*	*Mostly False*
39.	If I am asked to take on more work than I was originally scheduled to do, I think about the personal costs to me	*Mostly True*	*Mostly False*
40.	I have no sympathy for sex offenders who have been victims	*Mostly True*	*Mostly False*
41.	I feel compassionate towards sex offenders when I think they are genuinely making progress	*Mostly True*	*Mostly False*
42.	I feel responsible for the well-being of the sex offenders I work with	*Mostly True*	*Mostly False*
43.	I feel confused about how to treat sex offenders who have also been victims	*Mostly True*	*Mostly False*
44.	I feel contempt and loathing for men who slag off women	*Mostly True*	*Mostly False*
45.	I get very frustrated if I can't get a sex offender to make progress	*Mostly True*	*Mostly False*
46.	I think about my work with sex offenders a lot when I am on my own	*Mostly True*	*Mostly False*
47.	I feel guilty if I believe a sex offender	*Mostly True*	*Mostly False*
48.	I am more likely to discuss my concerns with co-facilitators than with my treatment manager	*Mostly True*	*Mostly False*
49.	When a sex offender holds bad attitudes to women I feel concerned for the safety of my female colleagues	*Mostly True*	*Mostly False*
50.	The psychological well-being of staff should come before accreditation targets	*Mostly True*	*Mostly False*
51.	If a sex offender cries in a group I feel I've achieved something	*Mostly True*	*Mostly False*
52.	I feel there is an expectation of me to challenge negative attitudes to women	*Mostly True*	*Mostly False*
53.	I sometimes think "why bother" in relation to treating sex offenders	*Mostly True*	*Mostly False*
54.	I feel protective towards my co-facilitator(s)	*Mostly True*	*Mostly False*
55.	I get irritated when group members don't pay attention	*Mostly True*	*Mostly False*
56.	If a sex offender seems to be targeting a female member of staff, it should be dealt with immediately, no matter what else is going on in the group	*Mostly True*	*Mostly False*
57.	When sex offenders justify their offending I want to tell them they are wrong	*Mostly True*	*Mostly False*
58.	I am more supportive/protective of sex offenders who have been abused themselves than those who haven't	*Mostly True*	*Mostly False*
59.	I would not tell my partner if work started intruding on my sex life	*Mostly True*	*Mostly False*

60.	I dwell on the plight of sex offenders who have been abused	*Mostly True*	*Mostly False*
61.	I would behave sympathetically to a distressed sex offender, even if I didn't feel it	*Mostly True*	*Mostly False*
62.	When a sex offender describes an abusive childhood I compare his experiences with my own	*Mostly True*	*Mostly False*
63.	I feel undervalued by my treatment manager	*Mostly True*	*Mostly False*
64.	Working with sex offenders is stressful enough without having to work with poor facilitators	*Mostly True*	*Mostly False*
65.	I feel anxious that my SOTP colleagues might not be as effective as me when challenging sex offenders thinking	*Mostly True*	*Mostly False*
66.	I feel confident enough in my own abilities to work with a colleague I find difficult	*Mostly True*	*Mostly False*
67.	A sex offender can't possibly know the harm he has caused	*Mostly True*	*Mostly False*
68.	If I find someone difficult to work with I try and figure out why	*Mostly True*	*Mostly False*
69.	If my manager asks me to do something I don't like, I find someone to moan to	*Mostly True*	*Mostly False*
70.	I would do my best to ensure that the group are not affected by conflicts between facilitators	*Mostly True*	*Mostly False*
71.	I take it out on other people if I have to work with someone I don't like	*Mostly True*	*Mostly False*
72.	You can tell a sex offender by looking at them	*Mostly True*	*Mostly False*
73.	I feel obliged to do what ever is asked of me in connection with SOTP	*Mostly True*	*Mostly False*
74.	I feel very uncertain how to respond when sex offenders get emotional	*Mostly True*	*Mostly False*
75.	I worry about what my co-facilitators think of me	*Mostly True*	*Mostly False*
76.	I am very disbelieving of sex offenders who say that they are at no risk of re-offending	*Mostly True*	*Mostly False*
77.	I sometimes feel unsupported by my line managers, given the effort I put into SOTP	*Mostly True*	*Mostly False*
78.	I don't like sex offenders who have negative attitudes to women	*Mostly True*	*Mostly False*
79.	I am very happy to do what is required to run SOTP	*Mostly True*	*Mostly False*
80.	I feel tired of the excuses sex offenders use to justify their offending	*Mostly True*	*Mostly False*
81.	I try to hide how much I think about SOTP outside work in case colleagues think there is something wrong with me	*Mostly True*	*Mostly False*
82.	My line manager doesn't understand how stressful SOTP work can be	*Mostly True*	*Mostly False*
83.	I think a lot about whether I can cope with what's expected of me in my job	*Mostly True*	*Mostly False*
84.	I am grateful to do tasks not related to SOTP as it takes my mind off it	*Mostly True*	*Mostly False*
85.	When I'm asked to take on more work by my line manager I think about how little my colleagues do who are not involved in SOTP	*Mostly True*	*Mostly False*

86. If I have ideas about the group outside work hours, I write them down to consider later	*Mostly True*	*Mostly False*
87. I feel a sense of achievement when I take on more than usual	*Mostly True*	*Mostly False*
88. There never seems to be any time available for training	*Mostly True*	*Mostly False*
89. I question the priorities of managers when events for staff (e.g. training) are cancelled at short notice	*Mostly True*	*Mostly False*
90. I feel responsible for lowering the risk of sex offenders	*Mostly True*	*Mostly False*
91. I need all the training I can get to keep me good at SOTP	*Mostly True*	*Mostly False*
92. I feel sick at the thought that a sex offender may re-offend even after treatment	*Mostly True*	*Mostly False*
93. There's no point in working hard if management don't notice	*Mostly True*	*Mostly False*
94. I feel deflated when my performance as an SOTP facilitator is criticised	*Mostly True*	*Mostly False*
95. I try to let everyone know, whenever I can, how good SOTP is	*Mostly True*	*Mostly False*
96. If my prison stopped running SOTP I would feel very let-down	*Mostly True*	*Mostly False*
97. I think it could be my fault if the prison receives a poor audit report	*Mostly True*	*Mostly False*
98. When things don't go too well with SOTP I watch my back	*Mostly True*	*Mostly False*
99. If I saw a young child alone I would feel fearful for them	*Mostly True*	*Mostly False*
100. If I was asked to work with an SOTP facilitator I don't like I would refuse	*Mostly True*	*Mostly False*
101. I would always ensure I had another adult with me if I had to look after someone else's children	*Mostly True*	*Mostly False*
102. I feel sad that my innocence has been affected by my work with sex offenders	*Mostly True*	*Mostly False*
103. I will make excuses not to be alone with someone else's children	*Mostly True*	*Mostly False*
104. I am cynical of the "I was abused when I was a child" stories that sex offenders use to justify their behaviour	*Mostly True*	*Mostly False*
105. I feel it is risky for a parent to ask another adult to bath their children	*Mostly True*	*Mostly False*
106. I would be tempted to intervene if I saw a man acting suspiciously round children	*Mostly True*	*Mostly False*
107. If I have intrusive thoughts about sex offenders I get very distressed	*Mostly True*	*Mostly False*
108. I would stop working on SOTP if it started to interfere with my personal life	*Mostly True*	*Mostly False*
109. I do not feel I can talk to anyone about the effect SOTP has on me	*Mostly True*	*Mostly False*
110. I worry about what my partner would think if s/he knew what goes on in my head sometimes	*Mostly True*	*Mostly False*
111. If someone I know was charged with a sex offence I would assume they were innocent	*Mostly True*	*Mostly False*

