# An exploration into the impact of care staff attitudes towards men who have sexually offended.

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## Abstract

**Background:** Understanding attitudes towards men who have sexually offended has been a research interest for many years. The existing research provides inconsistent findings, making it difficult to draw firm conclusions regarding the factors that are related to the attitudes that people hold towards men who sexually offend. This is an important area to understand, both for society, and for institutions that detain men who have sexually offended. Attitudes towards men who have sexually offended is related to the way in which the men engage in therapeutic treatment and also the way in which they can be successfully re-integrated into society. The thesis is motivated by a need to better understand the factors that are associated with the attitudes that people hold towards men who sexually offend and what changes are required to clinical practice to make positive improvements. Though each chapter is presented in sequence, they can be regarded as four independent studies, each of which utilise a different methodological design but are thematically linked.

**Aims and Objectives:** The overarching aim of the thesis is to further explore the factors that are associated with attitudes towards men who sexually offend and the effect that attitudes have on rehabilitation and re-integration. The four research questions were;

1. What does existing literature tell us about staff attitudes towards men who have sexually offended? How do these attitudes impact on the care and treatment provided?
2. Do the attitudes towards men who have sexually offended of forensic healthcare staff and the general public differ based on gender, levels of exposure and duration of exposure?
3. Is the Attitudes towards Sex Offenders Scale (ATS; Hogue, 1993) a psychometrically robust tool and should it continue to be so widely used?
4. What are the benefits of taking a narrative humanisation approach to staff training? Is it an effective method to encourage staff to privilege more positive narratives over less positive ones and what impact does it have on clinical practice?

**Method:** Four different research methods were employed to answer the four research questions. A systematic review was conducted to explore the existing literature base and data were synthesised to determine what factors are empirically supported as important in relation to attitudes towards men who sexually offend. An empirical research study was conducted to determine whether any differences were apparent based on gender of participants and the type and the duration of exposure to men who sexually offend. An online questionnaire was employed and data were statistically analysed using t-tests, Analysis of Variance (ANOVA) and post-hoc Newman-Keuls analysis. Research question three was answered by critiquing

the psychometric properties of the ATS, a tool which has been widely used in the attitudinal literature for many years. Finally, research question four is answered using a case study exploring the effectiveness of a narrative humanisation staff intervention as an alternative to traditional classroom based training.

**Overall Findings:**

1. The systematic review found a number of different factors that were important when considering the attitudes people hold towards men who have sexually offended; exposure, job role and gender. However, it also suggested that many findings were inconsistent between studies. As a result, the aim of chapter three was to further explore the factors.
2. The results from the empirical research study concluded that the gender of the participant did not relate to attitudes towards men who have sexually offended. Exposure was important; the general public who were not generally exposed to men who have sexually offended had significantly more negative attitudes in comparison to professionals and paraprofessionals who were exposed to the offenders in their work. The duration of this exposure did not influence attitudes.
3. The psychometric critique of the ATS suggests that the tool has a number of shortcomings in terms of validity and reliability. Therefore, the ATS may not be the most robust assessment of

attitudes because of the way in which it was adapted. Consequently, chapter five utilised alternative attitudinal measurements.

4. The narrative humanisation intervention demonstrates the strength of applied learning tasks to enhance changes in routine practice. A Reliable Change Index (RCI) evidences significant change in the positive attitudes and perceptions of staff when considering men who have sexually offended.

**Conclusion:** A number of factors are relevant when considering the attitudes that people hold towards men who sexually offend. Positive and negative attitudes impact on the care, treatment and re-integration options provided to men who have sexually offended. Enhancing the understanding of the impact of these attitudes allows for changes in therapeutic treatment, including strength-based approaches. It also promotes changes to clinical practice, for example alternative methods of training, whilst maintaining the risk-need-responsivity principles. In addition, it allows for the promotion of positive care to create an environment more conducive to rehabilitation.

## Statement of Authorship

Chapter two has been published in Aggression and Violent Behavior.

Challinor, L.E., & Duff, S. (2018). Factors influencing the development of attitudes towards men who sexually offend and the impact on their care and treatment: A systematic review between 1985 and 2015. *Aggression and Violent Behavior, 41,* 98-107.

Chapter three has been published in the Journal of Forensic Nursing.

Challinor, L., & Duff, S. (2019). Forensic Staff Attitudes Toward Men Who Have Sexually Offended: A General Public Comparison. *Journal of Forensic Nursing*.

Research linked to the aims of the thesis has been published in the Journal of Forensic Practice. This paper was co-authored by Dr Simon Duff from the Centre of Family and Forensic Psychology at the University of Nottingham.

Challinor, L.E., & Duff, S.C. (2017). Sexual offending hierarchies, personality attributes, and the clinical implications. *The Journal of Forensic Practice, 19*(3), 190-197.

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# Chapter One

# General Introduction to the thesis

## A Conceptualisation of Attitudes

According to the World Health Organisation, sexual offending constitutes a significant public health issue, and a public health approach to sexual violence offers greater hope for prevention. From a public health perspective, the focus of intervention becomes broader than the traditional 'treatment' focus and the conditions that support men who sexually offend (MSO) to desist become a central consideration. Essentially, the public health perspective encourages services to consider both the internal and external factors that would promote a healthy and harm free lifestyle. One factor that has been shown to constitute to such a good life, is the reintegration of men into communities (Laws & Ward, 2011). Although there are a range of factors that influence the success of reintegration, a recurring finding has been the nature and degree of social acceptance, with those men who fail to experience successful reintegration being more likely to re-offend (Laws & Ward, 2011). Amongst those issues that appear to influence reintegration are the attitudes that men experience as a result of their crimes. Not only do more general attitudes affect reintegration, so do the attitudes held by individuals working in secure services and MSO's integration into therapeutic

services. Attitudinal influence plays a role in this. Tewksbury (2012) found that when MSO were due to be released from prison, they received stigmatising communication from the community. Consequently, this produced feelings of shame and hopelessness. This therefore highlights the importance of understanding how socially stigmatised individuals such as MSO may or may not be affected by the attitudes that people hold towards them. This offers both theoretical and practical benefits.

Attitudes are defined as "psychological tendencies that are expressed by evaluating a particular entity with some degree of favor or unfavor" (Eagly & Chaiken, 1993, p.1). Breckler (1984) suggested attitudes comprise of three distinct components: (1) *cognition* – relating to types of beliefs that a person holds about something; (2) *affect* – relating to the intuitive emotional response towards something; and (3) *behaviour* – relating to the ways that people act towards something. When conceptualised in this manner it would seem apparent that broadly held attitudes will have an impact on the degree of acceptance for MSO and an understanding of the influence of attitudes would therefore seem important. Although there has been previous research examining attitudes towards MSO (e.g. Hogue, 1993), Hogue (2015) notes that not all researchers have comprehensively considered the three distinct components of attitudes. Much of the existing attitudinal research actually appears to explore perceptions (e.g. Church *et al.,* 2008), which are said to

be similar to stereotyped beliefs as opposed to knowledge-based attributions (Jussim, 2012). The exploration of attitudes rather than perceptions encourages the development of a more thorough understanding of the affective responses that one holds towards something, in this case, MSO. As a result, this thesis will utilise the three factor definition of attitudes throughout whilst also considering Eagly and Chaiken's (1993) definition; "psychological tendencies that are expressed by evaluating a particular entity with some degree of favor or unfavor". This definition was chosen as it was thought to most accurately reflect the aims of the attitudinal literature exploring MSO.

**Offending and re-offending**

The recorded prevalence of sexual offending in England and Wales in the year ending March 2017 had increased by 14% compared with the previous year (Office for National Statistics, 2018). This increase is at a new high, with 72% of 76,794 Multi-Agency for Public Protection Arrangements (MAPPA) registered offenders being sexual offence perpetrators (MAPPA Annual Report, 2016-2017). MAPPA ensure the successful management of violent and sexual offenders in the community by guiding the responsibilities of different organisations. An exact prevalence rate of the number of men who have committed sexual offences and are residing within secure forensic facilities within the United Kingdom is not currently known.

MSO are one of the lowest recidivist offender populations with an average re-offending rate of 15.5% (Ministry of Justice, 2017). Despite this, MSO are often perceived as the worst kind of offenders (Feldman & Crandall, 2007). Therefore, it is important that the current understanding of attitudes towards this population group is explored due to the psychological harm caused, to determine if changes to best practice are required, and if so, what changes need to be effectively implemented to have a positive effect on recidivism rates.

**Measuring attitudes**

Over the past two decades there has been an abundance of research conducted regarding attitudes and perceptions towards MSO. However, as discussed earlier this research reflects differing definitions of attitudes and some research claiming to measure attitudes actually measures perceptions (e.g. Church *et al*, 2008). Researchers have used a number of different methods to examine attitudes, some more valid and reliable than others. Perhaps most widely known and commonly used due to its valid and reliable psychometric properties is the Attitudes Towards Sex Offenders Scale (ATS; Hogue 1993). Adapted from the Attitudes Towards Prisoners Scale (ATP; Melvin, Gramling & Gardner, 1985), the 36-item ATS was designed to examine affective and evaluative judgements about MSO using self-report. The items consist of negative and positive attitudinal statements, which participants respond to on a 5-point

Likert-type scale. The ATS has consistently evidenced very good internal consistency ($\alpha$ >0.85) using a range of different samples including prisoners, prison officers and forensic healthcare staff (e.g. Blagden *et al.,* 2016; Craig, 2005; Ferguson & Ireland, 2006). The ATS comprehensively examines all three components of attitudes (Harper, Hogue & Bartels, 2017).

The Community Attitudes Towards Sex Offenders scale (CATSO; Church, Wakeman, Miller, Clements & Sun, 2008) is also widely used within the literature. The 18-item self-report measure uses a 6-point Likert-type scale for respondents to answer 18 statements regarding perpetrators of sexual offences. However, Harper, Hogue and Bartels (2017) have criticised the CATSO for claiming to explore attitudes, despite the statements actually examining knowledge-based attributions. Therefore, the CATSO is considered a measure of perceptions and researchers have suggested a partial or complete overhaul of the CATSO (e.g. Harper & Hogue, 2015; Shackley, Weiner, Day & Willis, 2014).

Another consideration in attitudinal research concerns the validity of self-report measures, highlighting the difficulty in determining whether respondents may answer in a socially desirable or politically appropriate manner; thus, attitudinal research may not reflect individual's true beliefs about MSO. By way of overcoming this, researchers have utilised indirect methods such as the Implicit

Association Test (IAT; Greenwald, McGhee & Schwartz, 1998). This method allows researchers to examine how fast a respondent categorises stimuli into a category (e.g. sex offenders - bad). Response times enable researchers to conclude how strongly participants associate certain categories, which would infer how positive or negative they feel towards MSO. Harper *et al.,* (2017) claim that there are numerous benefits in utilising such procedures when examining attitudes towards MSO, due to the focus being socially controversial.

'Positive' and 'negative' attitudes are referred to throughout the thesis to remain consistent with existing published literature. Although these cannot be quantified, they are used to support the reader to establish the differences in attitudes held by different people and to allow this identification to be concrete.

**Underlying Factors**

The current literature highlights a range of factors that seem to have a relationship with attitudes. Harper, Hogue and Bartels (2017) highlighted in a recent review that existing literature is mostly descriptive in nature and researchers have used a measure such as the ATS to identify differences in attitudes between different populations. However, it is also important to consider the contributory factors to attitudinal development and correlates to

change. Some contributory factors have been found to be more concrete than others.

*Gender*

The impact of gender on the nature of attitudes is unclear due to inconsistent findings. Craig (2005) found that ATS scores did not vary as a function of gender. Contrary to this, Ferguson and Ireland (2006) found men to have less positive attitudes towards men who offend against children, whereas women had overall more positive attitudes regardless of offence type.

*Age*

Another variable that may influence attitudes is age, although findings within the literature are also inconsistent. Craig (2005) found that participants aged 35 and over held more positive attitudes regarding the rehabilitation opportunities of MSO compared to younger participants. Similarly, Kjeslberg and Loos (2008) found that increasing age correlated positively with positive attitudes.

*Working with MSO*

Another factor found to have an important impact on the nature of attitudes is job role and type of exposure to MSO. Numerous authors (e.g. Blagden *et al.,* 2016; Gakhal & Brown, 2011; Hogue & Peebles, 1997; Jung *et al.,* 2012) have found that those working with MSO, particularly in treatment-based capacities, hold more positive

attitudes. However, those who are exposed in other capacities, for example criminal justice officials or police officers, have been found to hold more negative attitudes (Day *et al.,* 2014; Kjelsberg & Loos, 2008). It is hypothesised that these differences may be due to people holding less negative attitudes being attracted to jobs that require working in a positive manner with MSO. This view is supported by the fact that training on working with MSO has provided little evidence to suggest that it can improve attitudes any more than having no training at all (Craig, 2005; Simon & Arnaut, 2011). Therefore, it is likely that individuals with existing positive attitudes increase their positivity through being exposed to MSO.

*Parental status*

Another important variable is parental status. Parents have been found to be more fearful of MSO in comparison to individuals without children (Levenson *et al.,* 2007).

*Victim status*

The victim status of an individual has also been found to relate to the nature of attitudes. Katz-Schiavone *et al.,* (2008) found no differences between those who have, or have not been sexually victimised. However, Ferguson and Ireland (2006) found that those who reported being victims of sexual abuse, or knew someone who had, viewed MSO less negatively than those who had not been victimised.

*Offender characteristics*

Specific details about offender type have been found to impact on people's attitudes; older male offenders with assumed "*bad reputations*" are judged more negatively (Harper, 2012; Cohn, Dupuis and Brown, 2009).

**Clinical and Practical Implications**

This thesis aims to further explore the clinical and practical implications of differing attitudes towards MSO. There are a number of reasons why this is important. First, at a societal level, research has suggested that MSO are portrayed negatively within the media (e.g. Harper & Hogue, 2015[b]). Researchers have also found that tabloid newspapers describe perpetrators of sexual offences with more offensive language than that used by broadsheets (Harris & Socia, 2014). It appears that an exclusive focus on the label of 'sex offender' is distinct in contemporary society (Harris & Socia, 2014). This label is inevitably burdened with negative connotations and assumptions that are often ill-informed; however it is the extent of the negativity that is problematic. In a study analysing the linguistics used in the reporting of sex crimes, Harper and Hogue (2014[b]) found that language is angrier and more emotionally negative compared to reports of non-sexual crimes. The research also concluded that differences could be observed in use of headlines between tabloid and broadsheet newspapers, but the main bodies of text used similar

linguistics. 41% of articles had headlines including the words 'monster', 'fiend', 'beast', 'paedo' or 'pervert'. As a result, the evidence suggests that media portrayals can influence public attitudes and public attitudes reflect the dominant media representation of these men (Harris & Socia, 2014). Furthermore, MSO are perceived to be at high-risk of recidivism and not amenable to treatment (Harper and Hogue, 2014[b]), despite this not being reflected by the official figures previously referred to.

The dominant portrayal of MSO is likely to cause the general public to adopt stereotyped beliefs which can lead to stigmatisation (Tewksbury, 2012). Whilst some stereotyped beliefs may be reasonably proportionate to the crime committed, others are based on what is believed to be inaccurate information, leading to stigma and discrimination. This can inhibit efforts to reintegrate due to difficulties that include; finding housing or employment, both of which are linked to maintaining desistance from future offending (e.g. Laws & Ward, 2011; Willis & Grace, 2009). Furthermore, there is potential for a lack of societal support to have detrimental consequences for levels of self-esteem (Tewksbury, 2012), low levels of which are linked to higher rates of sexual recidivism (Thornton, Beech & Marshall, 2004).

A further clinical implication concerns the impact that attitudes have on the psychological welfare of the men who commit sexual offences.