112. If I have any worries about the way SOTP is affecting me I talk one of the SOTP team	*Mostly True*	*Mostly False*
113. SOTP is the most satisfying work I have done	*Mostly True*	*Mostly False*
114. I have felt aroused by what I have heard/read on SOTP	*Mostly True*	*Mostly False*
115. Child abusers should be locked up and the key thrown away	*Mostly True*	*Mostly False*
116. I have a responsibility to protect other people because of what I know about sex offenders	*Mostly True*	*Mostly False*
117. Hearing about sex offences against children makes me think about my own children/children I know	*Mostly True*	*Mostly False*
118. I am horrified at the thought that sex offences are committed in my own community	*Mostly True*	*Mostly False*
119. I am over-protective of my own children	*Mostly True*	*Mostly False*
120. I can discuss my feelings about sex offenders with colleagues	*Mostly True*	*Mostly False*
121. I feel perturbed when I can't switch off from SOTP	*Mostly True*	*Mostly False*
122. Children are safer with women	*Mostly True*	*Mostly False*
123. Thinking about sex offenders outside work is a sure sign I feel under too much pressure	*Mostly True*	*Mostly False*
124. I feel resentful when my line manager doesn't take into account the work I do for SOTP	*Mostly True*	*Mostly False*
125. If I see a man alone with children my first thought is that he's a paedophile	*Mostly True*	*Mostly False*
126. I wouldn't want to lose sleep over worrying about one of my group members	*Mostly True*	*Mostly False*
127. I feel let down when a sex offender's word is different from his actions	*Mostly True*	*Mostly False*
128. I find it hard to know who to trust anymore	*Mostly True*	*Mostly False*
129. I question the motives of anyone who would want to be alone with children	*Mostly True*	*Mostly False*
130. If someone I know was charged with a sex offence, I would question my judgement	*Mostly True*	*Mostly False*
131. I sometimes have to remind myself that not all men are sex offenders	*Mostly True*	*Mostly False*
132. If a sex offender gets emotional I am suspicious of his motives	*Mostly True*	*Mostly False*
133. I would want to help if someone I knew was charged with a sex offence	*Mostly True*	*Mostly False*
134. There is no point trying to change other staffs' attitudes about SOTP	*Mostly True*	*Mostly False*
135. I'd kill anyone who touched my children	*Mostly True*	*Mostly False*
136. Children do not lie about sexual abuse	*Mostly True*	*Mostly False*
137. I feel sad that in today's society I don't feel I could help a lost child	*Mostly True*	*Mostly False*

138. When things go wrong with SOTP it is invariably the facilitators that get the blame	*Mostly True*	*Mostly False*
139. I feel angry at parents who let their children wander off	*Mostly True*	*Mostly False*
140. Working with sex offenders has improved my intimate relationships	*Mostly True*	*Mostly False*
141. I have/have had nightmares about some of the sex offenders I have worked with	*Mostly True*	*Mostly False*
142. I think about sex offenders when I am not at work	*Mostly True*	*Mostly False*
143. At home, I always check who is at the door before I answer it	*Mostly True*	*Mostly False*
144. I feel sad that I have apprehensions about ordinary people	*Mostly True*	*Mostly False*
145. I am more tolerant of sex offenders since working on SOTP	*Mostly True*	*Mostly False*
146. I refuse to let my work affect me	*Mostly True*	*Mostly False*
147. If I suspect someone's motives for being with children eg in the park, I will watch them very closely	*Mostly True*	*Mostly False*
148. If I have to work immediately after an SOTP session I don't do it as well as I might otherwise do	*Mostly True*	*Mostly False*
149. I am very aware of my own behaviour when I am with other peoples children	*Mostly True*	*Mostly False*
150. I feel confident that I may be able to spot a sex offender when others can't	*Mostly True*	*Mostly False*
151. Knowing how offenders groom their victims makes me worry that if I behave in a similar way I could end up offending	*Mostly True*	*Mostly False*
152. I think people who criticise SOTP are just narrow-minded	*Mostly True*	*Mostly False*
153. I should know who is capable of committing a sex offence and who isn't	*Mostly True*	*Mostly False*
154. I feel unsupported by non-SOTP colleagues	*Mostly True*	*Mostly False*
155. SOTP is the most constructive work I've done	*Mostly True*	*Mostly False*
156. I know that I am doing the right thing working with sex offenders	*Mostly True*	*Mostly False*
157. Counselling is more trouble than it's worth	*Mostly True*	*Mostly False*
158. I have people outside work who I can talk to about SOTP	*Mostly True*	*Mostly False*
159. If a sex offender lapses in prison, then he most likely duped me throughout the programme	*Mostly True*	*Mostly False*
160. You can't trust sex offenders	*Mostly True*	*Mostly False*
161. Sometimes I think sex offenders will never change	*Mostly True*	*Mostly False*
162. If my judgement was proved wrong about a sex offender's progress, I would be more cynical in the future	*Mostly True*	*Mostly False*
163. If I wake up in the night thinking about work I make the most of the opportunity to think without distractions	*Mostly True*	*Mostly False*

164. I have felt more vulnerable in my personal life since I started working on SOTP	*Mostly True*	*Mostly False*
165. I would prefer to run groups with facilitators from the same discipline as me	*Mostly True*	*Mostly False*
166. I feel overly aware of situations in which sex offenders might commit an offence	*Mostly True*	*Mostly False*
167. If I saw a lost child I would feel responsible for their safety	*Mostly True*	*Mostly False*
168. I get mood swings that I think are directly related to being an SOTP facilitator	*Mostly True*	*Mostly False*
169. Working with sex offenders has damaged my intimate relationships	*Mostly True*	*Mostly False*
170. I would not approach a lost child as I could be mistaken for something I'm not	*Mostly True*	*Mostly False*
171. I am less interested in sex than I used to be	*Mostly True*	*Mostly False*
172. I worry that my sexual partner might view me as abusive	*Mostly True*	*Mostly False*
173. Non-SOTP colleagues have no idea what being a facilitator is like	*Mostly True*	*Mostly False*
174. I feel cross that I am affected by my work	*Mostly True*	*Mostly False*
175. I feel a conflict between my professional role and my SOTP role	*Mostly True*	*Mostly False*
176. I feel focussed when I challenge a sex offender	*Mostly True*	*Mostly False*

Thank you for your participation

Appendix C

SOTP Core Programme Impact Research

Personal Information

Please circle the appropriate response

1. Identification No:

2. Gender: Male Female

3. Age: **DoB:**

4. Occupation:

Prison Officer	Probation Officer	Chaplain
Psychological Assistant	Education Officer	Psychologist
Admin. Officer	Probation Service Officer	Other

5. Length of time in Prison Service:
(in years and months)

6. Do you/will you facilitate any of the following programmes in addition to the Core Programme (please circle any that apply):

Extended Adapted Rolling ETS R&R CSCP Other

7. Qualifications (please circle the highest level attained):

None GCSE (or equiv.) A level (or equiv.) HND/BTEC

Bachelors Degree Masters Degree Other (Please specify).....

8. Living Status:

Alone With Partner/family With others (non-intimate)

9. No: of children (Please include ages and gender)

10. Have you experienced any events in the last 6 months that you have found traumatic? (Please can you give a very brief description e.g. Bereavement)

11. The impact of this work on facilitators who have been sexually abused themselves is not well understood, and it would be extremely helpful if you felt able to answer the questions below. These questions are optional.

The term sexual abuse in these questions refers to abuse where physical contact was made by the perpetrator

Have you ever experienced sexual abuse as a child? Yes No

Have you ever experienced sexual abuse as an adult? Yes No

Appendix D

Factor Loadings for Items

Item	Factor 1 Negative Reactivity (NRO)	Factor 2 Ruminative Vulnerability (RV)	Factor 3 Organisational Disatisfaction (OD)
78	+.612		
132	+.538		
45	+.524		
57	+.521		
92	+.502		
129	+.493		
127	+.493		
25	+.487		
44	+.471		
139	+.448		
49	+.436		
18	+.435		
149	+.429		
104	+.428		
118	+.416		
116	+.415		
4	+.410		
2	+.410		
161	+.406		
23	+.405		
166	+.389		
130	+.387		
105	+.385		
19	+.382		
55	+.360		
162	+.342		
56	+.334		
35	+.329		
117	+.311		
90	+.310		
7	+.304		
147	+.304		
142		+.694	
146		-.599	
46		+.583	
164		+.548	
110		+.530	
168		+.511	
141		+.501	
83		+.464	

Item	**Factor 1** Negative Reactivity (NRO)	**Factor 2** Ruminative Vulnerability (RV)	**Factor 3** Organisational Disatisfaction (OD)
144	+.303	+.416	
24		+.378	+.333
102		+.373	
108		-.374	
131	+.304	+.374	
121		+.371	
59		+.349	
99		+.348	
15		+.330	
143		+.326	
124			+.692
77			+.658
82			+.600
89			+.493
154			+.482
85			+.456
63			+.441
138			+.383
88			+.380
173			+.375
148			+.359
100			+.355

Appendix E

Letter to NOTA Members

Dear Colleague,

HM Prison Service is currently sponsoring a three-year research programme as part of an ongoing commitment to supporting its Sex Offender Treatment Providers. This work is being undertaken at the University of York, under the supervision of Dr Derek Roger, and was prompted by a rise in reported psychological damage experienced by facilitators. The literature concerning the impact on treatment providers of working with sex offenders is growing, and although a vast majority of therapists report high levels of satisfaction with their work, this does not preclude experiencing some disturbing negative affects.

Part of the research at York has involved developing a scale of impact that is specifically designed for this type of work. Many of the measures used in previous research have been of a general nature and have not addressed the very specific needs of sex offender therapists. The scale has been constructed and tested using facilitators in the Prison Service, and it is important that its robustness is further tested using a wider range of therapists. For this reason NOTA have very kindly agreed to support the research by allowing the circulation of assessment material to all the Cardiff Conference attendees. It is hoped that with a high enough response rate, the scale can be fully and finally validated and then used by any Sex Offender Treatment Provider as part of an overall assessment of well-being.

I hope that over the course of the next few days you will find time to complete and return the enclosed questionnaires in the pre-paid envelope provided. I appreciate that it looks like rather an onerous task, but in practice completion should take no longer than 20 minutes. Although there isn't a deadline, if you were able to respond quite speedily, e.g. within a couple of weeks, it would be very helpful. All responses are strictly confidential, guaranteed by anonymity. Your consent to use your information is taken as implicit in its return, and should you wish, you can withdraw from this research at any time. For this reason you should keep a note of the identification number given at the top of the front sheet (Demographic Information) of the assessment information.

The success of this research is entirely dependent on the participation of therapists such as you, and I am very grateful for your time and co-operation. Many of the therapists who have been involved so far say they have enjoyed their involvement and look forward to hearing about the outcome. I hope yours is a similar experience.

If you have any questions about this or any other aspect of the research, please do not hesitate to contact me. Thank you in anticipation.

Best wishes.

Jo Clarke

Appendix F
The Assessment of Dynamic Adaptation

Sex Offender Treatment Provision

The ADA

(Assessment of Dynamic Adaptation)

Below you will find a series of statements relating to how working with sex offenders has impacted on peoples lives. Some of the statements relate directly to running treatment programmes and others are more general statements. Each statement requires a "Mostly True" or "Mostly False" response. For example:

I feel responsible for lowering the risk of sex offenders *Mostly True* *Mostly False*

If this statement is "Mostly True" of you, please circle "Mostly True" as shown. If it is "Mostly False", circle "Mostly False"

Please answer all the statements. If you are uncertain about how a statement relates to you, circle the response that is nearest to your ideal answer. Please do not leave any statement unanswered.

NB. "Facilitator" = therapist, group leader, tutor, etc: " Treatment Manager" = Manager responsible for treatment who may be different from your line manager

Thank you very much for your time.

	ITEM	**Mostly True**	Mostly False
1.	I feel angry when sex offenders describe children in a sexual way	*Mostly True*	*Mostly False*
2.	Sex offenders make excuses about their offending because they are selfish and don't care about anyone but themselves	*Mostly True*	*Mostly False*
3.	When a sex offender describes a child as knowing about sex, I start to think about how the child must have felt during the abuse	*Mostly True*	*Mostly False*
4.	Sometimes I lack confidence in the skills of my colleagues	*Mostly True*	*Mostly False*
5.	I get frustrated if a sex offender cannot rework his distorted thinking	*Mostly True*	*Mostly False*
6.	If I see a sex offender staring at a female colleague my first thought would be that he is getting aroused	*Mostly True*	*Mostly False*
7.	When a sex offender denies harm he should be made to feel how his victim felt	*Mostly True*	*Mostly False*