MSO are known to have increased feelings of hopelessness and worthlessness (Stinson, Becker & Tromp, 2005), and it seems possible that stigmatising attitudes will exacerbate such feelings. It is suggested that these feelings may be aggravated if the MSO get a sense of stigmatisation from the people who are caring for them. In an institutional context where staff uphold stigmatising attitudes, there is risk of malignant alienation becoming established. The term malignant alienation is described by Watts and Morgan (1994) and refers to deterioration in relationships between staff and patients due to staff losing empathy for patients or perceiving behaviour as intentionally provocative or unreasonable, evoking strong negative emotions. It is possible that under these circumstances, cultures evolve that allow attitudes to be acted out; an experimental example of this is the Stanford Prison Experiment (Zimbardo *et al.,* 1971), where negative attitudes towards prisoners facilitated negative behaviour towards prisoners. Zimbardo termed this *'The Lucifer Effect'*.

Such issues can become particularly problematic if patients are thought to be difficult to treat (Colson *et al.,* 1985). Consequently, Marshall (2005) advised that therapists involved in the treatment of MSO should be warm and non-confrontational. This may encourage motivation and thus have a more positive impact on one's willingness to engage and achieve positive outcomes. Whilst the literature focuses on the therapist's attitudes towards MSO, these men will have

a range of *therapeutic* relationships with non-therapy staff that can have a similar influence on their experience of acceptance. Indeed, part of this research is aimed at exploring the wider professional attitudes towards men who are detained due to their convictions of sexual offences, rather than simply exploring those who are the treatment provider/therapists.

The importance of attitudes of treatment providers (in the broadest sense) is perhaps reflected in the new generation of treatments and interventions. These newer therapeutic interventions are now taking an increasingly strength-based approach, as opposed to the previous heavily deficit-focussed approaches (Willis, Yates, Gannon & Ward, 2013). Strength-based approaches focus on criminogenic needs as targets to strengthen, rather than deficits to eradicate. Such programmes achieve a range of treatment targets and reduce recidivism (Marshall, Marshall, Serran & O'Brien, 2011). Thornton (2013) suggests that engagement is enhanced when treatment is strength-focussed rather than deficit focussed. However, in order to deliver a strength-based approach to treatment, it seems important that staff delivering therapy hold positive attitudes to support successful rehabilitation (Marshall, 2005; Miller, 2006).

This thesis will add to the literature base to help develop a better understanding of attitudes towards MSO and to consider the clinical and practical implications.

## Thesis Aims

The aims of this thesis are to explore and expand on the existing literature that describes attitudes towards men who commit sexual offences. Furthermore, the thesis will consider the clinical and practical implications of these attitudes. The thesis is motivated by the public health conceptualisation and the recognition that shame and social rejection can fuel further offending. Understanding how attitudes can contribute to the process is therefore important. Though presented in sequences, the chapters can be regarded as independent studies utilising a variety of different methodologies linked by a common theme of enquiry.

Chapter one provides an overview of the literature on attitudes towards MSO and considers some of the important factors thought to be associated with attitudes towards MSO. Chapter two reports on a systematic review of attitudes towards MSO and considers the relationship the attitudes have with the care and treatment provided to MSO. Chapter three reports on an empirical research study that aims to further explore differences in attitudes between different groups of people, and add further data to the literature base regarding the variables that influence the nature of attitudes. Chapter four critically appraises the psychometric properties of the Attitudes Towards Sex Offenders Scale (ATS; Hogue, 2003), considering the validity and reliability of the tool. Chapter five reports on an

alternative method to traditional classroom based training, utilising a narrative humanisation intervention. This approach is evaluated to determine the effectiveness of influencing attitude change. Finally, chapter six brings together the findings of each of the chapters and considers the clinical implications. Future research ideas are discussed, which encourages additions to the evidence base.

## Chapter Two

## Factors influencing the development of attitudes towards men who sexually offend and the impact on their care and treatment: a systematic review.


### Abstract

**Background:** Research has investigated the attitudes of a range of professional and paraprofessional staff who are exposed to men who have sexually offended. The evidence emerging from this work suggests that many factors appear to relate to the nature of attitudes, including the number of years in their job, gender, or parental status.

**Objectives:** The aim of this review is to explore these factors to determine the influence they have on the attitudes of staff and how these attitudes subsequently influence the care and treatment provided to men who sexually offend.

**Method:** An electronic search of seven bibliographic databases was conducted to identify primary research studies in addition to scanning reference lists of existing studies and contacting experts in the field. The search generated 13,987 hits. After scanning the titles and abstracts, 51 papers were subject to the exclusion criteria. A total of 13 studies met the inclusion criteria and were included in the final synthesis process.

**Results:** A number of factors appear to be important when exploring the relationship between attitudes and the care and treatment

provided to men who sexually offend. These include factors within the domains of cognitive, affective and behavioural attitudes.

**Conclusions:** The papers highlighted a range of factors that relate to the nature of attitudes. These factors appear to influence the flavour of attitudes and the nature of attitudes is seen to be an influencing factor in terms of the quality of relationships between men who commit sexual offences and professional staff. However, the definition of attitudes needs to be more carefully applied to empirical research. Results collected from the studies provide suggestions regarding the clinical implications.

**Key words:** sexual offenders; attitudes; treatment; rehabilitation; desistance.

## Introduction

### Background

Men who sexually offend (MSO) are assumed the worst offence perpetrators within society (Feldman & Crandall, 2007). This is not surprising given the way that this perpetrator group is represented in the media, which is often factually inaccurate. Great emphasis is placed on the label of 'sex offender' (Harris & Socia, 2014) and the accompanying negative connotations which include the words 'monster', 'fiend', 'beast', 'paedo' or 'pervert' (Harper & Hogue, 2014[b]). Despite this, many professionals and paraprofessionals choose to work with MSO and are willingly exposed to this population regularly. Previous research has explored the differences in attitudes towards MSO between different professions. This includes police, prison and probation officers, psychologists, nurses and criminal justice officials (e.g. Ferguson & Ireland, 2006; Jung *et al.,* 2011). In addition, studies have compared professional attitudes with those of the general public and have found that those who work with MSO hold more positive attitudes (e.g. Challinor & Duff, 2015). Furthermore, positive attitudes are linked to more positive treatment outcomes (Marshall, 2005). To examine the influence of the therapist within treatment for MSO, Marshall (2005) used video recordings of the delivery of treatment programmes within HM Prison Service. Raters experienced in the delivery of treatment for MSO independently rated the features of the therapists. Kappa statistics

determined the degree of agreement between raters. To determine the influence of therapist characteristics, pre and post assessment measures were correlated with characteristics. Empathy, warmth, rewardingness and directiveness were positively related to indices of behavioural change. Marshall (2005) concluded that a variety of therapist characteristics appeared to have an influence on treatment-induced benefits, more so than the procedures specified within the treatment manual.

As such, it is important to gain an understanding of the important factors influencing the nature of attitudes and to understand the relationship between attitudinal content and the quality of care and treatment for MSO. Historically, there have been concerning reports of abuse occurring in institutionalised settings due to a negative attitudinal climate taking hold. Examples include the Stanford Prison Experiment and more recently the Winterbourne View scandal (Flynn, 2012) which highlighted a range of behaviours and attitudes that were demonstrated by staff and impacted on the quality of care provided to individuals in the hospital.

**Existing Knowledge**

A number of empirical studies have explored the factors that underpin attitudes towards MSO and how attitudes impact on their care and treatment. A recent non-systematic review of the attitudinal literature highlighted a number of important factors regarding staff

attitudes towards MSO (Harper, Hogue & Bartels, 2017). These include demographic influences, offence related influences and professional influences. In addition it was found that a number of factors play a role in the malleability of attitudes. These include professional training programmes, social education programmes and the use of labels, such as 'sex offender' or 'a man who has committed an offence of a sexual nature'. The authors conclude that staff attitudes towards MSO play an important role in the care and treatment of this perpetrator group. Therefore, it is important to understand the role that staff attitudes may play in motivation of MSO to engage in treatment and the desistance from engaging in sexually harmful behaviours.

## The role of staff in desistance

### *Research Evidence*

Protective factors are important in facilitating change and supporting the desistance process (Ward & Laws, 2011). A stable environment, pro-social support, intimate relationships, employment, ageing, cognitive transformation, spirituality and military service have all been identified as factors important in facilitating change and achieving desistance (Hanson & Morton-Bourgon, 2005; Hanson & Harris, 2000; Hepburn & Griffin, 2004; Laws & Ward, 2011; Willis & Grace, 2009). Despite this knowledge, treatment programmes have historically been deficit focussed (e.g. Marlatt, 1982) which may

increase feelings of worthlessness and low self-esteem due to focussing on an offender's negative characteristics rather than their potential strengths. Both factors are linked to increased risk of recidivism (Thornton, Beech & Marshall, 2004). Therefore, the more recent implementation of strength-based theoretical programmes such as those utilising the Good Lives Model (GLM; Ward & Stewart 2003) addresses attitudes and reflects the need for a positive alliance. Although there are extensive evidence-based directives for sex offender treatment (Laws & Ward, 2011), there is also evidence to suggest that treatment may only be successful if the man perceives the therapist to have positive characteristics that one believes to support their rehabilitation (Marshall, 2005). These include non-judgemental attitudes and warm, approachable characteristics (Marshall, 2005). This would seem to suggest that it is important for staff to adopt positive attitudes that are supportive of treatment and rehabilitation, which may subsequently have the potential for positive change and desistance.

### *Theoretical Evidence*

The GLM (Ward & Stewart, 2003) can be used to direct treatment towards equipping offenders with the skills and knowledge to attain the primary goods highlighted as being necessary for desistance. This is an alternative to placing an emphasis on risk factors and avoidance of high-risk situations as in the Relapse Prevention Model (Laws,

1989). However, utilising both models in line with the Risk Need Responsivity Model (RNR; Andrews & Bonta, 2006) increases the emphasis on all of the factors important to maintain desistance and support reintegration into the community.

Staff who work with MSO require an understanding of the desistance process, which is considered a complex process of change (Bushway, Thornberry & Krohn, 2003), to ensure they are equipped with the knowledge and skills to support this process adequately. The Integrated Theory of Desistance from Sexual Offending (ITDSO; Gobbels, Ward & Willis, 2012) was designed as a complimentary model to further understand the psychological processes within desistance. The ITDSO explains the desistance process in four phases; decisive momentum; rehabilitation; re-entry; and normalcy. Particular emphasis on the role of staff is placed within phase two; rehabilitation. The rehabilitation phase places importance on thorough assessment and formulation of the offender's difficulties, goal setting and intervention. By working with the offenders to identify important primary goals, staff begin to develop an understanding of the needs of the offender beyond their label, which are influenced by the media representations of labels discussed in chapter one. Increased understanding allows for more effective support to facilitate change. On balance, it seems there is sufficient evidence and sufficient concern within the clinical and professional arenas to develop greater insight and understanding into the

relationship between staff attitudes and the care and treatment provided to MSO.

**Objectives**

The primary objective of this systematic review is to (1) examine the factors that relate to the nature of attitudes, and (2) to consider how these attitudes relate to the care and treatment provided to MSO. The definition of attitudes that is provided in chapter one of the thesis will be applied to all studies. Those studies that are not considered to adequately apply this definition will be excluded from the synthesis.

**Method**

A comprehensive search was undertaken to systematically identify literature that explores factors that influence the nature of attitudes towards MSO (1), and how these attitudes affect the care and treatment of this group of perpetrators (2). Inclusion and exclusion criteria were applied and the quality of the included literature was critically appraised and the evidence synthesised.

**Search Strategy and Information Sources**

The search strategy comprised the following main elements; (1) searching of electronic databases, (2) contact with experts (considered to be those with frequent publications in the literature); and (3) scanning bibliographies of retrieved papers. The following electronic databases were searched between May and July 2015:

psycINFO, Medline, Embase, Web of Science, ASSIA, psycARTICLES, and SCOPUS.

The following search terms were developed from a thorough search of the literature to ensure inclusivity. Necessary modifications were made dependent upon the database being searched.

*(nurs* or psycholog* or counsel* or staff or professional* or paraprofessional* or prison officer* or prison staff or psychiatrist or therapist) AND (male sex* offen* or sex* abuse* or sex* assault or p#dophile or rapist or child molest* or indecent assault or exhibition* or internet sex* offender or contact sex* offen* or non-contact sex* offen* or perpetrator not victim) AND (attitud* or perception* or behavi#r or perspective*) AND (prison or forensic or hospital or secure or psychiatric or community).*

## Inclusion and Exclusion Criteria

### *Inclusion Criteria*

Initial screening of study titles and abstracts was conducted using the following inclusion and exclusion criteria.

***Population/Exposure***: staff of any profession (i.e. professional or paraprofessional; staff to whom a particular aspect of a professional task is delegated, but who is not licensed to practice as a fully qualified professional) working with male perpetrators of any sexual offence. Participants must work within a forensic service.

***Outcome:*** the outcome of the study must focus on attitudes and/or the relationship with the care/treatment of adult men who sexually offend.

***Study Types:*** cohort studies using professional and paraprofessional staff were included in the review. Only studies published after 1985 were included as this coincides with the publication of the Attitudes Towards Prisoners Scale (ATP; Melvin, Gramling & Gardner, 1985) which generated further interest in the research area.

***Exclusion Criteria***

Studies exploring attitudes towards female sex offenders were excluded due to the limited literature available and the likely variance between attitudes towards female sex offenders. Studies using the Community Attitudes Towards Sex Offender (CATSO) scale (Church *et al.,* 2008) were excluded due to the criticisms discussed in chapter one. Based on the conflicting evidence, a decision was made to exclude the CATSO from the synthesis to reduce the risk of jeopardising the quality. Articles using solely qualitative methods were excluded to provide a more concise synthesis.

**Study Selection**

Studies that did not meet the inclusion criteria were excluded. Three references were identified and access could not be gained, therefore authors were contacted. Studies were omitted from the review if no reply was received within three months. Replies from experts were

also limited to a three-month time period. No replies were received and therefore no further information was obtained.

Figure one demonstrates the search outcomes and the systematic review process.