8.	I feel angry towards sex offenders who deny they have damaged their victims	*Mostly True*	*Mostly False*
9.	I feel anxious that someone I have reported positively about might re-offend	*Mostly True*	*Mostly False*
10.	I feel contempt and loathing for men who slag off women	*Mostly True*	*Mostly False*
11.	I get very frustrated if I can't get a sex offender to make progress	*Mostly True*	*Mostly False*
12.	I think about my work with sex offenders a lot when I am on my own	*Mostly True*	*Mostly False*
13.	When a sex offender holds bad attitudes to women I feel concerned for the safety of my female colleagues	*Mostly True*	*Mostly False*
14.	I get irritated when group members don't pay attention	*Mostly True*	*Mostly False*
15.	If a sex offender seems to be targeting a female member of staff, it should be dealt with immediately, no matter what else is going on in the group	*Mostly True*	*Mostly False*
16.	When sex offenders justify their offending I want to tell them they are wrong	*Mostly True*	*Mostly False*
17.	I would not tell my partner if work started intruding on my sex life	*Mostly True*	*Mostly False*
18.	I feel undervalued by my treatment manager	*Mostly True*	*Mostly False*
19.	I sometimes feel unsupported by my line managers, given the effort I put into SOTP	*Mostly True*	*Mostly False*
20.	I don't like sex offenders who have negative attitudes to women	*Mostly True*	*Mostly False*
21.	My line manager doesn't understand how stressful SOTP work can be	*Mostly True*	*Mostly False*
22.	I think a lot about whether I can cope with what's expected of me in my job	*Mostly True*	*Mostly False*
23.	When I'm asked to take on more work by my line manager I think about how little my colleagues do who are not involved in SOTP	*Mostly True*	*Mostly False*
24.	There never seems to be any time available for training	*Mostly True*	*Mostly False*
25.	I question the priorities of managers when events for staff (e.g. training) are cancelled at short notice	*Mostly True*	*Mostly False*
26.	I feel responsible for lowering the risk of sex offenders	*Mostly True*	*Mostly False*
27.	I feel sick at the thought that sex offender may re-offend even after treatment	*Mostly True*	*Mostly False*
28.	If I saw a young child alone I would feel fearful for them	*Mostly True*	*Mostly False*
29.	If I was asked to work with an SOTP facilitator I don't like I would refuse	*Mostly True*	*Mostly False*
30.	I feel sad that my innocence has been affected by my work with sex offenders	*Mostly True*	*Mostly False*

31.	I am cynical of the "I was abused when I was a child" stories that sex offenders use to justify their behaviour	*Mostly True*	*Mostly False*
32.	I feel it is risky for a parent to ask another adult to bath their children	*Mostly True*	*Mostly False*
33.	I would stop working on SOTP if it started to interfere with my personal life	*Mostly True*	*Mostly False*
34.	I worry about what my partner would think if s/he knew what goes on in my head sometimes	*Mostly True*	*Mostly False*
35.	I have a responsibility to protect other people because of what I know about sex offenders	*Mostly True*	*Mostly False*
36.	Hearing about sex offences against children makes me think about my own children/children I know	*Mostly True*	*Mostly False*
37.	I am horrified at the thought that sex offences are committed in my own community	*Mostly True*	*Mostly False*
38.	I feel perturbed when I can't switch off from SOTP	*Mostly True*	*Mostly False*
39.	I feel resentful when my line manager doesn't take into account the work I do for SOTP	*Mostly True*	*Mostly False*
40.	I feel let down when a sex offender's word is different from his actions	*Mostly True*	*Mostly False*
41.	I question the motives of anyone who would want to be alone with children	*Mostly True*	*Mostly False*
42.	If someone I know was charged with a sex offence, I would question my judgement	*Mostly True*	*Mostly False*
43.	If a sex offender gets emotional I am suspicious of his motives	*Mostly True*	*Mostly False*
44.	When things go wrong with SOTP it is invariably the facilitators that get the blame	*Mostly True*	*Mostly False*
45.	I feel angry at parents who let their children wander off	*Mostly True*	*Mostly False*
46.	I have/have had nightmares about some of the sex offenders I have worked with	*Mostly True*	*Mostly False*
47.	I think about sex offenders when I am not at work	*Mostly True*	*Mostly False*
48.	At home, I always check who is at the door before I answer it	*Mostly True*	*Mostly False*
49.	I feel sad that I have apprehensions about ordinary people	*Mostly True*	*Mostly False*
50.	I refuse to let my work affect me	*Mostly True*	*Mostly False*
51.	If I suspect someone's motives for being with children e.g. in the park, I will watch them very closely	*Mostly True*	*Mostly False*
52.	If I have to work immediately after an SOTP session I don't do it as well as I might otherwise do	*Mostly True*	*Mostly False*
53.	I am very aware of my own behaviour when I am with other people's children	*Mostly True*	*Mostly False*
54.	I feel unsupported by non-SOTP colleagues	*Mostly True*	*Mostly False*
55.	Sometimes I think sex offenders will never change	*Mostly True*	*Mostly False*

56.	If my judgement was proved wrong about a sex offender's progress, I would be more cynical in the future	*Mostly True*	*Mostly False*
57.	I have felt more vulnerable in my personal life since I started working on SOTP	*Mostly True*	*Mostly False*
58.	I feel overly aware of situations in which sex offenders might commit an offence	*Mostly True*	*Mostly False*
59.	I get mood swings I think are directly related to being an SOTP facilitator	*Mostly True*	*Mostly False*
60.	Non-SOTP colleagues have no idea what being a facilitator is like	*Mostly True*	*Mostly False*
61.	I feel cross that I am affected by my work	*Mostly True*	*Mostly False*

Thank you for your participation

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Appendix G

Emotion Control Questionnaire 3

Instructions : Indicate how you feel about each item by circling either "TRUE" or "FALSE". If an item is neither entirely true nor false, choose the alternative most like you. If you haven't been in the situation, please say how you feel you would behave in that situation.

1.	I remember things that upset me or make me angry for a long time afterwards	TRUE	FALSE
2.	I don't bear a grudge - when something is over, it's over, and I don't think about it again	TRUE	FALSE
3.	When someone upsets me, I try to hide my feelings	TRUE	FALSE
4.	Some people need somebody to confide in but I prefer to solve my own problems	TRUE	FALSE
5.	I get worked up just thinking about things that have upset me in the past	TRUE	FALSE
6.	I often find myself thinking over and over about things that make me angry	TRUE	FALSE
7.	Even when I feel upset about something I don't feel the need to talk to anyone about it	TRUE	FALSE
8.	People find it difficult to tell whether I'm excited about something or not	TRUE	FALSE
9.	I like to talk problems over to get them off my chest	TRUE	FALSE
10.	I feel vulnerable if I have to ask other people for help	TRUE	FALSE
11.	In the past I have found a problem easier to solve if I have talked it over with someone	TRUE	FALSE
12.	It is good to hear problems out loud	TRUE	FALSE
13.	If I receive bad news in front of others I usually try to hide how I feel	TRUE	FALSE
14.	It helps to discuss a problem even if it is impossible to reach a solution	TRUE	FALSE
15.	I seldom get preoccupied with worries about my future	TRUE	FALSE
16.	I have friends who I know would help me but I find it difficult to ask	TRUE	FALSE
17.	I seldom show how I feel about things	TRUE	FALSE
18.	If I see something that frightens or upsets me, it stays in my mind for a long time afterwards	TRUE	FALSE
19.	I think people show their feelings too easily	TRUE	FALSE
20.	My failures give me a persistent feeling of remorse	TRUE	FALSE

21.	When something upsets me I prefer to talk to someone about it than to bottle it up	TRUE	FALSE
22.	For me, the future seems to be full of troubles and problems	TRUE	FALSE
23.	There are some situations in which I am unable to confide in anybody	TRUE	FALSE
24.	I often feel as if I'm just waiting for something bad to happen	TRUE	FALSE
25.	When I am reminded of my past failures, I feel as if they are happening all over again	TRUE	FALSE
26.	If I get angry or upset I usually say how I feel	TRUE	FALSE
27.	Sometimes I have to force myself to concentrate on something else to keep distressing thoughts about the future out of my mind	TRUE	FALSE
28.	Intrusive thoughts about problems I'm going to have to deal with make it difficult for me to keep my mind on a task	TRUE	FALSE
29.	I don't feel embarrassed about expressing my feelings	TRUE	FALSE
30.	I don't let a lot of unimportant things irritate me	TRUE	FALSE
31.	I wish I could banish from my mind the memories of past failures	TRUE	FALSE
32.	I am unable to trust anybody with my problems	TRUE	FALSE
33.	I am afraid that if I confide in someone they will tell my problems to others	TRUE	FALSE
34.	I never get so involved thinking about upsetting things that I am unable to feel positive about the future	TRUE	FALSE
35.	I am not afraid to ask somebody for help	TRUE	FALSE
36.	I worry less about what might happen than most people I know	TRUE	FALSE
37.	It takes me a comparatively short time to get over unpleasant events	TRUE	FALSE
38.	Sometimes I am unable to confide even in someone who is close to me	TRUE	FALSE
39.	Any reminder about upsetting things brings all the emotion flooding back	TRUE	FALSE

Thank you for your help

Appendix H

Emotional Sensitivity Scale

INSTRUCTIONS: This scale consists of number of statements. Read each statement carefully and circle the one alternative which is most like you. There are no correct or incorrect answers. **Please do not omit any of the statements.**

1.	I often get the feeling that I just want to give up altogether	True	False
2.	I often worry that I have done something to upset people	True	False
3.	Unexpected changes in my life often leave me absolutely gutted	True	False
4.	I often think about ways to help people in difficulty	True	False
5.	It often feels that my burden is greater than anyone else's	True	False
6.	I often get angry with myself	True	False
7.	I find it easy to understand other's people feelings	True	False
8.	I get angry when things don't work out	True	False
9.	I easily get anxious and distressed when I see any of my family or close friends facing a problem, and I wish I wasn't there	True	False
10.	I find it easy to understand others' feelings when they are distressed	True	False
11.	If someone said I was an agitated person, they would probably be right	True	False
12.	I try not to get emotionally involved with people experiencing difficult situations	True	False
13.	I find it easy to share in other's happiness	True	False
14.	When people close to me are having problems, I worry on their behalf	True	False
15.	When I feel miserable, the worst thing is to hear other people laughing and having fun	True	False
16.	I worry constantly about making mistakes in my work	True	False
17.	I get very upset if my friends do not show up as planned	True	False
18.	When things do not go according to plan, I can usually accept it if there is nothing I can do about it	True	False
19.	I find it easy to recognise the feelings and moods of people around me, even if they try to hide them	True	False
20.	I'm easily affected by others' emotional problems	True	False
21.	I feel upset when I realise that there is nothing I can do to help other people who are having problems	True	False

22.	I am easily frustrated	True	False
23.	Little things are often enough to put me in foul mood	True	False
24.	I often feel sorry for myself	True	False
25.	I feel really upset about the plight of people on the edge of society	True	False
26.	I sometimes feel that no-one cares about me	True	False
27.	I often feel despair when facing difficult situations	True	False
28.	I would try to help someone crying in the street	True	False
29.	When a project I am working on starts off badly, I often see it as a bad omen for the rest of the project	True	False
30.	As long as I try my best in whatever I do, that's enough to make me happy	True	False
31.	I'm often more concerned about others' feelings and concerns than my own	True	False
32.	It's quite difficult for me to know the feelings and moods of people around me	True	False
33.	I often think about how not to make a fool of myself when facing a novel situation	True	False
34.	I feel more concerned than most people about those who are unfairly treated	True	False
35.	I often feel let down by my friends	True	False
36.	I can handle criticism well	True	False
37.	Whenever I see someone in trouble, I feel it's my responsibility to help and give support	True	False
38.	I get upset when other people are having a hard time	True	False
39.	I feel very put out if people don't pick up on how I feel	True	False
40.	I am very questioning of myself	True	False
41.	I am generally an apprehensive person	True	False
42.	I often picture the worst case scenario for whatever I am about to do	True	False
43.	I can easily control my nerves	True	False

Appendix I

Coping Styles Questionnaire

Instructions: Although people may react in different ways to different situations, we all tend to have a characteristic way of dealing with things which upset us. How would you describe the way you typically react to stress? Circle **Always (A), Often (O), Sometimes (S), or Never (N)** for each item below:

1.	Feel overpowered and at the mercy of the situation.	**A**	**O**	**S**	**N**
2.	Work out a plan for dealing with what has happened.	**A**	**O**	**S**	**N**
3.	See the situation for what it actually is and nothing more.	**A**	**O**	**S**	**N**
4.	Become miserable or depressed.	**A**	**O**	**S**	**N**
5.	Feel that no-one understands.	**A**	**O**	**S**	**N**
6.	Do not see the problem or situation as a threat.	**A**	**O**	**S**	**N**
7.	Feel that you are lonely or isolated.	**A**	**O**	**S**	**N**
8.	Take action to change things.	**A**	**O**	**S**	**N**
9.	Feel helpless - there's nothing you can do about it.	**A**	**O**	**S**	**N**
10.	Try to find out more information to help make a decision about things.	**A**	**O**	**S**	**N**
11.	Keep things to myself and not let others know how bad things are.	**A**	**O**	**S**	**N**
12.	Feel independent of the circumstances.	**A**	**O**	**S**	**N**
13.	Sit tight and hope it all goes away.	**A**	**O**	**S**	**N**
14.	Take my frustrations out on the people closest to me.	**A**	**O**	**S**	**N**
15.	Resolve the issue by not becoming identified with it.	**A**	**O**	**S**	**N**
16.	Respond neutrally to the problem.	**A**	**O**	**S**	**N**
17.	Pretend there's nothing the matter, even if people ask.	**A**	**O**	**S**	**N**
18.	Get things into proportion - nothing is really that important.	**A**	**O**	**S**	**N**
19.	Believe that time will somehow sort things out.	**A**	**O**	**S**	**N**
20.	Feel completely clear-headed about the whole thing.	**A**	**O**	**S**	**N**

21.	Try to keep a sense of humour - laugh at myself or the situation.	A	O	S	N
22.	Keep thinking it over in the hope that it will go away.	A	O	S	N
23.	Believe that I can cope with most things with the minimum of fuss.	A	O	S	N
24.	Daydream about things getting better in future.	A	O	S	N
25.	Try to find a logical way of explaining the problem.	A	O	S	N
26.	Decide it's useless to get upset and just get on with things.	A	O	S	N
27.	Feel worthless and unimportant.	A	O	S	N
28.	Trust in fate - that things will somehow work out for the best.	A	O	S	N
29.	Use my past experience to try to deal with the situation.	A	O	S	N
30.	Try to forget the whole thing has happened.	A	O	S	N
31.	Become irritable or angry.	A	O	S	N
32.	Just give the situation my full attention.	A	O	S	N
33.	Just take one step at a time.	A	O	S	N
34.	Criticise or blame myself.	A	O	S	N
35.	Pray that things will just change.	A	O	S	N
36.	Think or talk about the problem as if it did not belong to me.	A	O	S	N
37.	Talk about it as little as possible.	A	O	S	N
38.	Prepare myself for the worst possible outcome.	A	O	S	N
39.	Look for sympathy from people.	A	O	S	N
40.	See the thing as a challenge that must be met.	A	O	S	N
41.	Be realistic in my approach to the situation.	A	O	S	N

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Appendix J

Compassion Satisfaction/Fatigue Self-Test for Helpers

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Idaho State University

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self-test helps estimate your compassion status, particularly the degree of satisfaction you experience as a result of helping others. Consider each of the following characteristics about you and your current situation. Write in the number that honestly reflects how frequently you experienced these characteristics in the last week.