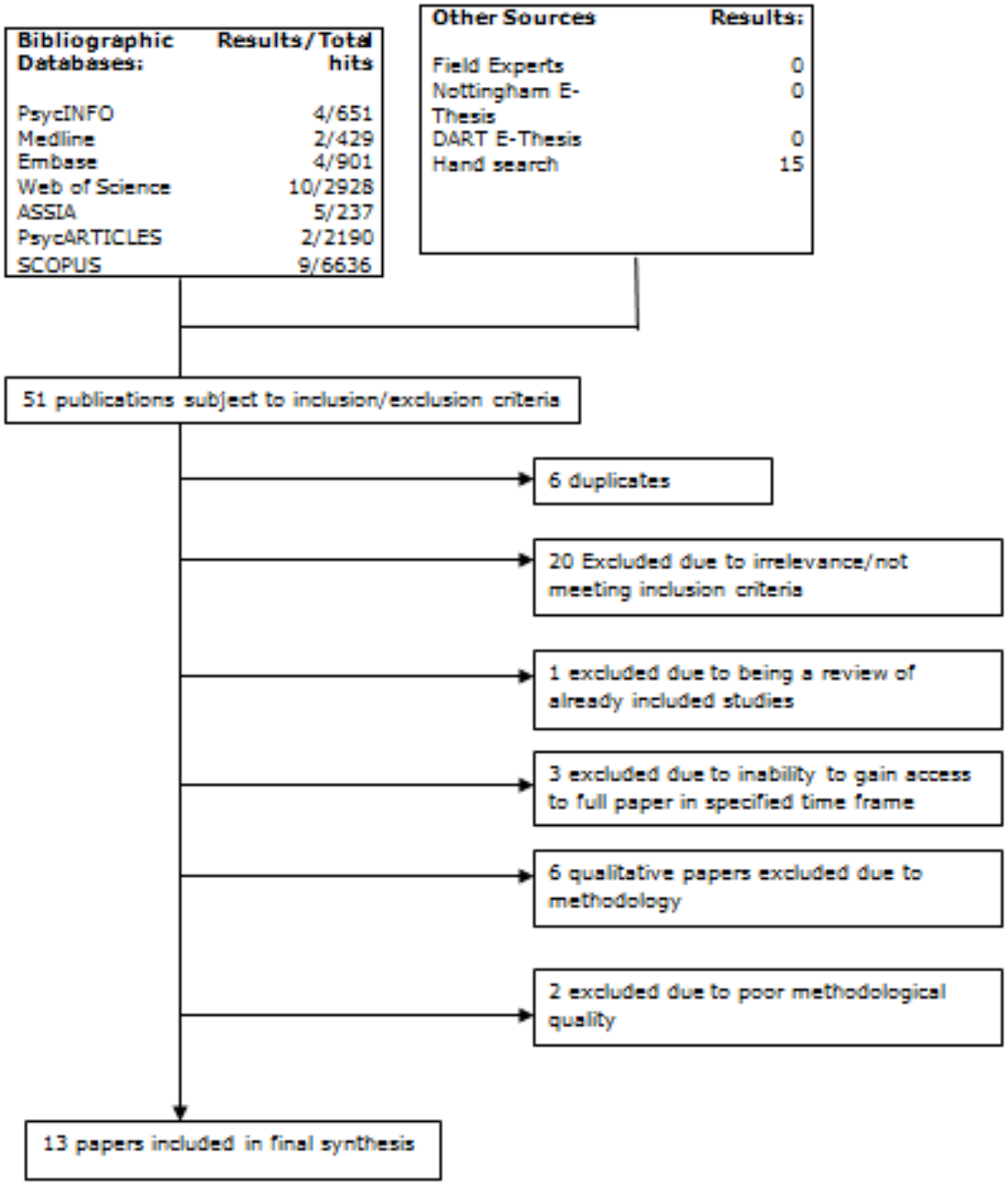



Figure One. Search outcomes and systematic review process.

## Quality Assessment

To assess the risk of bias within the studies, core quality domains focussed on areas including reporting bias, researcher bias, measurement bias and the management of confounding variables. The Critical Appraisal Programme checklist for cohort studies (CASP; 2013) was adapted; this version can be found in appendix a. In particular, items were scored to enable numerical comparison of quality. Domains were scored 'yes' (2), 'partial' (1), 'no' (0) or 'unclear' (0). A second independent rater appraised 20% of the papers using the adapted CASP form to check for inter-rater reliability; this was calculated at .95 (Cohen's Kappa), indicating excellent inter-rater reliability. Disagreements were discussed and the first author made the final decisions based on the discussions.

## Data Extraction

The data were extracted from included studies using a set template which was informed by the literature (appendix b). Extracted data included the type of study, methods used, participant demographics and relevant outcome data relating to the research objectives.

## Data Synthesis

The data were synthesised using a narrative synthesis. Data were extracted and consistent themes were identified, whilst considering the definition of attitudes provided in chapter one. A meta-analysis

of the data was not conducted due to the heterogeneity of the included data.

## Results

Figure one demonstrates the outcome of the search process and reasons for exclusion. A total of 51 full text articles were assessed for eligibility against the inclusion/exclusion criteria. Thirteen articles were included in the final narrative synthesis.

## Characteristics of Included Studies

A total sample of 2213 participants contributed to the data. Data were obtained from community, forensic healthcare and prison environments in the UK, USA, Canada and Norway. Findings across countries appear to be comparably consistent. For instance training does not seem to have a significant impact on attitudes (Craig, 2005, UK; Jones, 2013, USA; Kjelsberg & Loos, 2008, Norway) whilst prison and police officers appear to hold consistently negative attitudes across countries (Kjelsberg & Loos, 2008, Norway; Higgins & Ireland, 2009, UK). There also appears to be strong support for exposure and experience equating to more positive attitudes across countries (e.g. Simon, 2010, USA; Sanghara & Wilson, 2006, UK). Participants were from a variety of professional and paraprofessional backgrounds including psychologists, probation workers, prison staff and counsellors. Six of the studies used a combination of different professional roles including teachers, healthcare workers and case

managers. One included study did not specify the professional roles of their participants, instead opting for an overarching term of 'mental health professionals', a review of the paper implied that the criteria to be included within the category of mental health professionals was stringent and therefore it was deemed appropriate to retain this paper for analysis.

Table one provides an overview of the study characteristics. Eight of the included studies used the Attitudes Towards Sex Offenders Scale (Hogue, 1993). Five used alternative methods which are detailed in table one.

| Study, setting, country and study type | Aim(s) | Questionnaire/ survey method | Sampling strategy; sample | Main results/ attitudinal scores | Total quality score (/28) |
|---|---|---|---|---|---|
| **Craig (2005)**<br>Community; UK<br>Cohort | To compare differences in attitudes towards prisons and sex offenders and to provide normative ATS data | ATS | Opportunity sampling; (n=74) residential hostel workers and probation officers | ATS mean score pre training = 76.44 (SD 12.95) and post training = 76.05 (SD 12.46).<br>Females significantly more punitive than males t(71), 2.03, P<0.05<br>Females more negative about sex offenders ability to change compared to males t(57), 2.42, p<0.05.<br>Males felt sex offenders had feelings compared with females t(57), 2.76, p<0.01. | 20 |
| **Dooley (2009)**<br>Community; USA<br>Cohort | To examine perceptions of mental health professionals who treat sex offenders | Vignettes specifically created for the research | Opportunity sampling; (n=75) mental health professionals | More treatment received, more likely to perceive sex offender as rehabilitated (m=1.52, SD .67); reservations among professionals regarding offenders presence within the community (m=1.87, SD .98) | 17 |
| **Engle *et al.,* (2008)**<br>Prison, Community, Forensic | To examine whether the belief that sex offenders cannot be cured and re-offend is shared by professionals | Questionnaire specifically designed for the research | Opportunity sampling; (n=540) psychologists, psychiatrics, psychotherapists, social workers, | 88% do not feel sex offenders are safe to be released into the community; 62% believe sex offenders will re-offend; 81% believe that sex offenders should be treated differently to other | 17 |

| | | | | | |
|---|---|---|---|---|---|
| Healthcare; USA Cohort | working with sex offenders | | parole/probation officers | offenders; 69% believe sex offenders suffer from personality disorder or psychiatric diagnoses. | |
| **Ferguson and Ireland (2006)** Prison; UK Cohort | To explore attitudes towards different groups of sex offenders and explore gender differences in attitudes | ATS and specifically created vignettes | Opportunity sampling; (n=90) psychologists, prison officers, probation officers, counsellors and prison governors | Females had significantly more positive attitudes than males $F[1,137] = 6.33$, $p<.05$. Indecent assault (MATS=119.9) and incest (MATS=119.2) were seen more negatively than stranger rapists (MATS=126.6) and acquaintance rapists (MATS=132.5) | 20 |
| **Fortney *et al.,* (2009)** Prison, Community and Forensic Healthcare; USA Cohort | To examine the perceptions of professionals working with sex offenders | Questions developed specifically for the research | Opportunity sampling (n=86) psychologists, social workers, counsellors, family therapists and criminal justice professionals | 88% believe that child sex abuse would reduce if Sex Offender Treatment Programmes (SOTP) were offered to all sex offenders in prison; 94% believe outpatient SOTP would be effective; believe that 38% of convicted sex offenders will reoffend; believe that 40% of rapists will reoffend; believe that 42% of child molesters will reoffend | 14 |
| **Higgins and Ireland (2009)** Prison and | To explore forensic staff and prison officers attitudes towards male sex offenders and the | ATS | Opportunity sampling (n=160) forensic staff and prison officers. | Prison officers had more negative attitudes than forensic staff within each construct of the ATS. | 16 |

| | | | | | |
|---|---|---|---|---|---|
| community; UK Cohort | influence of respondent gender and victim type | | | | |
| **Johnson *et al.,* (2007)** Community; UK Cohort | To explore police officers attitudes towards sex offenders | ATS Empathy Scale Locus of Control Scale (LOC) | Opportunity sampling (n=75) police officers | Attitudes were significantly more positive compared with the public ($F(1,170) = 4.38$, $p=0.04$). Attitudes were more positive before training (MATS=100.8, SD13.5) than after training (MATS=89.5, SD 17.9). | 20 |
| **Jung *et al.,* (2011)** Prison and Forensic Healthcare; Canada Cohort | To examine the inherent biases about sex offenders held by professionals | Fabricated newspaper articles manipulating variables about type of offence, involvement of alcohol and admittance of offender | Opportunity sampling (n=120) probation officers and other professionals | Professionals felt that exhibitionists were more amenable to treatment. Professionals believe sex offenders to be accountable for their behaviours and at high risk of sexual violence. Child molesters were viewed most negatively and were perceived to deserve severe punishment. Involvement of alcohol did not impact on attitudes regarding accountability. | 16 |
| **Kjelsberg and Loos (2008)** Prison; Norway Cohort | To investigate prison employees attitudes towards sex offenders and monitor changes after an educational programme | ATS | Opportunity sampling (n=105 before training, n=90 post training); prison officers and other professionals | Training had no significant impact on attitudes ($t=0.44$, $p=.66$). Prison officers held significantly less positive attitudes (MATS=80, SD 18.7) compared with professionals (MATS=92, SD 15.6); $t=3.07$, $p=.003$. | 17 |

| | | | | | |
|---|---|---|---|---|---|
| **MacKinlay and Langdon (2009)** Forensic Healthcare; UK Cohort | To compare staff attributions towards sex offenders with intellectual disability; attributions of sex offending compared with challenging behaviours | Attribution Style Questionnaire (ASQ) | Opportunity Sampling (N=48) direct care staff | Perceived sex offending to be more external to the staff than challenging behaviours (z= -2.88, p=0.004) and less controllable by the client (z= -5.54, p<0.001).<br>The higher the client's IQ, the more likely staff were to attribute an internal responsibility to the client. | 16 |
| **Nelson *et al.,* (2002)** Community; USA Cohort | To explore counsellors attitudes towards sex offenders and the relationship between experience, training and personal characteristics | ATS | Opportunity sampling (n=437); professional counsellors | Attitudes were significantly more positive than the underlying anchor of the ATS (*t*=14.82, p=.00) and were significantly more positive than Hogue (1993) data.<br>Significant positive relationship found between attitudes and experience (*r*=.18, p=.000).<br>Significant positive relationship found between number of sex offenders on caseload and attitudes (*r*=.19, p=.000).<br>No significant relationship with training, gender or educational level. | 23 |
| **Sanghara and Wilson (2006)** Prison, | To investigate the differences in stereotypes of sex offenders between | ATS | Opportunity sampling (n=131) professionals and teachers | Teachers significantly more likely to stereotype than professionals (t=(129)=-3.14, p<.001). | 22 |

| | | | | | |
|---|---|---|---|---|---|
| Community and Forensic Healthcare; UK Cohort | treatment professionals and teachers | | | Professionals report significantly more positive attitudes than teachers; t(129)=-8.64, p<.001. | |
| **Simon (2010)** Prison, Community and Forensic Healthcare; USA Cohort | To explore psychologists attitudes towards sex offenders and examine the impact of participant characteristics and experiences | ATS | Opportunity sampling (n=272); psychologists | If actively working with sex offenders, attitudes were significantly more positive; F(1, 269) = 19.95, p<.05.<br>More years of experience resulted in significantly more positive attitudes; F(5,269) = 6.005, p<.05.<br>Training resulted in significantly more positive attitudes; F(4, 266)=6.407, p<.05.<br>No effect of gender. | 25 |

Table 1: data extraction table

## Quality of Included Studies

The average total quality score of all the studies was 19 out of a possible 28; seven of the studies fell below this average score. The highest quality score was 25 (Simon, 2010) and the lowest score was 14 (Fortney *et al.,* 2009). Fortney *et al's* (2009) study lost quality points as a result of utilising a questionnaire specifically designed for the research. No validity or reliability statistics were provided, therefore these details remain unclear. However, Fortney *et al* (2009) utilised a wide range of professional participants (psychologists, social workers, counsellors, family therapists and criminal justice officials) and therefore it was felt to sufficiently add to the literature base. On the other hand, Simon's (2010) study used the valid and reliable ATS and provided sufficient detail regarding recruitment of participants and data analysis. However, Simon (2010) failed to report statistical power or response rates and lacked sufficient detail regarding ethical approval. Studies commonly lost quality points due to inadequate explanations of recruitment methods or poor reporting of ethical approval and considerations (e.g. Higgins & Ireland, 2006; Johnson, Hughes & Ireland, 2007; Jung *et al.,* 2012; Kjelsberg & Loos, 2008; Sanghara & Wilson, 2006). None of the included studies reported conducting a power analysis or reported effect sizes; therefore, it is not clear whether sufficient power was achieved for the statistical analyses.

Nine of the thirteen studies sampled participants from a number of different sites (Dooley, 2009; Engle *et al.,* 2008; Ferguson & Ireland, 2006; Fortney, Baker & Levenson, 2009; Higgins & Ireland, 2009; Kjelsberg & Loos, 2008; Nelson Herlihy & Oescher, 2002; Sanghara & Wilson, 2006; Simon, 2010). Three studies gathered participants from single sites (Craig, 2005; Johnson, Hughes & Ireland, 2007; Jung *et al.*, 2011) and one study did not specify specific participant information (MacKinlay & Langdon, 2009).

Two studies obtained data from participants who were equally split between two gender groups (Higgins & Ireland, 2009; Johnson, Hughes & Ireland, 2007). Seven studies obtained a larger sample of female participants (Craig, 2005; Ferguson & Ireland, 2006; Fortney, Baker & Levenson, 2009; Jung *et al.*, 2011; Nelson Herlihy & Oescher, 2002; Sanghara & Wilson, 2006; Simon, 2010) whereas only one study obtained more male participants (Engle *et al*., 2007). Three studies did not provide any data regarding gender split (Dooley, 2009; Kjelsberg & Loos, 2008; MacKinlay & Langdon, 2009).

All of the studies used self-report measures to collect their data; therefore, it is subject to possible socially desirable responding. Respondents may not have answered honestly to the statements for a number of reasons, such as conforming to socially acceptable views or for fear of reprimand in their work. As such, the validity of all results should be considered in this context.

The quality of the included studies was variable, with limitations relating to sampling bias and justifications regarding statistical analyses. The generalisability of some of the included studies is questionable and thus affects the quality of the studies. Nevertheless, the included studies did meet a minimum quality standard.

**Data Synthesis**

Congruent with the definition of attitudes, all of the included studies reported findings in the context of the three attitudinal domains; cognitive, affective or behavioural. As such, the synthesis will adopt the domains as overarching themes to explore the relationship that each factor has with the care and treatment provided to MSO.