0=Never 1=Rarely 2=A few Times 3=Somewhat Often 4=Often 5=Very Often

Items About You

1	I am happy	_____
2	I find my life satisfying	_____
3	I have beliefs that sustain me	_____
4	I find that I learn new things from those I care for	_____
5	I feel connected to others	_____
6	I feel calm	_____
7	I believe that I have a good balance between my work and my free time	_____
8	I am the person I always wanted to be	_____
9	I have good peer support when I need to work through a highly stressful experience	_____
10	Working with those I help brings me a great deal of satisfaction	_____
11	I feel invigorated after working with those I help	_____
12	I have happy thoughts about those I help and how I could help them	_____
13	I have joyful feelings about how I can help the people I work with	_____
14	I feel that I might be positively "inoculated" by the traumatic stress of those I help	_____
15	Some people I help are particularly enjoyable to work with	_____

Items About Being A Helper And Your Helping Environment

16 I like my work as a helper _____

17 I feel like I have the tools and resources I need to do my work as a helper _____

18 I have thoughts that I am a "success" as a helper _____

19 I enjoy my co-workers _____

20 I depend on my co-workers to help me when I need it _____

21 My co-workers can depend on me for help when they need it _____

22 I trust my co-workers _____

23 I am pleased with how I am able to keep up with helping technology _____

24 Although I have to do paperwork that I don't like, I still have time to work with those I help _____

25 I am pleased with how I am able to keep up with the helping techniques and protocols _____

26 I plan to be a helper for a long time _____

Thank you again!

Appendix K

Interpersonal Reactivity Index

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The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A,B,C, or D. When you have decided on your answer, make a circle around the letter corresponding to the item. **READ EACH ITEM CAREFULLY BEFORE RESPONDING.** Answer as honestly as you can. Thank you.

	Does not describe me well			*Describes me very well*
1. I daydream and fantasize, with some regularity, about things that might happen to me.	A	B	C	D
2. I often have tender, concerned feelings for people less fortunate than me.	A	B	C	D
3. I sometimes find it difficult to see things from the "other guy's" point of view.	A	B	C	D
4. Sometimes I don't feel very sorry for other people when they are having problems.	A	B	C	D
5. I really get involved with the feelings of the characters in a novel.	A	B	C	D
6. In emergency situations, I feel apprehensive and ill-at-ease.	A	B	C	D
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.	A	B	C	D
8. I try to look at everybody's side of a disagreement before I make a decision.	A	B	C	D
9. When I see someone being taken advantage of, I feel kind of protective towards him or her.	A	B	C	D
10. I sometimes feel helpless when I am in the middle of a very emotional situation.	A	B	C	D
11. I sometimes try to understand my friends better by imagining how things look from their perspective.	A	B	C	D
12. Becoming extremely involved in a good book or movie is somewhat rare for me.	A	B	C	D

13. When I see someone get hurt, I tend to remain calm.	A	B	C	D
14. Other people's misfortunes do not usually disturb me a great deal.	A	B	C	D
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.	A	B	C	D
16. After seeing a play or movie, I have felt as though I were one of the characters.	A	B	C	D
17. Being in a tense emotional situation scares me.	A	B	C	D
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for him or her.	A	B	C	D
19. I am usually pretty effective in dealing with emergencies.	A	B	C	D
20. I am often quite touched by things that I see happen.	A	B	C	D
21. I believe that there are two sides to every question and try to look at them both.	A	B	C	D
22. I would describe myself as a pretty soft-hearted person.	A	B	C	D
23. When I watch a good movie, I can very easily put myself in the place of a leading character.	A	B	C	D
24. I tend to lose control during emergencies.	A	B	C	D
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.	A	B	C	D
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.	A	B	C	D
27. When I see someone who badly needs help in an emergency, I go to pieces.	A	B	C	D
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.	A	B	C	D

Appendix L

Scenarios used in Chapter Four

INSTRUCTIONS

Below are a number of scenarios describing situations that may be encountered while working with offenders generally or sex offenders in particular. Please could you read each scenario, describe your gut reaction to it, and rate it on the scale provided. Please be as descriptive as possible. Your responses are completely anonymous. Thank you.

A. You have spent the morning reading victim statements taken from 2 children who have been severely sexually abused by their step-father. The statements are graphic and written in the children's own words, including things like "he tried to put his thing up my bottom, but it hurt and I cried so he smacked me with something, but I don't know what because I was trying to hide. I didn't cry anymore", from a 6 year boy, and "when he put his thing in my fanny he pushed very hard and I was sick" from the boys 8 year old sister. As you are leaving the prison an officer you only know by sight comes up to you and says quietly, so no else can hear: "Hey, nonce-lover, been getting your kicks with the beasts this morning".

B. A prisoner seems to have taken you into his confidence, and talks to you a lot about his offending. Consequently you have built up a good working relationship with him. He's done 10 years of a life sentence for the attempted murder of an elderly woman, which he says was a robbery went wrong. The forensic evidence suggests a sexual element i.e. her breasts were exposed and her underwear removed, but he has consistently denied it and there was no sexual prosecution. One day he asks to speak to you privately, saying that there's something he wants to tell you that he has never told anyone before. After a long silence, during which he is very obviously nervous he says "I made her suck me 'til I came in her mouth, and told her if she said a word ever, I would come back and kill her. She never said a thing - she just stared at me crying, without a sound - she never told the police".

C. On reading the file you discover the victim would now be in her late 80's. A statement taken from the victim's son at the time of the offence tells of a very proud woman who has become totally withdrawn as a result of the assault and won't talk to anyone. His statement says, "I'm only glad she wasn't sexually assaulted - she could never live with that humiliation."

D. You are working with a group of prisoners, and one of them is talking about his offence. He gains confidence as he realises he has the attention of all around him. You know the general detail of his offence having read his file, but he's including details about things that weren't recorded. For example, he talks about rehearsing the abduction of his 10-year-old victim

several times, "I did a few dry runs, worked out how where I'd have to stand to pull her off her bike first time" and of masturbating at the scene before he actually committed the offence..."It really got me going. Best wank ever". During the offence he describes the child crying and pleading for her mum, and of taunting the girl by telling her he was going to get her mum next... "She just kept whimpering 'I want my mummy, I want my mummy', so I told her if she didn't shut it her "mummy" would get it next". He looks round the group and smiles.