*Cognitive Attitudes; beliefs and stereotyped responses*

Five of the included studies support an argument that exposure to MSO relates to more positive attitudes and decreases negative, stereotyped beliefs (Ferguson & Ireland, 2006; Johnson, 2007; Nelson, Herlihy & Oescher, 2002; Sanghara & Wilson, 2006; Simon, 2010). Simon (2010) concluded that psychologists who work with MSO think more positively of them in comparison to psychologists who do not work with MSO. Nelson *et al.,* (2002) found that professionals with more MSO on their caseloads had more positive attitudes. This is a theme throughout the five studies that support an exposure argument and lead to conclusions that those with direct experience of working with MSO are less likely to endorse stereotyped

views (e.g. Sanghara & Wilson, 2006). This is also supported at different levels of professionalism; police officers held more positive attitudes in comparison to the general public which suggests even limited professional knowledge and exposure can influence the nature of attitudes (Johnson *et al.*, 2007). The care and treatment of MSO provided by experienced staff who are less influenced by social biases is more likely to be non-judgemental, which is considered to increase the compliance with treatment (Vermeire, Hearnshaw, Royen & Denekens, 2001). Positive attitudes are also thought to facilitate MSO's adaption to incarceration, acceptance of treatment and motivation to desist (Sanghara & Wilson, 2006). That said; Simon (2010) found evidence to suggest that after 20 years of working with MSO, attitudes begin to decline. There is a potential issue of burnout or compassion fatigue in working with this challenging client group, which requires the monitoring of staff wellbeing over time. Only one study did not support an exposure argument, concluding that professionals are still subject to social biases (Jung *et al.*, 2011). This was one of the lower scoring papers in terms of quality.

Two studies discussed behavioural attitudes with regards to staff beliefs about MSO capacity to change, with varying conclusions. Dooley (2009) and Fortney, Baker and Levenson (2009) report positive beliefs regarding MSO's capacity to change and place an emphasis on the benefits of rehabilitation. Staff optimism may potentially have a positive impact on the optimism and engagement

of MSO in treatment, which links in with affective attitudes and therapist characteristics (e.g. Marshall, 2005).

*Affective Attitudes; emotional responses*

Three studies report on the possible relationship between gender and affective attitudes. Whilst Craig (2005) reports that women are fearful for their safety when working with MSO, Ferguson and Ireland (2006) and Johnson, Hughes and Ireland (2007) suggest that women may be more empathetic in comparison to males. Ferguson and Ireland (2006) suggest that the gender differences may be as a result of women being naturally more empathetic than males. Ferguson and Ireland's (2006) hypothesis is supported by other empirical research (e.g. Mestre, Samper, Frias & Tur, 2009) and it is thought that influential therapist characteristics include empathy (Marshall, 2005). Therefore, an important consideration for staff working with MSO is their ability to feel empathetic towards MSO as this has the potential to impact on treatment outcomes. Harsh and punitive therapist styles have been linked to poor treatment outcomes (Marshall, 2005), so it is important to consider empathy playing a positive role. Ferguson and Ireland (2006) also report that participants who had an emotional link to the men they work with, for example if they had been abused or know someone who has, are more likely to hold positive attitudes. Contrary to this, Nelson (2002) found a relationship in the opposite direction, concluding that participants

who had been a victim of a sexual offence had more negative attitudes. Victim exposure to MSO shows varying results, although it is likely that emotional connections will develop, the direction in which they develop will be person and experience specific.

Five of the included studies refer to 'like' or 'dislike' of MSO. There was a general pattern that those working directly with MSO 'like' them (e.g. Higgins & Ireland, 2009), although studies do not define 'like' therefore it is considered a subjective description. Despite this, it was reported that no amount of rehabilitation would result in someone feeling comfortable to live next door to a man who had committed a sexual offence (Dooley, 2009) and some remained fearful of them returning to the community (Engle *et al.*, 2008). Jung *et al.,* (2011) found that men who committed offence against children were the least likeable MSO, which indicates that offence type may be important in the development of attitudes.

*Behavioural Attitudes; the ways people act and the things they do*

Many papers considered the relationship of positive and negative attitudes and the behaviour of staff working with MSO. Kjeslberg & Loos (2008) and Higgins and Ireland (2009) found that staff who were required to contain and control MSO, for example prison officers, held more negative attitudes whilst those facilitating education or therapy were more positive. Therefore, the behavioural aspects of a job role influence the nature of attitudes, which may

result in a cyclical effect (i.e. containment and control influences negative attitudes, which in turn may result in more punitive care, reinforcing more negative attitudes). Higgins and Ireland (2009) report that prison officers believe that MSO require harsh treatment.

Although positive and negative attitudes seemingly play a large part in the care and treatment of MSO, it is important to consider whether extremely low and extremely high attitudinal scores could be counterproductive and result in boundary violations or risk aversion or leniency.

Two studies consider whether attending training on working with MSO has any effect on behavioural responses (Craig, 2005; Nelson, Herlihy & Oescher, 2002). Craig (2005) concluded that training increases confidence. However, increased confidence does not necessarily influence attitudes and the type of care or treatment provided. Nelson, Herlihy and Oescher (2002) did not find a significant relationship between training and behaviour or attitudes.

Three studies reported specifically about the delivery of treatment. Engle *et al.,* (2008) and Jung *et al.,* (2011) consider how treatment should be different, both in comparison to non-sexual offenders but also between different types of MSO. Jung *et al.,* (2011) conclude that staff believe exhibitionists are the easiest to treat and consider how this may increase facilitator's motivations to treat this group because it may be easier. However, Dooley (2009) concluded that

regardless of treatment amount or intensity, landlords or employers were no more willing to offer housing or employment opportunities to MSO.

## Discussion

The aim of the review was to explore the factors that influence the correlates of attitude change and how these attitudes subsequently influence the care and treatment provided to MSO. The empirical studies included in this review build on a body of evidence that considers the contributing factors that appear to relate to the nature of attitudes and how this affects the way professional and paraprofessional staff work with MSO. A recent non-systematic review of the existing literature suggests factors that are consistent with the outcomes of this review (Harper, Hogue & Bartels, 2017).

### Variables associated with staff attitudes

*Exposure*

The preceding review has highlighted that there is a strong argument for exposure to MSO being a key factor relating to more positive attitudes (Ferguson & Ireland, 2006; Johnson *et al.*, 2007; Simon, 2010; Sanghara & Wilson, 2006). Only one study suggests contrary evidence to this, concluding that professionals are still subject to social biases (Jung *et al.*, 2011). However, Simon (2010) highlighted that professionals who had worked with MSO for more than 20 years

began to evidence a decline in positive attitudes. This may be because of burnout. On the other hand, it may be that positive attitudes are falsified and staff tire of such falsehood. This suggests that exposure may be more complex than the general evidence suggests and might be better represented by an inverted u-shaped curve. The variation in results could be because of a number of possible confounding variables. This may include the behaviour of the MSO within their living environment; high frequency verbal aggression perpetrated by men in institutional care, although not specific to MSO, has been found to correlate with negative attitudes (Needham, Abderhalden, Halfens, Dassen, Haug & Fischer, 2005). The type of index offence committed may also correlate with attitudes. Research has found that attitudes towards MSO differ based on the type of offence they have committed (Challinor & Duff, 2017), and being aware of the differences is central to developing best practice (Allam, Middleton & Browne, 1997).

*Empathy*

Levels of empathy were an important factor relating to positive attitudes and there appears to be a focus within the literature on the links between empathy and therapist characteristics. Marshall (2005) suggests that empathy is an important therapist characteristic for positive outcomes. Studies found that women were reported to show higher levels of empathy in comparison to their male colleagues.

However, as eight of the studies had more female participants than male, there may be issues with drawing conclusions regarding attitudes due to the unequal ratio of male and female participants. This finding may reflect the composition of gender within the field of forensic care. Future research should attempt to even out the gender split although this may be an on-going limitation of research due to the gender composition.

*Job Role*

Finally, the review suggests a link between the behavioural aspect of one's job and the type of attitude one holds. Professionals whose role involves control and containment, such as police and prison officers were found to have more negative attitudes in comparison to those within a therapeutic capacity such as psychologists (Ferguson & Ireland, 2006; Higgins & Ireland 2009). It is unclear whether the attitudes held by these groups of professionals were influenced by the job role or whether people with more negative attitudes were attracted to these jobs.

## Implications

The systematic review has identified a number of factors that seem to have an influence on the nature of attitudes. These factors are important to consider within the context of providing MSO with care and treatment. Whilst evidence suggests that exposure to MSO influences more positive attitudes, Simon (2010) also notes potential

for burnout after a significant period of time. This is supported by Farrenkopf (1992) who found that over time, staff became emotionally hardened and experienced increased anger, suspicion and confrontation. As staff burnout can lead to a decline in positive attitudes, it is important to monitor staff wellbeing. Future research may wish to apply longitudinal follow-ups to provide further data on burnout or compassion fatigue over time. Furthermore, such evidence may suggest that services need to respond proactively to a decline in staff wellbeing and this may prevent future decline in attitudes. In addition to regular completion of burnout inventories such as the Copenhagen Burnout Inventory (Kristensen, Borritz, Villadsen & Christensen, 2007) staff may benefit from regular reflective practice to share concerns and seek support from colleagues. Such forums should be considered safe to openly acknowledge difficulties or negative emotions. Clinical supervision should be accessed on a regular basis and staff should be given an opportunity to have therapeutic breaks from working with MSO where possible.

The review also highlighted some important considerations for those staff who deliver treatment to MSO. Consistent with findings from Marshall (2005), it appears that positive therapist characteristics, such as empathy, are important for treatment outcomes. Empathy is context specific (Segal, 2011) and can be influenced by specific circumstances that link the person who is empathising to the person

who is receiving the empathy. According to Marshall (2005), therapist features have the potential to influence treatment-induced benefits far beyond the procedures specified in a treatment manual. Positivity from treatment facilitators will go hand in hand with more recent shifts towards strength-based, rather deficit focussed treatment programmes (Willis, Yates, Gannon & Ward, 2013). Emerging evidence points to findings consistent within the general psychotherapy field. Given high non-responsivity, it is possible for services to consider ways to assess the characteristics and competencies of therapists before working with MSO.

Alongside therapist characteristics, there was some indication that training can influence staff attitudes. Craig (2005) reported that training to work with MSO increased confidence and confidence has been found to be an important characteristic in supporting treatment facilitators to develop non-critical challenges (Marshall, 2005). Due to inconsistent findings within the literature, evaluating the effectiveness of such training programmes (e.g. Craig, 2005; Nelson, Herlihy and Oescher, 2002) revisions of content may be required to increase attitudinal change. According to Briggs (1994), training should include; information on the nature of sexual offending, theoretical and contextual issues in offender work, awareness of methods for managing denial and minimisation, and relapse prevention and recidivism. However, this study is dated and appears to be relatively deficit-focussed in its recommendations. Content that

challenges negative attitudes and may promote positive attitudinal change might include; challenging sex offender/rape myths (e.g. Ryan, 2011) and understanding MSO in the context of the Good Lives Model (GLM; Ward & Stewart, 2003). In addition, it is important for trainees to understand empirically supported risk factors rather than factors that are assumed to be risk factors but are not empirically supported (e.g. poor victim empathy or callousness; Mann, Hanson & Thornton, 2010). Moreover, information should be provided to promote understanding of care and treatment of MSO in the context of the RNR model (Andrews & Bonta, 2006) to ensure that an appropriate level of emphasis is placed on the 'risk' principle. Harper, Hogue and Bartels (2017) suggest presenting humanised exemplars is an effective method to challenge stereotyped beliefs and encourage MSO to be seen as people, rather than 'monsters'.

**Quality of evidence and future recommendations**

As was reported earlier, the quality of the studies included in the review varies. While the methodology clarifies the steps taken to ensure that the papers that have been included satisfied a clear standard, we have seen that the quality concerns remain. For example, none of the thirteen included studies reported conducting a power analysis or reported effect sizes. Given the availability of computer programmes, future researchers should demonstrate this

to gain increased understanding of the results of statistical analyses and effect sizes.

Similarly, all of the thirteen studies used self-report measures, which are vulnerable to biases in the data because of the potential for socially desirable responding. Future research may benefit from utilising a social desirability measure in addition to a self-report tool to account for any biases in responding.

Many of the studies published in the area of attitudes were excluded from the review due to validity concerns. As discussed earlier in the review, the CATSO (Church *et al.,* 2008) is considered to measure knowledge-based perceptions rather than attitudes, despite claiming to measure the latter. Future studies should seek to utilise a valid and reliable measure of attitudes and may wish to consider the recently reimaged CATSO scale; the Perceptions of Sex Offenders Scale (PSO; Harper & Hogue, 2015), which is said to more specifically tap into affective judgements of sexual offenders.

**Conclusion**

This review illustrates the complex relationship between the correlates of attitude change and the care and treatment provided to MSO in forensic services. Although there remain some inconsistent relationships, this review evidences a number of important factors for providers to consider, which appear to be consistent between countries and environments. Given the number of factors that have

been found to relate to the care and treatment provided to MSO, future research is warranted to examine the complex relationships further. The review provides further evidence for the importance of understanding the role of attitudes in forensic services to promote therapeutic engagement and positive outcomes for future reintegration.

Chapter two highlights a number of factors that influence the nature of staff attitudes towards men who have sexually offended. The review concluded that some of the factors, such as gender, appeared to have an inconsistent relationship with attitudes. The review also highlighted differences in attitudes between professions and between people who have not been exposed to MSO. As a result of these findings, chapter three aims to further explore factors including gender and profession and their relationship with attitudes towards MSO from a social reintegration and public health perspective.

# Chapter Three

## Attitudes towards Men who have Sexually Offended: a Comparison of Forensic Staff and the General Population


### Abstract

**Objectives:** To explore attitudes towards men who have sexually offended (MSO) and compare those held by the general public, professionals and paraprofessionals in forensic settings.

**Background:** Existing research demonstrates a number of different factors that appear to influence the nature of attitudes towards MSO. These factors require further exploration.

**Method:** An opportunistic sample was used for the study. A total of 553 participants were recruited from the general public and forensic hospitals, both private and National Health Service (NHS). An online survey containing the Attitudes Towards Sex Offenders scale (ATS; Hogue, 1993) was distributed via email and social media.

**Results:** Gender was not found to influence the attitudes individuals held towards MSO. The general public were found to have significantly more negative attitudes in comparison to professional and paraprofessional staff who were exposed to MSO. Regardless of the duration of employment of the staff, attitudes did not alter significantly over time.

**Conclusion:** The clinical and societal implications of the research are important for ensuring that MSO are adequately rehabilitated within forensic establishments and supported to reintegrate successfully into the community. Without the support from both staff and the general public at each stage of rehabilitation, desistance is less likely to be maintained. Research continues to provide varying results regarding the factors that influence the nature of attitudes towards MSO.

## Introduction

Chapter one noted an increase in the prevalence rate of sexual offending in England and Wales in the last year. Given that the increased prevalence is at a new high (Office for National Statistics, 2018), it seems important that research into men who sexually offend (MSO) continues. In particular, this involves exploring the way in which society and staff working with MSO think and feel about this perpetrator group, as this is important for rehabilitation. An increased understanding of attitudes towards MSO will help to consider whether changes to current societal and institutional procedures need to take place to enhance positive rehabilitation and successful reintegration. This insight will ensure that MSO are managed in a more rehabilitative manner both in society and within institutions.

## Factors thought to affect attitudes towards MSO

The current literature would seem to suggest that there are a range of variables that appear to influence the nature of attitudes towards MSO.

### *Exposure to offenders and men who sexually offend*

Research has explored the influence that exposure to ex-offenders has on the nature of attitudes towards offenders, and what factors are important (e.g. Maruna & King, 2009; Harper, Hogue & Bartels, 2017). Whilst many studies focus on a particular type of offence, some research explores general offending behaviours. Hirschfield and

Piquero (2010) gathered data from an ethnically diverse sample of residents across four American states to analyse attitudes towards ex-offenders. They concluded that exposure to ex-offenders softens the view towards offenders in general. It was also concluded that exposure was the strongest predictor of more positive attitudes towards offenders. Furthermore, Kjelsberg, Skoglund and Rustad (2007) suggested that gender, age, socioeconomic status, crime victimisation and education were all important characteristics of people that appeared to influence attitudes towards offenders both positively and negatively. Results from Hirschfield and Piquero (2010) support the relevance of these factors. The results showed that age was negatively related to stigmatising attitudes and urban residents had more positive attitudes than suburban residents.

As described in chapter two, the systematic review concludes that there are a number of different factors which appear to influence the nature of attitudes towards MSO. Exposure was a key factor within the review and this has also been found to influence attitudes towards other offender populations (e.g. Hirschfield & Piquero, 2010). The literature clearly highlights the complexity of the exposure relationship; however, it is consistently represented as being important in the nature of attitudes (e.g. Ferguson & Ireland, 2006; Simon, 2010). Simon (2010) also acknowledges that although exposure was found to increase positive attitudes, these attitudes can deteriorate after 20 years of exposure to MSO. The reasons for such

deterioration can be speculated about and may include the impact of environment. Those working in prison and healthcare environments may hold different attitudes about MSO, and MSO with mental illness may also impact on attitudes regarding locus of control or responsibility. The current research therefore aims to explore the correlates of attitudinal change towards MSO further.

From a slightly different perspective, Levenson, Brannon, Fortney and Baker (2007) compared the attitudes of prisoners, students and prison employees towards prisoners. Participants completed the Attitudes Towards Prisoners scale (ATP; Melvin, Gramling & Gardner, 1985). Results showed that prison officers held more negative attitudes compared to other prison staff, particularly to those who deliver therapy. This suggests that this is not a straight forward 'exposure equates to better attitudes' relationship and that other factors play a role. Consequently, it is expected that there are a number of factors to take into consideration when exploring attitudes towards MSO.

*Occupation*

Linked to exposure, occupation has also been found to be an important factor when considering the nature of attitudes towards MSO. It is thought that those who have therapeutic input with MSO have more positive attitudes (e.g. Sanghara & Wilson, 2006), whilst

those who have no consistent contact with MSO such as police officers, are said to have more negative attitudes (e.g. Johnson *et al.,* 2007). The current research aims to further explore the influence of professional role on attitudes towards MSO.

*Gender*

Gender was also highlighted as an important factor, but with conflicting results. Some studies found that females were more empathetic and had more positive attitudes towards MSO (e.g. Johnson, Hughes & Ireland, 2007), whilst some found little difference in the attitudes between males and females (Hogue & Peebles, 1997). The current research will also aim to explore this factor further.

*MSO Specific Factors*

Other important factors highlighted in chapter two include beliefs about capacity to change offending behaviours through treatment and rehabilitation, levels of empathy, victimisation and access to training. Exploration of all the factors highlighted in chapter two were beyond the scope of the current research.

**Clinical and Societal Implications**

Acceptance into society and access to primary goods (as discussed in the context of the Good Lives Model in chapter two) such as housing and employment after being released are key factors in successful reintegration and maintenance of desistance (Laws & Ward, 2011).

More successful reintegration will encourage desistance and provide support for the offender (Levenson *et al.,* 2007). If a community has collectively more positive attitudes towards MSO, they are more likely to gain employment and seek accommodation. Primary goods such as these will promote more successful reintegration. However, it appears that the general consensus regarding MSO is that they cannot be rehabilitated and society holds a stereotypical view due to their perceived dangerousness (Quinn *et al.,* 2004). This highlights the importance of gaining a greater understanding of the attitudes the general public hold towards MSO.

Finally, attitudes amongst individuals who work with MSO may have clinical implications for the care, treatment and rehabilitation of men. Kjlesberg *et al.,* (2007) found that individuals who are involved in delivering therapy as part of a rehabilitative programme are more likely to have positive attitudes in comparison to individuals who are responsible for the day-to-day management of MSO, such as prison officers. Marshall *et al.,* (2005) found that therapists who are empathic and warm produce more positive treatment induced changes. Furthermore, research into negative attitudinal climates highlights the similar significance of attitudes. Zimbardo (1971, 2007) has described the potential for negative attitudes to provide a fertile base for the misuse of power, the neglect of client needs and ultimately (and potentially) a culture of abusive care. This would

suggest that it is important to explore attitudes of individuals working with MSO at different professional levels rather than simply focussing on those with a direct therapeutic role.

**Purpose of the present study**

We have seen that attitudes may have an impact on the readiness or ability of MSO to successfully engage in treatment and successfully reintegrate into society. Understanding the nature of these attitudes is therefore a significant research interest in the context of reducing recidivism and preventing abuse. The purpose of the present study is to explore differences in attitudes between three population groups; general public, paraprofessionals and professionals. In addition, gender will be explored to determine whether there are differences in attitudes between men and women. Duration of occupation will also be explored to determine whether this has an influence on attitudes.

**Aims**

The study aims to explore attitudes towards men who have sexually offended. Attitudes will be compared between forensic staff who are exposed to this offender group in their jobs, and the general public. It is assumed that the general public will have little or no exposure to MSO in comparison to the staff groups and therefore this is an important comparator to determine how exposure influences attitudes. Forensic staff will comprise of professional and

paraprofessional staff. For the purpose of this study, paraprofessional staff are defined as anybody who works with MSO but do not have a professional qualification. This includes healthcare assistants, assistant psychologists and students. Professional staff are defined as those who have attained a professional qualification. This includes occupations such as psychologists, psychiatrists, occupational therapists and social workers.

The study aims to add to the existing literature base and to answer the following research questions:

- Do attitudes towards MSO differ between males and females?
- Does being exposed to MSO at work have an impact on attitudes?
- Does length of time working with MSO impact on attitudes?

Based on existing knowledge regarding attitudes towards MSO, the hypotheses for the research study are:

- Females will have more positive attitudes towards MSO in comparison to males;
- Staff working with MSO will have more positive attitudes in comparison to the general public;
- As length of time working with MSO increases, an increase in positive attitudes will be observed. Those who have worked with MSO for more than 10 years may evidence a decline in attitudes.

A 10 year time period was identified within the research question to potentially identify when the deterioration in attitudes might begin. Only one study within the research literature (Simon, 2010) suggests that there is a decline after 20 years of working with MSO, therefore a 10 year time period was felt to be an appropriate starting point. In addition, the largest available pool of participants was from an establishment that had been open for eight years, and therefore it was felt less likely that staff would have worked in the environment for a longer period of time.

## Method

### Data Collection Procedure

A convenience sample was used for the research study. Participants were recruited from various forensic healthcare organisations (public and private sector) and the general public. Emails were sent out via global distribution lists in forensic healthcare organisations and the research was advertised on LinkedIn. The general population were recruited via social media.

The research was conducted using the Attitudes Towards Sex Offenders Scale (Hogue, 1993; appendix c), adapted from the Attitudes Towards Prisoners Scale (Melvin *et al.,* 1985). Hogue (1993) replaced the word 'prisoner' with 'sex offender'. The ATS comprises 36 attitudinal statements. Nineteen statements are said to represent negative attitudes, for example *"most sex offenders never*

*change"*. Seventeen items are said to represent positive attitudes, such as *"most sex offenders have the capacity for love"*. Respondents' score each of the statements using a five-point Likert scale, ranging from strongly agree (4) to strongly disagree (0). The nineteen negative statements are reversed scored. The scores are then summed and a constant of 36 is removed. Total scores range from 0-108 and higher scores indicate more positive attitudes. The ATS has been validated as a reliable method of measuring attitudes towards sex offenders (Hogue, 1993; 1995) and has excellent internal consistency; Cronbach α .92 (Nelson, Herlihy and Oescher, 2002).

The ATS was presented using Bristol Online Surveys, making it accessible to a wide range of participants. It is estimated that on average, the questionnaire was completed within five to ten minutes.

Standardised emails were sent out to the communications department of each hospital and emails were distributed to all employees via a global distribution list. Social media posts were also standardised and posted on a regular basis to recruit participants from the general public. The advertisements directed potential participants to the online questionnaire. If the participant chose to partake, they were directed to the ATS on Bristol Online Surveys. First, participants were required to read the information sheet (appendix d) to ensure they could provide informed consent to

participate. Participants were also required to provide demographic information, including their age range, gender and participant category (i.e. professional, paraprofessional or general public). After completion of the ATS, respondents were taken to a debrief sheet (appendix e). Anonymity was maintained throughout the study and participants were informed of their right to withdraw at any time.

**Ethical Approval**

The research study was approved by the University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee. In addition, it was approved by individual organisation's Research and Development departments.

**Participants**

Due to the nature of convenience sampling, it was not possible to determine response rates. A power analysis was conducted using GPower. A minimum of 192 participants were required to fulfil the needs of the Analysis of Variance (ANOVA) with a medium effect size (alpha 0.05, power 0.8).

A total of 557 participants from multiple sites were recruited to the research study. Four participants were excluded due to incomplete data sets; therefore, the total number of participants subject to data analysis was 553. A significant proportion of the participants (66.2%, $n$=366) were female. It is possible that females may be more willing to participate in research, or may be that more females work in

forensic services. There were more female participants within all participant categories (88/136 in the professional sample, 70/105 in the paraprofessional sample and 205/304 in the general public sample). 32.9% (*n*=182) of the participants were male, whilst 0.9% (*n*=5) chose not to specify their gender. Gender frequencies are displayed in Figure 2.

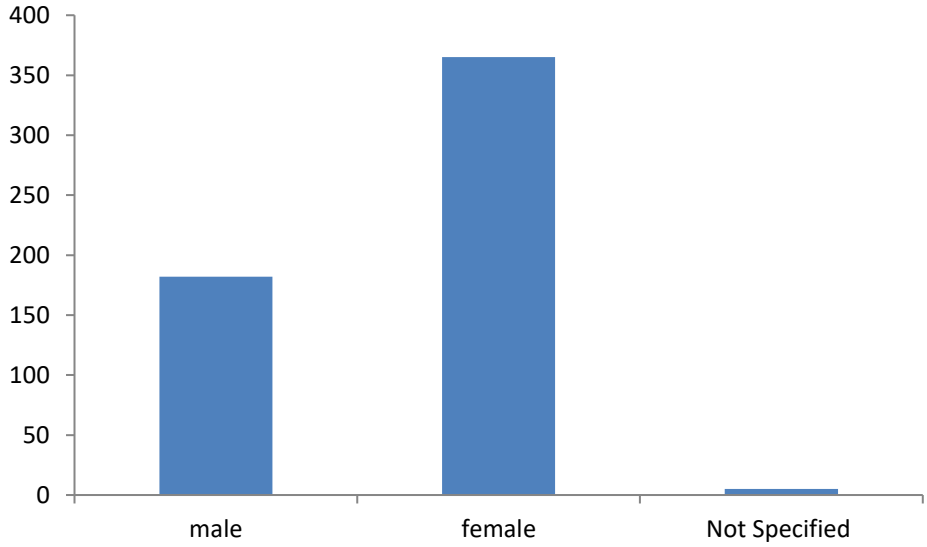



Figure 2. Gender Frequencies.

Age ranges were represented as follows: 18-24 (*n*=104), 25-31 (*n*=191), 32-40 (*n*=110), 41-50 (*n*=83), 51-60 (*n*=48) and 61 and over (*n*=17).

A total of 282 participants (51%) were members of the general public. 124 were paraprofessional staff (22.4%) and 147 were professional staff (26.6%). The distribution of participant categories is displayed in Figure 3.

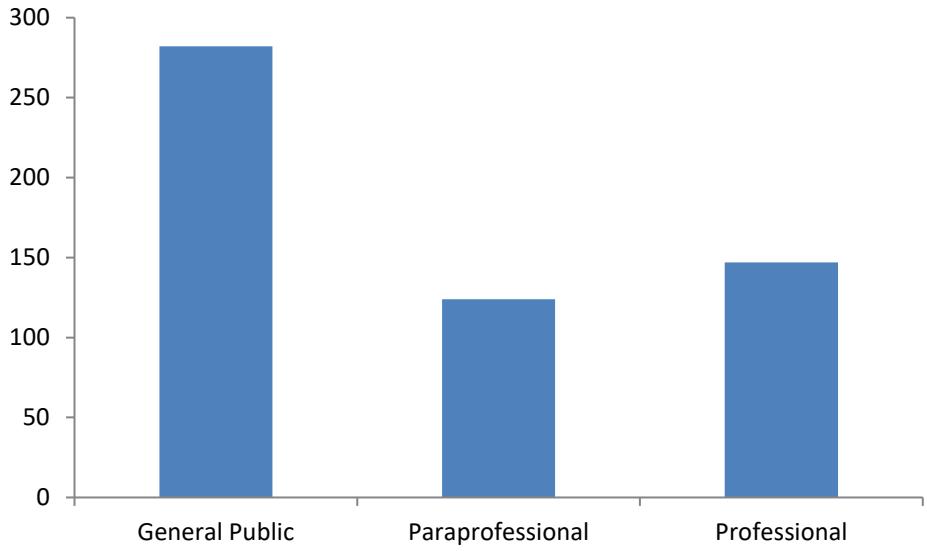



Figure 3. Participant category distribution.

Of the 244 total forensic staff, almost half had worked with MSO for between one and five years (43.8%, *n*=114), whilst 25% had worked with MSO for more than 10 years (*n*=65). The distribution of length of time working with MSO is displayed in Figure 4.

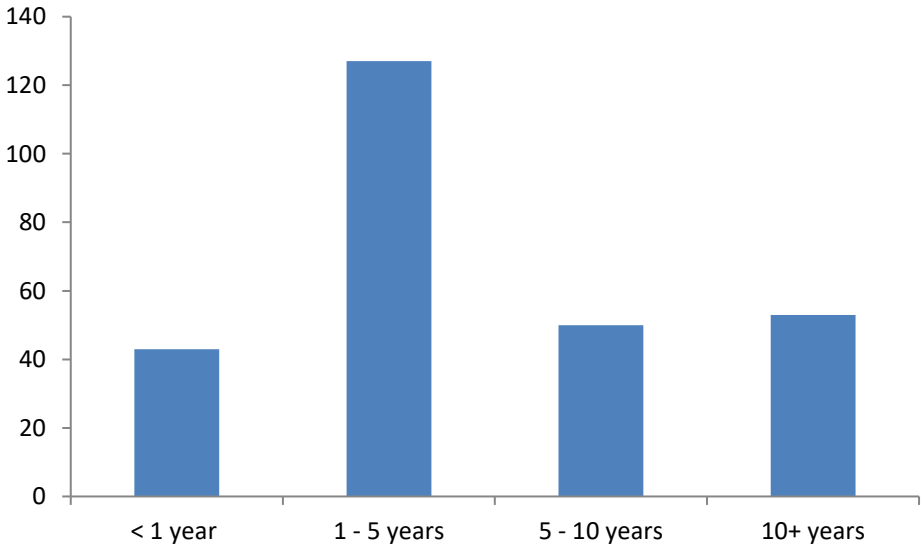



Figure 4. Length of time working with MSO.

## Data Analysis

The data were analysed using Statistical Package for the Social Sciences (SPSS 24.0 for Windows). A data screen was conducted to check for any obvious errors in the data. Data were transferred to Excel for coding. Total ATS scores for each participant were also computed in Excel using the sum formula and Hogue's scoring guidelines. Data were checked for normality and a descriptive analysis was conducted to obtain percentages, means and standard deviations. All assumptions for the statistical tests were met. Data distributions are provided in appendix f. The study demonstrated the ATS to have excellent internal consistency (.95 Cronbach's Alpha).

## Results

The quantitative analysis of this paper is separated into three parts:

1. An analysis of the differences in ATS scores between male and female participants using an independent t-test.
2. A one-way ANOVA and a Newman-Keuls post-hoc analysis was conducted to determine whether there are any significant differences in ATS scores depending on the type of exposure.
3. A one-way ANOVA was conducted to determine whether duration of exposure results in significantly different in ATS scores.