E. You have recently been on a training course to learn different methods of working with prisoners who are trying to address their offending. Some of the techniques were new to you, and are difficult to use, but you're determined to get it right. One day, while working with a group of prisoners, you get into an argument with one particular group member who is denying that his victim suffered in any way. You know from the victim statements that this isn't the case, and that the woman he raped has attempted suicide twice, but because this information falls under the victim's charter, you can't say anything.

F. You end up getting into an argument with him, and feel indescribably frustrated that you can't make him see the damage he's caused. At the end of the session you feel really deflated. Just when you think all the prisoners have gone back to the wing, the prisoner in question comes back into the room, walks straight up to you, and through gritted teeth says "just what gives you the right to make judgements about me when you can't even do your job properly - 2 weeks training and you think your fucking Gods gift. Well you can fuck off, I'm not coming back here again," and storms out.

G. A prisoner who has been doing group work to address his sexual offending is required to keep a diary of thoughts and/or events that occur that could put him at risk of offending in future. During a routine cell search a bundle of papers is found in his cell that depict offences in which you are the victim.

H. As part of your job you are required to work closely with colleagues from other professions, but you are rarely given a choice about whom you work with. The work you do is stressful and is much easier when you all pull together. However, one of the team seems to you to be less competent and less committed to the work, resulting in you taking on more than your share.

I. You run offending behaviour groups for prisoners, and the group meets twice a week. The first few sessions were really difficult, with group members being really hostile and difficult, questioning the course, moaning constantly about prison and other staff, and questioning your competence to run groups. After an exhausting amount of effort, the group is now going well and the men are working quite hard. You and your co-workers have just finished planning what should be a really helpful session, when

another member of staff barges in and shouts, "no tea and sympathy today, it's bang-up", and slams the door shut.

J. For the last year you have worked as a facilitator for the Sex Offender Treatment Programme. It is a core part of your establishments business and contributes to national targets. However, your line manager has not included this work in your annual performance review, and hints at it being a "side-line". You end up with an "Almost Achieved" marking and the comment "Although all the targets were met, this was done with minimal effort. Too much attention was given to other areas.

K. While reading a prisoners file you come across a bundle of court papers, including victim statements and details of forensic evidence. The forensic evidence includes a Teletubbies duvet cover stained with semen and blood.

L. You are walking along the road on your way home after a days work. It's warm and bright and you are planning what to do for the evening. You notice an advertisement for a film that has just been released that you'd really like to see, so decide to phone a friend to make arrangements to go to the cinema.

M. You are shopping in the local supermarket. It's unusually quiet and every item on your shopping list is easily found. You find an empty check-out, with someone available to help with packing. Due to a range of special offers you bill is less than you thought. You finish shopping and go home and relax.

Appendix M

Consent Form

CONSENT FORM
For Participation in SOTP Impact Research

I confirm that I have been informed about the aims and procedures involved in this research. I reserve the right to withdraw at any stage in the proceedings, and information that I provide as part of the study will be destroyed, or my identity removed, unless I agree otherwise.

Signed: _____

Name (please print): _____

Establishment: _____

Date: _____

Appendix N

Chapter Four Pilot Study Data:
Means and F Ratios for Blood Pressure Measures at Baseline and in Response to Experimental Scenarios

	Baseline	S1	S2	F	p
SBP	118.75	119.63	119.13	0.11	0.98
DBP	74.62	73.75	72.75	0.66	0.54
HR	65.25	69.38	67.00	3.49	0.06

SBP=Systolic Blood Pressure; DBP=Diastolic Blood Pressure; HR=Heart Rate;
S1=Management Scenario; S2=Forensic Scenario

Appendix O

Treatment Manager Ratings used in Longitudinal Study

Facilitator.....

Establishment.....

Please rate the above named facilitator on the items listed below.
Thank you

A. Modelling (professional behaviour, anti-disciminatory behaviour/attitudes, self disclosure

1 2 3 4 5 6

Very poor Excellent

B. Treatment Style (is s/he warm, empathic, genuine, friendly, not overly directive?)

1 2 3 4 5 6

Very poor Excellent

C. Questioning Skills (use of Socratic questioning, cognitive restructuring)

1 2 3 4 5 6

Very poor Excellent

D. Positive reinforcement (reinforcement of change in attitudes or behaviour)

1 2 3 4 5 6

Very poor Excellent

E. Understanding of Sex Offending (does s/he work on the right areas, understand what information is relevant and what isn't?)

1	2	3	4	5	6
Very poor					Excellent

F. Group Process Skills (encouragement of participation, tolerance of emotion)

1	2	3	4	5	6
Very poor					Excellent

G. Personal Coping (ability to remain detached and objective, appropriate engagement with group members, enthusiasm)

1	2	3	4	5	6
Very poor					Excellent

Appendix P

Means for Each Testing Period on Each Psychometric Scale for Experimental and Control Groups

Measure	Experimental Group		Control Group	
	Mean	SD	Mean	SD
PES	9.39	(3.22)	10.00	(2.78)
APES	9.18	(2.72)	9.24	(3.01)
ZPES	8.82	(3.41)	9.91	(3.39)
NES	5.50	(3.28)	6.47	(3.36)
ANES	5.56	(4.04)	5.76	(2.91)
ZNES	7.18	(6.00)	4.55	(2.42)
CSQDET	42.96	(5.50)	41.00	(6.09)
ACSQDET	42.43	(5.73)	41.47	(5.65)
ZCSQDET	41.50	(6.86)	42.27	(2.97)
CSQRAT	20.04	(3.55)	19.00	(3.26)
ACSQRAT	19.39	(3.97)	18.82	(3.76)
ZCSQRAT	18.93	(3.81)	19.27	(2.87)
CSQAVOI	6.54	(3.44)	8.41	(2.55)
ACSQAVOI	7.39	(4.52)	7.35	(2.60)
ZCSQAVOI	7.36	(3.64)	8.09	(3.59)
ECQINH	3.46	(2.77)	6.41	(4.21)
AECQINH	3.89	(3.65)	5.76	(4.32)
ZECQINH	5.00	(4.03)	5.27	(5.68)
ECQRUM	4.04	(2.60)	6.29	(3.65)
AECQRUM	4.64	(93.34)	4.65	(3.72)
ZECQRUM	5.75	(4.05)	4.27	(2.83)
IRIFS	10.36	(3.56)	9.24	(4.48)
AIRIFS	9.89	(3.69)	7.65	(5.21)
ZIRIFS	10.29	(4.03)	11.45	(5.15)
IRIEC	15.28	(2.54)	15.24	(2.91)
AIRIEC	13.71	(3.14)	14.6471	(2.85)
ZIRIEC	13.64	(3.07)	14.64	(3.83)
IRIPT	16.00	(2.71)	17.59	(5.86)
AIRIPT	15.54	(2.92)	16.00	(2.40)
ZIRIPT	16.50	(2.44)	17.45	(2.70)
IRIPD	6.00	(2.71)	6.47	(2.96)
AIRIPD	6.36	(2.56)	5.18	(3.21)
ZIRIPD	5.21	(3.41)	6.27	(1.68)
CS	100.32	(11.51)	89.53	(12.51)
ACS	94.54	(18.99)	88.41	(13.30)
ZCS	90.75	(15.88)	96.36	(15.71)

PES=Postitive Emotional Sensitivity; NES=Negative Emotional Sensitivity; CSQDET=Detached Coping; CSQRAT=Rational Coping; CSQAVOI=Avoidance Coping; ECQINH=Emotional Inhibition; ECQRUM=Rumination; IRIFS=Fantasy; IRIEC=Empathic Concern; IRIPT=Perspective Taking; IRIPD=Personal Distress; CS=Compassion Satisfaction; Prefix A=Second Testing Period; Prefix X=Third Testing Period

Appendix Q

Repertory Grid Elicitation Instructions for Trainee Facilitators

1) How to Elicit a Grid

I) Present the cards to your partner in sets of three in the following combinations. You only need to see the numbers at this point, and this is important to maintain confidentiality and privacy.
1,2,3; 4,5,6; 7,8,9; 10,1,4; 2,5,7; 3,6,8; 4,7,10; 5,8,10; 6,7,10; 7,8,1; 9,10,2; 10,3,4; 5,7,1; 6,2,4.

II) After each presentation ask one of the following questions:

a) Tell me something that any of these two have in common which makes them different from the third?
Or
b) In what way are any two of these similar but different from the third?

III) Record the responses on a spare piece of paper then ask (if necessary)

How would you describe the others by contrast?

*NB. When you are responding you do not need to say which cards you are responding to.

You should end up with something looking like this:

Fun Loving	Serious
Happy	Sad
Calm	Chaotic
Friendly	Standoffish
.....	.....

2) Try laddering – be sensitive!

- The purpose of laddering is to learn more about what the constructs mean to an individual
- Choose some of the personal constructs that do not immediately seem to represent personal values e.g. Friendly vs Standoffish
- You do not necessarily know which is the preferred position for you partner and you shouldn't guess or make assumptions
- Laddering is a way of finding out

3) Laddering Example

- Ask "If you could chose between 'friendly' and 'standoffish' which would you choose?
- The answer may be "On the whole I prefer to be standoffish"
- Underline the word STANDOFFISH

- Then ask "Why is it important to you to be standoffish rather than friendly
- The answer may be "If you are standoffish it gives you time to suss things out and not be gullible"
- Write down under 'standoffish' 'time to suss things out'
- Check with your partner the contrast of 'time to suss things out'...the answer might be 'gullible
- Your ladder should now look something like this

Friendly.....Standoffish
Gullible.....Time to suss things out

- You could then ask one more time "In general, which do you prefer, to have time to suss things out or to be gullible?"
- Answer: "It's pretty obvious really, I don't want to be gullible"
- Question: "So what is the advantage for you in having time to suss things out?"
- Answer: "Well if you have time to suss things out you stay in control, and that's very important to me...I never want to lose control".
- The Ladder finally looks like this

Friendly.....Standoffish
Gullible.....Time to suss things out
Lose control....In control

- The underlying personal construct or core value for this person is about control. S/he will resist losing control whenever possible so s/he cannot chose to be friendly
- Ladder one or two of the personal constructs on your list so that the underlying values are revealed

4) Constructing your own grid

- Retrieve your list of constructs elicited by your partner and choose at least 10 that really matter to you
- On the blank grid in your information pack write out your constructs in the column provided, putting the construct you prefer in the left hand column and the contrasting construct in the right hand column
- Score each element (scenario) on each of your constructs on a scale of 1-6, in terms of how likely that scenario is to evoke that pole of that construct

1=the negative end of the construct 6=the positive end of the construct

ß CONSTRUCTS	ELEMENTS
Not being able to switch off from work	
Seeing a man in the park watching a chil	
A colleague being derogatory	
Seeing a child alone and distressed	
Your treatment style being commended	
Seeing a group member change for the better	
Being supported by colleagues	
Being told by your partner that you have mood swings	
Feeling as if other professionals value your opinion	
Feeling mentally and physically exhausted	
ß CONSTRUCTS	

Appendix S

Attitude to Sex Offenders Scale

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The statements listed below describe different attitudes towards sex-offenders in prisons in the United Kingdom. There are no right or wrong answers, only opinions. You are asked to express <u>your</u> feelings about each statement by indicating whether you (1) Disagree Strongly, (2) Disagree, (3) Agree, or (4) Agree Strongly. Indicate your opinion by writing the number that best describes your personal attitude in the left-hand margin. Please answer <u>every</u> item.

RATING SCALE

1	2	3	4
Disagree Strongly	Disagree	Agree	Agree Strongly

_____ 1. Sex-offenders are different from most people.

_____ 2. Only a few sex-offenders are really dangerous.

_____ 3. Sex-offenders never change.

_____ 4. Most sex-offenders are victims of circumstances and deserve to be helped.

_____ 5. Sex-offenders have feelings like the rest of us.

_____ 6. It is not wise to trust a sex-offender too far.

_____ 7. I think I would like a lot of sex-offenders.

_____ 8. Bad prison conditions just make a sex-offender more bitter.

_____ 9. Give a sex-offender an inch and he'll take a mile.

_____ 10. Most sex-offenders are stupid.

_____ 11. Sex-offenders need affection and praise just like anybody else.

_____ 12. You should not expect too much from a sex-offender.

_____ 13. Trying to rehabilitate sex -offenders is a waste of time and money.

_____ 14. You never know when a sex-offender is telling the truth.

_____ 15. Sex-offenders are no better or worse than other people.

_____ 16. You have to be constantly on your guard with sex-offenders.

_____ 17. In general, sex-offenders think and act alike.

_____ 18. If you give a sex-offender your respect, he'll give you the same.

_____

_____ 19. Sex-offenders only think about themselves.

_____ 20. There are some sex-offenders I would trust with my life.

_____ 21. Sex-offenders will listen to reason.

_____ 22. Most sex-offenders are too lazy to earn an honest living.

_____ 23. I wouldn't mind living next door to an ex sex-offender.

_____ 24. Sex-offenders are just plain mean at heart.

_____ 25. Sex-offenders are always trying to get something out of somebody.

_____ 26. The values of most sex-offenders are about the same as the rest of us.

_____ 27. I would never want one of my children dating an ex sex-offender.

_____ 28. Most sex-offenders have the capacity for love.

_____ 29. Sex-offenders are just plain immoral.

_____ 30. Sex-offenders should be under strict, harsh discipline.

_____ 31. In general, sex-offenders are basically bad people.

_____ 32. Most sex-offenders can be rehabilitated.

_____ 33. Some sex-offenders are pretty nice people.

_____ 34. I would like associating with some sex-offenders.

_____ 35. Sex-offenders respect only brute force.

_____ 36. If a sex-offender does well in prison, he should be let out on parole.