**Attitudes towards MSO: Gender**

Five participants were excluded from the independent t-test due to not specifying their gender; therefore 548 participants were included in this analysis. Results indicate that there were no significant differences in attitudes towards MSO between male (*M* = 39.68, *SD* = 16.38) and female (*M* = 40.20, *SD* = 15.58) participants (*t* (545) = 1.52, *p* =.219). As a result, gender was not differentiated in the following analyses.

**Attitudes towards MSO: Exposure**

A one-way ANOVA was conducted to explore differences in ATS scores between the general population, paraprofessionals and professionals. Results of the one-way ANOVA indicate a significant difference between ATS scores of the three participant groups (*F*(2, 550) = 35.95, *p* <.05). A Newman-Keuls post-hoc analysis was conducted as it is considered to have more power than other post-hoc tests. The Newman-Keuls analysis indicates that paraprofessionals (*M* = 43.53, *SD* = 14.34) and professionals (*M* = 46.75, *SD* = 14.80) have significantly more positive attitudes (p = .42) towards MSO in comparison to the general public (*M* = 34.74, *SD* = 15.26) who are not thought to be exposed to MSO in the same frequency or intensity as professional and paraprofessional staff are. The effect size of this difference was calculated using Cohen's *d*, due to its recommended use on normally distributed data (Rice & Grant, 2005). The difference

between mean ATS scores was found to have a moderate effect size ($d$=0.7, Cohen, 1988). No significant differences were found between the attitudes of professionals and paraprofessionals.

**Attitudes towards MSO: Duration of Exposure**

The general population ($n$ = 282) were excluded from this analysis as they are not applicable to the research question. A one-way ANOVA explored differences between ranges in duration of working with MSO. No significant differences were found between the duration of exposure to MSO and ATS scores ($F$(3, 269), = 1.11, $p$ = .344).

**Discussion**

The aim of this study was to explore how attitudes towards MSO differ depending on gender, exposure and duration of exposure. Results from an independent t-test show no significant differences between the attitudes of the male and female participants in this study. Results from a one-way ANOVA and Newman-Keuls post-hoc analysis evidence that the general public, who are least likely to be exposed to MSO, have significantly more negative attitudes towards MSO, in comparison to staff who work with MSO. No significant differences were found between paraprofessional and professional staff. It can be speculated that the moderate effect size suggests that it may be important to educate people about the real lives of the men who commit sexual offences. Finally, a one-way ANOVA found no

significant differences between total ATS scores and the duration that staff had worked with MSO.

**Gender**

The current study did not find any significant differences in the attitudes towards MSO between male and female participants. Therefore, the hypothesis for gender differences is not supported.

The findings from this study are consistent with other research studies (e.g. Nelson, Herlihy & Oescher, 2002; Kjelsberg & Loos, 2008; Simon, 2010) where it has been reported that gender did not influence attitudinal scores. Contrary to this, some studies have found significant differences between gender and attitudinal scores (e.g. Craig, 2005; Ferguson & Ireland, 2006), although these results were in opposite directions. Craig (2005) found that males had more positive attitudes than females, whereas Ferguson & Ireland (2006) found females to have more positive attitudes than males. There may be many reasons for the conflicting evidence between research studies such as participants being from different environments which can impact on the attitudes people hold. In addition, idiosyncratic or personal factors are not disclosed within such research but may warrant further investigation. Such factors that may have a greater influence on attitudes towards MSO include age, professional role, victim experiences or cultural background. Women, individuals under the age of 24, single individuals, women with disabilities, students

and women without children have all been found to be at higher risk of being the victim of a sexual assault (Office for National Statistics, 2018). This evidences the extent to which other variables can influence an individual's attitudes towards MSO. A limitation of the current study may be the lack of demographic information collected. Therefore, future research may benefit from gathering more demographic information, such as the factors discussed above, to conduct a more in-depth analysis of the factors that may influence individual's attitudes towards MSO.

**Exposure**

Participant's exposure to MSO based on their participant category (i.e. general public, paraprofessional or professional) was also examined. The general public, who were less likely to be exposed to MSO had significantly more negative attitudes in comparison to paraprofessionals and professionals who are exposed to MSO in their occupational roles. This supports the hypothesis that being exposed to MSO at work is related to attitudes that are more positive. These findings are also consistent with previous research including forensic staff (Ferguson & Ireland, 2006; Hogue, 2003), police officers (Johnson, 2007), counsellors (Nelson *et al.,* 2002) and psychologists (Sanghara & Wilson, 2006; Simon, 2010).

The current research found no significant differences between paraprofessional and professional's attitudes towards MSO. Previous

research has indicated a difference in attitudes towards MSO between professionals who are or are not involved in the therapeutic treatment of MSO (e.g. Simon, 2010). The present study did not differentiate between those who were or were not involved in treatment; therefore, this cannot be included as a correlate. The findings suggest that regardless of involvement with MSO, being exposed to them within the workplace increases positive attitudes. Future research may wish to replicate the current study and include a distinction between those working primarily with MSO and delivering treatment, compared to those who are not. Additionally, assessing therapist's attitudes prior to their involvement in the delivery of therapy to MSO may be a consideration. This will not only determine the suitability of therapists for the role, it will also allow the monitoring of the impact of delivering therapy to MSO over a period of time. This will provide further information regarding the hypothesis that working with MSO for over 20 years causes a decline in positive attitudes. It would also allow the exploration of whether therapists have more positive attitudes and are therefore attracted to the role, or whether it is therapeutic exposure that promotes more positive attitudes. All factors to be considered could have important clinical implications.

As there are no significant differences evidenced between paraprofessionals and professionals, this may indicate that education or training are less important when considering the nature of attitudes and the correlates of attitudinal change. It may be that

regardless of training and education, being exposed to MSO and interacting with them in different capacities is the important factor. Such interactions may increase insight into the factors that contribute to a man committing a sexual offence, which in turn may increase empathy and understanding. The lack of significant differences between professional and paraprofessional staff also fits with the suggestion in chapter one that staff attitudes are important at all levels to promote integration into therapeutic climates and future reintegration into the community.

The significantly more negative attitudes held by the general public must also be considered within the context of society. It may be that these negative attitudes are a protective factor in some instances, promoting vigilance within the community and potentially reducing the risk of an individual being victimised. On the other hand, paraprofessional and professional's views on MSO may be more positive whilst they are working with them in forensic establishments where risk is mitigated and they pose a smaller risk to the community whilst incarcerated. Additionally, the general public are at higher risk of being influenced by what is reported in the media (e.g. Harper & Hogue, 2015), whereas direct exposure is likely to be more influential on staff attitudes.

**Duration of Employment**

No significant differences were found between the duration of employment of paraprofessionals and professionals and their attitudes towards MSO. The lack of significant difference suggests that regardless of how long an individual has worked with MSO, their attitudes seem to remain stable. This is contrary to evidence that suggests working with MSO for more than 20 years correlates negatively with positive attitudes (Simon, 2010). The current study does not support the hypothesis that positive attitudes would increase over time of employment. It also did not provide significant evidence of deterioration of attitudes within the group of staff who had been employed for more than 10 years, although this may be dependent on job role.

It may be that individuals who work with MSO in forensic establishments are drawn to such roles because they have more positive attitudes prior to seeking employment. There is no evidence from the results in this study to suggest that attitudes at the start of employment are more negative in comparison to those who have worked with MSO for longer. Neither is there evidence to suggest that attitudes deteriorate after many years of being exposed to MSO. Reasons for the lack of significant difference may be that paraprofessionals and professionals are adequately supported in their roles through clinical supervision and reflective practice. Such

practices may prevent burnout and allow a safe space for personal exploration of the impact of working with MSO regardless of occupational role. This may prevent negative attitudes manifesting in the first place or prevent deterioration over time. Alternatively, those who do experience deterioration in their attitudes towards MSO may opt to leave their job role to prevent further decline or burnout.

**Differences in ATS Scores**

The current research reports much lower total ATS scores in comparison to Hogue's (1993) original published data (see table 2). The current results are compared only to Hogue's original data as he reports that many studies have not followed the specific scoring criteria. Some studies have not conducted the reverse scoring and some have not subtracted the constant of 36 to obtain accurate scores. Therefore, much of the published data are inaccurate.

If one were to answer 'undecided' (2) to all 36 questions, a neutral score would be 36. Therefore professional and paraprofessional groups both have mean scores which fall significantly above the neutral score, whereas the general public evidence attitudes more negative than the neutral score. As such, although the current scores are significantly lower than those previously published by Hogue (1993), they cannot necessarily be considered to fall within a negative attitudinal range as they remain above a neutral score of 36.

| | Current Study ATS (SD) | Hogue ATS (SD) |
|---|---|---|
| General Public | 34.75 (15.26) | Not explored |
| Paraprofessionals/Prison officers | 43.54 (14.34) | 80 (13.75) |
| Professionals/Psychologists | 46.75 (14.80) | 98.5 (10.57) |

Table 2. Current ATS scores and Hogue (1993) scores.

It is important to consider potential reasons for such a large difference in scores. Firstly, it is noteworthy that the current data were collected between November 2017 and January 2018; some 17 years after the original data collection. Within this time, there has been an increase in the reporting and recording of sex crimes (Office for National Statistics, 2018). Researchers were unable to find prevalence rates dating back to the early 1990s. However, recording by the Office for National Statistics dates back to 2003 and since then, there has been an increase year on year in the prevalence of sex crimes. Increased awareness of MSO over the last 17 years may have resulted in a decline in attitudes. Adding to this, a 295% increase in the reporting of sex crimes since the 'Yew Tree' police operation involving a number of high profile celebrities (Harper & Hogue, 2016) and the #MeToo movement may have caused a state decrease in attitudes towards MSO, rather than this being a trait decline. In addition, as described earlier in the thesis, media reporting has become increasingly derogatory towards MSO, with negative

labelling and use of provocative language (e.g. Harper & Hogue, 2015).

**Clinical Implications**

It is important to consider staff attitudes towards MSO within establishments that support this population. Having extremely positive or extremely negative attitudes both have clinical implications. Staff with extremely positive attitudes may be less vigilant in recognising risk behaviours or warning signs. This could result in staff becoming vulnerable to grooming, exploitation or boundary violations. It may also result in inaccurate risk assessment, causing teams to become lenient and take more positive risks, potentially putting others at risk. This highlights the importance of multi-disciplinary risk assessment and risk management.

Although training was not explored within this study and previous results have been inconsistent regarding the effectiveness of training to modify attitudes towards MSO (Craig, 2005; Jones, 2013), it is nevertheless an important consideration. Traditional classroom training such as the package used within Craig's (2005) research focuses on offender deficits and reasons for offending, with little emphasis on the interpersonal aspects of a therapist's job role. It may therefore be important to revise the content of such training and provide education for staff on the interpersonal difficulties that can arise when working with MSO. Additionally, taking an alternative

approach to training such as that described in chapter five could be a better substitute to classroom based training.

Alternatively, staff with extremely negative attitudes towards MSO may be equally as problematic. Negative attitudes may result in harsh and punitive behaviours towards MSO with an emphasis on risk aversion. This can prevent the development of therapeutic alliance, which has implications for treatment. As discussed previously, therapists with warm and empathic characteristics provide MSO with optimism and hope which has positive influences on treatment induced changes (Marshall, 2005). Negative staff attitudes may reduce treatment compliance and therefore reduce the likelihood of positive treatment outcomes and reduced recidivism rates. Aside from therapeutic environments, staff with negative attitudes working in secure hospital wards or prison wings risk their attitudes manifesting into a culture of abusive care if they negatively influence other staff. This may be akin to the manifestation observed in the Stanford Prison Experiment (Zimbardo *et al.,* 1971). It is also possible that MSO begin to transfer the negative attitudes back towards the staff causing a toxic environment that is not cohesive to risk reduction and rehabilitation, nor is it a strength-based approach to treatment.

Within society, MSO require support to reintegrate into the community following successful risk reduction and discharge from

forensic establishments. Whilst it is acknowledged that having the general public hold negative attitudes can be perceived to be a protective factor, equally it can have a significant negative impact on the MSO themselves. Negative attitudes held by members of the public are likely to prevent successful reintegration due to reluctance from the community to offer opportunities that are known to promote successful reintegration. These factors are discussed within the Good Lives Model (Ward & Stewart, 2003), placing an emphasis on the importance of recreational, social and occupational activities, in addition to a primary need for stable housing. A lack of opportunities afforded to MSO upon discharge from forensic establishments may have negative implications for the MSO which could result in feelings of rejection or stigmatisation. This may compromise their resilience against relapse.

**Strengths and limitations**

One strength of the study includes the large sample size ($n$=553). This sample size was sufficiently large to produce meaningful results, although not all were significant. Despite this strength, the participant sample was recruited through opportunistic sampling and therefore it was difficult to determine response rates. It relied on potential participants self-selecting to participate, and for those who chose not to participate, it would have been interesting to find out their reasons why. Furthermore, the sample may not be generalizable

due to the ratio of men to women. However, this ratio is representative of the gender composition within forensic healthcare, specifically psychology. Therefore, although there are large differences, it may be representative of the staff populations.

Furthermore with regards to the staff samples, the study did not ask professionals and paraprofessionals to specify whether or not they were involved in the therapeutic treatment of MSO. This limited the extent to which researchers could draw conclusions about the different types of exposure and professional role and how they influence attitudes. In addition, more demographic information such as marital status or victim experience may allow for a more meaningful analysis. Future studies should endeavour to gain as much demographic information as possible, to ensure a thorough analysis of a wide range of potentially important factors can be explored.

Although not necessarily a limitation of the study, it is important to consider whether attitudes may differ depending on the type of offence a MSO has committed. Previous research has found that contact offenders were perceived as more dangerous than non-contact offenders (Challinor & Duff, 2017). Therefore, it is possible that attitudes towards men who commit a contact sex offence, such as rape, would attract more negative attitudes than a voyeur, for example. It is also possible that the victim profile will influence

attitudes. A man who commits a sexual offence against a child may be perceived more negatively than a man who commits a sexual offence against his wife, for example. Future research may wish to consider whether providing specific information regarding offence type and victim profiles influences attitudes towards MSO.

A final strength of the study was its use of the ATS (Hogue, 1993); a valid and reliable tool which has been used numerous times to measure attitudes towards sexual offence perpetrators. The psychometric properties of the tool are discussed in chapter four. Although there have been some criticisms of the ATS, it was considered the best available tool at the time of the research due to its psychometric strengths and wide use within the existing literature.

**Conclusion**

Research into the attitudes of different populations towards MSO is important to understand the clinical and societal implications required to make positive changes and reduce recidivism. The research has highlighted the differences in attitudes towards MSO based on the level of exposure to the population. Staff who work with MSO were found to have more positive attitudes in comparison to the general public. Attitudes were not influenced by the participant's gender or the length of time they had worked with MSO. Some of the factors explored appear important; however, it is difficult to determine a causal relationship. Sexual offending is increasing as a societal

problem, resulting in high numbers of offenders being placed in forensic establishments. The quality of care and treatment delivered within these forensic establishments impacts on recidivism rates, alongside the ease of reintegration into the community through support from the general public. Therefore, the importance of further understanding within the area of study is considered important to reduce offending rates and relapse.

Chapter three uses the Attitudes Towards Sex Offenders scale (ATS; Hogue, 2003) to further explore some of the factors influencing attitudes. The ATS continues to be a widely used tool in the sex offender literature, although has been criticised for several reasons. Because of the published criticisms, chapter four aims to critically evaluate the psychometric properties of the ATS to determine its strengths and weaknesses. Chapter four also considers alternative methods to assessing attitudes towards MSO.

# Chapter Four

# The Attitudes Towards Sex Offenders Scale: An Exploration of the Psychometric Properties

## Introduction

As noted in Chapter Two, the Attitudes towards Sex Offenders Scale (Hogue, 1993) is one of the most commonly used tools to measure people's attitudes towards men who sexually offend (MSO). The tool is adapted from the original Attitudes towards Prisoners scale (ATP; Melvin, Gramling & Gardener, 1985). The ATS has been used in a large number of research studies, forming a literature base providing evidence regarding the factors that influence the nature of attitudes towards MSO. These have included profession (e.g. Fortney, Levenson & Baker, 2009), gender (e.g. Higgins & Ireland, 2009) and training (e.g. Craig, 2005).

The ATS was validated alongside the ATP by Hogue in 1993. One-hundred and sixty-four participants contributed to the data. British participants were recruited from four occupations, in addition to a group of men who had committed sexual offences. The occupations recruited included police officers, prison officers involved in the treatment of MSO, prison officers not involved in treatment, probation officers and psychologists. Hogue reports that police and

prison officers had significantly more negative attitudes than the other participant groups.

Exploring people's attitudes towards MSO is important for a number of reasons. Considering the research on general offenders, there is evidence to suggest that staff attitudes are linked to treatment outcomes, rehabilitation and recidivism (Marshall *et al.,* 2003). Attitudes towards sexual offenders affect the legal decisions made by criminal justice officials (Hogue & Peebles, 1997). It is important to assess the attitudes of those working with MSO to explore the relationship that attitudes have with compliance and responses to regimes and procedures within institutions. It is also important to consider the broader notion of attitudes towards MSO, due to the indirect link to risk of recidivism, for example through other people's reluctance to offer stable accommodation or employment (e.g. Willis & Grace, 2009).

From a public perspective, attitudes are thought to be linked to recidivism as a result of discrimination (e.g. Clark, 2007; Levenson, D'Amora & Hern, 2007). Discrimination towards ex-offenders can result in a lack of accessibility to primary goods, as outlined in the Good Lives Model (GLM; Ward & Maruna, 2007). Primary goods are described as certain states of mind, personal characteristics, experiences and actions that are thought to be valued by all human beings (Emmons, 1999). All individuals seek out primary goods and

some primary goods are given higher priority to others. It is suggested that some individuals may offend to attain their primary goods. In the context of committing sexual crimes, the primary good 'relatedness' may not be easily achieved for various reasons, therefore someone may offend against a victim to seek intimacy.

The considerations discussed highlight the importance of a psychometrically robust tool to assess attitudes towards MSO within a number of different populations.

**Aims**

Despite the wide use of the ATS within the literature, there is currently no critique that seeks to amalgamate the reported psychometric properties of the tool. The aim of this critique, therefore, is to combine the psychometric properties currently reported in the literature, in addition to further exploring the reliability and validity of the ATS.

## The Attitude Towards Sex Offenders Scale

The ATS (Hogue, 1993) is an adaptation of the ATP (Melvin *et al.,* 1985). In the construction of the ATS, Hogue omitted the word 'prisoner' from each item and replaced it with the words 'sex offender'. The ATP is considered to have good psychometric properties including good test-retest reliability (.82; Melvin *et al.,* 1985). The ATP has a split-half reliability varying between .84 and .92, suggesting good internal consistency (Gramling, 1979). The ATP

has not been found to be influenced by social desirability bias based on a correlation of -.02. (Melvin *et al.,* 1985).

The ATS comprises of 36 items referring to sex offenders. Of the 36 items, 19 are considered negative attitudinal statements, such as *'sex offenders never change';* and *'sex offenders should be under strict, harsh discipline'.* The remaining 17 items are positive statements, such as *'most sex offenders can be rehabilitated'.* Respondents are required to score each of the items on a five-point Likert-type scale. Responses range from strongly agree (4) to strongly disagree (0), with the mid-point response as undecided (2). The 19 negative statements are reverse scored. After summing the scores, a constant of 36 is removed, making the possible scale score range from 0-108. Higher scores indicate more positive attitudes and a score of 36 is considered to represent neutral attitudes.

The ATS has been widely used within the research literature (see table 3). Mean scores in the literature range from 64.5 in a general public sample (Ghakal & Brown, 2008); to 123.3 in a sample of forensic healthcare staff (Ferguson & Ireland, 2006). This range is to be expected if we consider the evidence that suggests an exposure cause and effect model. Those with the least therapeutic contact with MSO within the criminal justice system (e.g. police officers or judges) score the lowest on the ATS, indicating more negative attitudes (e.g. Higgins & Ireland, 2009; Johnson *et al.,* 2007). Those working within

a therapeutic capacity (e.g. prison officers, psychologists, or occupational therapists), or offenders themselves, score higher (e.g. Blagden *et al.,* 2014; Simon, 2010). Importantly, Hogue has recognised that a large proportion of the published data using the ATS has not considered the scoring guidelines discussed above. Some published research fails to remove a constant of 36 and some fails to reverse score negative items. The results provided in table three are from a range of studies, some of which have not scored the ATS correctly. This may be one explanation for why the results from chapter 3 are significantly lower than other published literature. Table three provides a selection of studies that have utilised the ATS to measure attitudes towards people who commit sexual offences. The studies in table three use a range of different participant groups and were selected to demonstrate the range of scores that are obtained across different populations when using the ATS.

| Study | N | Participants | Mean ATS (SD) | Country | Scoring |
|---|---|---|---|---|---|
| Blagden *et al.,* (2014) | 149 | Prison staff<br>Sex offender prisoners | 92.9 (18.1)<br>103.6 (14.2) | UK | Correct |
| Craig (2005)* | 74 | Hostel workers and probation officers | 76.2 (12.7) | UK | Correct |
| Ferguson & Ireland (2006) | 139 | Students<br>Forensic staff | 94.6 (18.3)<br>123.3 (15.0) | UK | No details provided |
| Gakhal & Brown (2008) | 176 | General public<br>Probation officers<br>Psychology students | 64.5 (14.9)<br>99.6 (9.5)<br>70.63 (14.1) | UK | Correct |
| Hogue (1993) | 164 | Police officers<br>Prison officers (no treatment)<br>Prison officers (treatment)<br>Psychologists & Probation<br>Sex offenders | 71.1 (15.78)<br>80 (13.75)<br>84.3 (12.3)<br>98.5 (10.57)<br>98.4 (17.34) | UK | Correct |
| Hogue (1995)* | 53 | Prison staff | 82.3 (not provided) | UK | Correct |
| Johnson *et al.,* (2007) | 175 | Probationer police officers<br>General public | 100.8 (13.2)<br>94.8 (20.0) | UK | Incorrect |

| | | | | | |
|---|---|---|---|---|---|
| Kjelsberg & Loos (2006) | 517 | Prison officers<br>Students | 84 (17.9)<br>74 (18.2) | Norway | Correct |
| Sanghara & Wilson (2006) | 131 | Professionals<br>Teachers | 109.5 (10.3)<br>90 (14.7) | UK | Incorrect |

Table 3. Existing ATS Literature and published data. *studies do not separate participant group scores.

## Psychometric Properties

### Reliability

The reliability of a psychometric tool is the degree to which it measures the construct that it intends to measure, whilst also providing consistent results across different samples and different time scales.

### Internal Consistency

Internal consistency measures how reliably different questions on a tool measure the same construct. Construct refers to an underlying theme or characteristic, i.e. one's attitude towards MSO. For example, one would expect a respondent with positive attitudes towards MSO to respond favourably to the statement "*most sex offenders can be rehabilitated*" and unfavourably to the statement "*trying to rehabilitate sex offenders is a waste of time and money*", as the statements both purport to measure attitudes regarding rehabilitation. Kline (1986) suggests that alpha coefficients of .70 or above denote good internal consistency.

The ATS has been found to have ranges in alpha coefficients from .86 to .96 (e.g. Craig, 2005; Ferguson & Ireland, 2006; Higgins & Ireland, 2009). Therefore, it is considered to have excellent levels of internal consistency. The majority of the studies reporting internal consistency appear to be limited to forensic staff populations in the

United Kingdom. The studies referenced do not differentiate the internal consistency between participant groups. For example, Ferguson and Ireland (2006) explored student and forensic staff attitudes; however report one overall Cronbach's Alpha value. It may be more informative if researchers were to provide alpha ranges for each participant group. It is also recommended that future research should seek to replicate such results in a more varied sample population; for example manipulating the culture or occupation of the participants.

**Test re-test reliability**

Test-retest reliability refers to a tool's ability to produce and reproduce the same results at different times. There is not currently any data to determine the test-retest reliability of the ATS. Although the ATP was found to have acceptable test re-test reliability ($r$=.82) this result cannot be generalised to the ATS. It is recommended that future research using the ATS aims to provide preliminary results regarding test re-test reliability.

**Validity**

Validity refers to the degree to which a tool to measures the construct it claims to be measuring. There are a number of different types of validity, which will be discussed in turn in relation to the ATS.

## Face Validity

Face validity refers to the appearance of a tool; does the tool appear to measure what it is claiming to be measuring, based on what one sees? Face validity is the most basic form of validity, although it has been criticised for being a superficial representation and not specifically validity (Downing & Haladyna, 2004).

On the surface to those completing the ATS, it appears to measure attitudes towards sex offenders. All of the 36 statements are clear in using the words sex offender. However, the ATS appears to have been simplistically adapted, which leads to questions regarding the sensitivity of the tool. Willis *et al*., (2010) argue that by omitting the word 'prisoner' and replacing with the words 'sex offender', the tool fails to tap into specific sex offender stereotyped attitudes. There is a risk that the ATS continues to measure more general attitudes towards offenders, rather than specifically sex offenders. The ATS may have been more effective at measuring what it purports to measure if it had been adapted in a way that tapped into more specific attitudes towards sex offenders. This may have been achieved by altering the entire language of the ATP, rather than just the wording. As a result, it can be assumed that the face validity of the ATS is poor as it lacks specificity.

A criticism of face validity is related to risk of socially desirable responding due to respondents being aware of what the tool is

measuring. This has the potential to increase the likelihood of one responding in a dishonest manner, so as not to be seen to be prejudiced.

**Social Desirability Bias**

Socially desirable responding is defined as *'the tendency for people to present a favourable image of themselves'* (van de Mortel, 2008, pp. 40). Attitudes towards sex offenders can be a controversial topic for discussion, particularly due to the way this offender group is portrayed by the media (Harper & Hogue, 2015). There is potential for respondents to manipulate their answers in order to represent themselves as more socially desirable than their true attitudes.

The ATP was not found to be associated with socially desirable responding (Melvin *et al.,* 1985), however there is currently no research to support or deny this claim in relation to the ATS. Therefore, further research is required to determine potential bias. Van de Mortel (2008) conducted a systematic review to determine the differences between tools that used statistical methods to control for socially desirable responding, with those that did not. Results found that almost half of the studies that used a socially desirable responding scale found that the concept did influence their findings. Therefore, future research using the ATS may benefit from the use of a scale to measure socially desirable responding in parallel, in order to ensure the reliability of the results produced.

## Factor Structure

Johnson, Hughes and Ireland (2007) conducted Exploratory Factor Analysis (EFA) to investigate the underlying structure of the ATS based on data obtained from the general population and police officers in the UK (*n*=174). The ATS was found to have three factors relating to; interpersonal qualities of sex offenders (*α*=.81); similarities of sex offenders to others in society and a willingness to engage with them (*α*=.81); and supporting treatment for sex offenders (*α*=.61). The three factors can be related back to the primary definition of attitudes with them representing interpersonal qualities (affective), similarities with other offenders (cognitive), and willingness to engage and support treatment (behavioural).

Higgins and Ireland (2009) went on to repeat the EFA producing different results. Five factors emerged from the response data provided by forensic staff and the general public (*n*=240); like, harsh, trust, respect and immoral. It is difficult to ascertain how similar the five factors found may be in comparison to Johnson *et al's.,* (2007) three factors. This is due to a lack of elaboration on what each factor, represented by a single word, actually refers to. Furthermore, The EFA suggests 19 items are positive attitudinal statements. However, Hogue (1993) describes 19 negative statements requiring reverse scoring. It is unclear from the methodology provided by Higgins and Ireland (2009) how they conducted their EFA; there is no alpha

coefficients provided or any information regarding factor loadings and eigenvalues. It may be possible, therefore, that the EFA by Higgins and Ireland (2009) was of poor quality and has provided unreliable results which lead to variable conclusions. It is possible that some of the neutral statements in the ATS-36 have been misinterpreted as positive statements. No firm conclusions can be drawn about this due to a lack of information provided regarding the statements that fall into each factor. It is noteworthy that EFA interpretation is a subjective process and this may account for the differences between different studies factor structures, in addition to different participant groups, which may provide different data for factor loadings.

More recently Hogue confirmed the factor structure of the ATS using a community sample and the original data (Hogue, 1993). This indicated a three factor structure; trust ($a$=.83; affective); intent ($a$=.84; cognitive), and social distance ($a$=.79; behavioural). From the three factor structure, Hogue re-designed the ATS-36 and created the ATS-21 based on the 21 questions that yielded the highest factor loadings. The original 36-item and the revised 21-item ATS were found to be very highly correlated ($r$=.983, p<.000; Harper & Hogue, 2014). Whereas the original ATS-36 presented attitudes as a single dimension, the revised ATS-21 clearly identifies three subscales based on the factor structure and relating to the definition of attitudes in chapter one.

## Cultural validity

Cultural validity can be defined as '*the extent to which a tool addresses the socio-cultural influences [...] and the ways in which we make sense of [...] items and respond to them'* (Solano-Flores & Nelson-Barber, 2001, p. 555). To our knowledge, the ATS has only been used in research in one non-English language country (Norway; Kjelsberg & Loos, 2008), where the tool was translated into Norwegian. Internal consistency was consistent with that reported in the wider literature, suggesting the tool was culturally valid in a Norwegian population. However, aside from Norway, the tool has only been used in English language countries (UK and USA), therefore, it can only be considered to have fair cultural validity and would benefit from more research across cultures to further examine the cultural validity of the tool.

## Ecological Validity

Ecological validity refers to the extent to which any piece of research reflects real life (*Key Issues: Ecological Validity*, 2013). Ecological validity involves maintaining the integrity of the real life situation in the experimental context, while remaining faithful to the larger social and cultural context (Schmuckler, 2001). The ATS has been widely used with a number of different professional, paraprofessional, non-professional and offender populations in a variety of different environments. However, there are concerns with self-report tools

such as the ATS regarding possible social desirability bias. Therefore, with the presence of social desirability, the ATS may not maintain the integrity of real life situations because respondents may be motivated to bias their responding for several reasons, e.g. to conform to socially acceptable values or to avoid criticism. As such, the ecological validity of the ATS is questionable.

**Normative Data**

Normative data and the standardisation of a tool across different groups of participants enhance the utility and meaningfulness of data (Kline, 1986). Normative data allows for meaningful comparisons between groups of participants. As previously discussed, the ATS is a widely used tool within the research literature. Normative data can be taken from a number of different environments (i.e. community, forensic healthcare and prison environments). Normative data were also provided using a number of different participant groups including; prisoners and prison staff (Blagden *et al.,* 2014), forensic healthcare staff (Ferguson & Ireland, 2006), community support staff (Craig, 2005), psychologists (Ferguson & Ireland, 2006), police officers (Johnson *et al.,* 2007), counsellors (Nelson *et al.,* 2002), the general public (Sanghara & Wilson, 2006) and MSO (Hogue, 1993). The wide-ranging normative data within the literature means that researchers are able to compare their results with other published results from the ATS, in order to make more meaningful conclusions

regarding their data. As previously identified, Hogue does not provide any information to enable researchers to categorise their data into positive or negative attitudinal scores. Currently, the best available comparisons to make are against the neutral score of 36 and normative data published in the research literature. However, Hogue also notes that many researchers have not followed his scoring criteria regarding the items that require reverse scoring and subtracting a constant of 36 from the total ATS scores. Whilst some of the studies using the ATS describe their scoring procedure, not all researchers report this. Therefore, it is unclear in some studies if the data has been scored correctly and if it can be used as a reliable comparison.

**Nature of Likert-type Scales**

Likert-type scales are commonly used within research to provide respondents with a simple response scale. However, the scale has been criticised for not conceptualising the distance between each point on the scale, leaving this open for interpretation by respondents. During Likert's formulation of the scale (Likert, 1932), the purpose of the mid-point was to provide respondents with a neutral, or impartial mid-way point between the 'agree' and 'disagree' continuum. Within the ATS, Hogue named the mid-point (2) 'undecided', which can be perceived as a response to select if one does not know their opinion on a question. This could lead to

inaccurate data regarding people's attitudes towards sex offenders and could mislead researchers to inaccurate conclusions. To overcome this, the ATS could utilise a non-response option to prevent inaccurate data collection. When the current authors conducted research using the ATS (Challinor & Duff, 2015), feedback from general public participants identified that they found it difficult to answer some questions as they did not feel they had the appropriate knowledge and therefore selected undecided. This not only highlights the potential overuse of the undecided option, it also highlights the importance of ensuring tools are accessible to all populations. This potentially suggests that the ATS is more accessible to those with previous knowledge or experience regarding sex offenders.

A further criticism of the use of undecided in the Likert-type scale is highlighted in data published by Nelson *et al.,* (2002). It is noteworthy that Nelson *et al.,* (2002) incorrectly scored the ATS; a constant of 36 was not subtracted from total scores and the Likert-type scale was scored 1-5, rather than 0-4 as per Hogue's (1993) instructions. However, the method used by Nelson *et al.,* (2002) may be useful to better interpret ATS scores. Nelson divided raw ATS scores (range 36-180) by 36 (number of items) to convert the raw scores back to the 5-point Likert scale in an attempt to increase the interpretability of the scores. Results confirmed that the counsellor participants did hold positive attitudes towards sex offenders, as their mean scores computed using the above description, fell significantly

above the mid-point of three. Thus, future researchers may wish to interpret attitudinal scores relative to the underlying anchors of the scale, rather than the initial mean score.

Finally, some researchers have been criticised for using parametric statistics on ordinal data; the type of data being produced by the ATS Likert-type scale. Statisticians have suggested that such statistics cannot be used on ordinal scales (Kuzon, Urbanchek & McCabe, 1996). However, there is evidence to suggest that parametric statistics are extremely robust and should be used in preference to non-parametric statistics (Rasch & Guiard, 2004). The majority of the literature reporting the ATS has used parametric Analysis of Variance (ANOVA) to statistically analyse the data (e.g. Challinor & Duff, 2015; Higgins & Ireland, 2009). ANOVA is reported to control for type one error successfully, under the conditions of skew, kurtosis, or non-normality (i.e. non-parametric data; Field, 2009). Therefore, those studies utilising parametric statistics to measure the ordinal data from the Likert-type scale of the ATS should not be criticised for having done so, provided other assumptions are not violated.

**Alternative Measures**

As previously discussed, the ATS-21 is thought to provide a more comprehensive measure of attitudes, as a confirmatory factor analysis identifies a factor structure that maps onto the definition of attitudes described in chapter one (Breckler, 1984). Harper, Hogue

and Bartels (2017) recommend that the ATS-21 be used as a complimentary measure to the Perceptions towards Sex Offenders Scale (PSO; Harper & Hogue, 2015[a]; Appendix H). The PSO was developed after poorly-loaded CATSO items were removed and eight new items were added that were thought to have a better conceptual fit. A confirmatory factor analysis revealed three underlying factors; 'sentencing and management', 'stereotyped endorsement' and 'risk perception'. Harper and Hogue (2015[a]) suggest that using the ATS-21 (an attitudinal measure) and the PSO (a measure of perceptions) provides a more comprehensive analysis of attitudes and perceptions when used together. Therefore, future research may wish to utilise the ATS-21 and PSO, rather than using the ATS-36 as a single measure.

## Discussion

To continue to develop the best evidence-based therapeutic treatment for sexual offenders, researchers must accurately assess the contributory factors to successful treatment. Within this, an important contributory factor is the attitudes of the staff working with sexual offenders in varying capacities. Therefore, a reliable, psychometrically robust tool must be utilised to allow accurate, non-bias recording of attitudes to enable people's attitudes towards sex offenders to be addressed or challenged as necessary.

The ATS was developed to facilitate an accurate assessment of people's attitudes towards sex offenders. The tool has been found to have good internal consistency; however it requires further testing to determine accuracy of test-retest reliability. In addition, the ATS is seemingly a simplistic adaptation of the ATP which raises questions regarding the sensitivity of the tool to measure attitudes towards sex offenders. Willis *et al.,* (2010) suggest that simply omitting the word 'prisoner' from the ATP and replacing with 'sex offender', does not specifically tap in to sex offender stereotype attitudes, but continues to measure attitudes towards general offenders.

By way of overcoming this criticism, researchers recommend that either the ATS-36 or the ATS-21 be used alongside the PSO to conduct a thorough analysis of attitudes and perceptions, consistent with the definitions provided in chapter one. The PSO was not critiqued in the current review due to the small amount of data currently available within the literature. The PSO may enable improved understanding of perceptions and could enable researchers to improve communication and understanding between a number of different agencies, including law enforcers, judiciary and the general public regarding sex offenders. However, Harper and Hogue (2014) recommend that the PSO be used as part of a battery of measures to ensure all aspects of attitudes, perceptions and social cognitions are covered when assessing the constructs. Therefore, it is recommended

that future research should seek to use a battery of tests including the PSO and the ATS-21.

## Conclusion

Whilst this chapter highlights some of the psychometric strengths of the ATS, it also recognises a number of limitations. In addition, it is clear that some researchers experienced ambiguity regarding the correct scoring processes, resulting in some of the published literature being inaccurate. As such, it is recommended that alternative tools are used to measure attitudes and perceptions of MSO and that scoring methods are considered carefully to ensure accurate reporting.

Chapter four highlights the psychometric shortfalls of the original ATS-36 and makes suggestions for the future use of alternative scales to measure attitudes and perceptions towards MSO. As a result of the findings from chapters two and three, chapter five reports on a narrative humanisation intervention conducted with staff from a forensic service who subjectively report difficulties in working with MSO. Due to the recommendations made in chapter four, the ATS-21 and the PSO were used as alternatives to measure the pre and post outcomes from the intervention.

# Chapter Five

## Understanding staff attitudes towards men who have committed sexual offences: a narrative intervention


### Abstract

This chapter describes a narrative intervention carried out with forensic nursing staff who self-referred as a result of subjective difficulties in working with men who sexually offend. The aim was to explore existing narratives about those who commit sexual offences, before working to build more humanised and more person-centred narratives. The intervention was delivered through a one-day workshop (n=3). Pre and post measures evidence clinically significant change in the attitudes and perceptions of staff, with change evident in a positive direction. Qualitative analysis evidences increasingly humanised narratives. An increase in person-centred care plans and a decrease on the reliance of restrictive practices to safely manage perceived risks occurred throughout the day. The results highlight the strength of applied learning tasks centred on care aspects of the forensic nursing role to enhance changes in routine practice and to challenge stereotyped attitudes.

## Introduction

### The effects of labelling 'Sex Offenders'

The label 'sex offender' has assumed a distinctive place in contemporary vocabulary (Harris & Socia, 2014). The label carries its own assumptions and beliefs, which promote and reinforce negative attitudes. Regardless of whether one commits an offence or not, a label such as 'paedophile' holds connotations that one would associate with committing a sexual crime (Jahnke, Imhoff & Hoyer, 2014). Surveys of the general public conclude that sex offenders are at high risk of recidivism (Katz-Schiavonne, Levenson & Ackerman, 2008); despite official figures demonstrating that those who commit sexual offences are one of the lowest recidivist offender populations (Harris *et al.,* 2003). Forensic nursing staff have been found to have more positive attitudes that are less stereotyped (e.g. Blagden *et al.,* 2016). However, it should be considered when one's attitude improves in the context of length of time in employment. It is important to support newly appointed staff to begin to challenge their own attitudes. In practice, it would seem that the label of 'sex offender' invites people to react emotively and reinforces pre-conceived attitudes and beliefs about the potential risk presented by this type of offender. It potentially compromises our capacity to make accurate, evidence-based conclusions regarding suitably proportionate risk management.

## Narrative Humanisation

Dehumanisation of MSO has been found to be associated with support for social exclusion and harsh punishments (Viki *et al.,* 2012). The dehumanisation of MSO is linked to the way in which the media portray this offender group and their crimes. Based on previous discussions regarding the portrayal of MSO in the media, it seems important that presenting more humanised information about MSO and their crimes has the potential to improve the attitudes of those receiving the information. Narrative humanisation is a process whereby information is presented from a personalised perspective of somebody who has committed a sexual offence. The process has been used to determine whether the method has more profound impacts on stigmatisation and punitive attitudes about this perpetrator group than other established methods such as informative presentations (Harper, Hogue & Bartels, 2018). Previous research has found that narrative humanisation does have a profound impact on the responses towards the individuals (Walkington & Ashton-Smith, 2015; Harper, Hogue & Bartels, 2018). On the basis of this information, it seems that there is potential for the efficacy of narrative humanisation to have a positive effect on attitude change. Therefore, this case study aims to examine whether humanised information presented about MSO in different forms can improve the attitudes of staff working in forensic settings with MSO.

## Aims

The aims of the intervention were threefold;

I. To explore nursing staff's existing narratives about MSO, which could reveal existing unique outcomes;

II. To challenge any negative narratives that emerge and to facilitate the development of more positive narratives through the process of narrative humanisation;

III. To measure the effectiveness of narrative humanisation both quantitatively and qualitatively using pre and post measures.

## Method

### Participants

To recruit to the research intervention, an email was sent to all staff employed on Ward R, a low-secure step down ward predominantly populated by MSO. Staff were invited to self-refer to the group on the basis that they personally experienced difficulties with this client group. Six staff self-referred however, staffing limitations on the ward limited the release of participants; three staff were able to attend the intervention on the day. An overview of the participant demographics is presented in table 4.

| | Participant 1 | Participant 2 | Participant 3 |
|---|---|---|---|
| **Gender** | Female | Male | Female |
| **Age** | 44 | 30 | 28 |
| **Parent** | Yes | Step-Parent | No |
| **Gender of child(ren)** | Female | Male and Female | N/A |
| **Length of time working in secure care** | 20 years | 2.5 years | 3 months |
| **Length of time working with men who have sexually offended** | 11 months | 2.5 years | 3 months |
| **Job role** | Senior Staff Nurse | Healthcare Assistant | Student Nurse |
| **Previous training regarding men who have sexually offended** | No | No | No |

Table 4. Overview of participant demographics.

## Pre and Post Measures

*Perceptions of Sex Offenders Scale (PSO; Harper & Hogue, 2014)*

The PSO seeks to measure changes in perceptions following education initiatives, rather than specifically measuring attitudes. It

is designed as an alternative to the Community Attitudes Towards Sex Offenders (CATSO) questionnaire (Church *et al.,* 2008). The CATSO has been criticised for measuring knowledge-based attributions towards those who commit sexual offences, rather than respondent's affective judgements (Harper & Hogue, 2014). The PSO seeks to examine; an understanding of who those who commit sexual offences are and perceptions about how they should be sentenced or managed post-conviction. Six items are reverse-scored and a constant of one is subtracted from each item. Scores range from 0-5 per item on a Likert-type scale, and from 0-100 for the full scale. Higher scores on the PSO are indicative of more punitive perceptions of those who sexually offend. The PSO has excellent internal consistency (.92; Harper & Hogue, 2014).

*Attitudes Towards Sex Offenders Scale 21 (ATS-21; Hogue, in press)*

The 21-item ATS is a revalidated version of Hogue's 36-item ATS (1993), which was an adapted version of Melvin, Gramling and Gardner's (1984) 'Attitudes towards Prisoners scale' (ATP). The ATS-21 was used within the current research as an alternative to the ATS-36 due to the findings from chapter four. The ATS-21 has improved psychometric properties (Hogue, in press), whilst remaining highly correlated with the original version. The items are responded to on a five-point Likert-type scale (ranging from 1; strong disagree, to 5;

strongly agree). Eleven items are reverse-scored and a constant of one is removed from each item; thus the scoring range for the ATS-21 is 0-84. Higher scores indicate more positive attitudes.

**Procedure**

The intervention was delivered by two psychologists over the course of one day. A PowerPoint presentation was shown detailing the overarching aims for the day, Finkelhor's (1984) pathway to sexual offending and an overview of narrative humanisation. There were also three key practical group exercises mapped onto the theoretical aims. The intervention used a routine clinical nursing activity 'care planning' and exercises to demonstrate practically how staff attitudes inform the healthcare role and the way they work with service users. The intervention comprised of three stages. Each stage built on the former with increasing amounts of humanised information being provided regarding the case vignette.

| Stage | Materials |
|---|---|
| One | Initial referral letter outlining Mr X's offence history and diagnosis, requiring admission to a specialist low secure hospital (Appendix I). |
| Two | Letter from Mr X's sister to provide further information about childhood and upbringing (Appendix J). |
| Three | Proposed integrated psychological formulation for Mr X following initial psychological assessment and intervention (Appendix K). |

Table 5. Stages of intervention.

At each stage participants were asked to discuss which piece of information was most salient and why. Secondary to this, the group were asked to develop care plans for Mr X and to reflect on how the care plans changed after each new piece of information.

After stage one, participants were provided with psycho-education using Finkelhor's Pathway to Offending. The purpose of this information was to encourage the participants to consider the process leading to committing a sexual offence. Next, participants were provided with some brief information about the concept of narrative humanisation to help them to understand the sequence that the intervention would follow.

Participants were then issued with a letter from Mr X's sister and were encouraged to discuss the ways that stigmatising narratives may perpetuate problems. This included the perspectives of the offender, the staff's work, their relationship with others, and the capacity to provide support to MSO. Participants were then issued with the final piece of information, designed to build their stigmatising narratives into, better-informed, person-centered narratives, which should be privileged within a treatment setting. This included discussions around sharing unique outcomes and to consider alternative explanations as to why people may commit sexual offences.

After reading the formulation in stage three, the group were asked to re-author their original care plans and consider whether there had been a shift in their personal thoughts and feelings. Post-intervention measures were re-administered.

**Qualitative Data**

In addition to the pre and post quantitative data gathered, hand-written verbatim notes were kept to record the discussions throughout the intervention. Data were analysed using a thematic-informed phased approach, as outlined by Braun and Clarke (2006). This method was adopted due to its flexibility and accessibility for the researchers. It required the researchers to become familiar with the data gathered by reading and re-reading a number of times. An inductive approach was used, as the researchers were not bound by

a pre-existing coding frame. Next, the researchers identified frequently recurring patterns of responses and codes, in addition to data that was considered salient to the research aims. Sub-themes were generated using the common language identified within the narratives, before refining sub-themes into overarching themes that represented the way in which participant's thoughts and feelings appeared to have changed over time. Finally, themes were compared against the original data to ensure they accurately represented the views of the participants.

**Ethical Considerations**

Due to the sensitivity of the research topic, ethical aspects were an important consideration to protect and reassure participants. Prior to self-referring, staff were given information to confirm that their anonymity and confidentiality would be maintained throughout the research and within the write-up. At the beginning of the intervention, participants were informed of their right to withdraw at any time and were told that any information previously gathered would be destroyed. Participants were only identifiable through a personal identification number. All relevant material for the research was kept in a locked drawer in line with the charity's Information Governance policy. Participants were provided with a de-brief by facilitators at the end of the intervention and were provided with

contact details for both facilitators. Alternatively, participants had the option to self-refer to the charity's counselling psychologist.

## Results

## Quantitative Data

Quantitative data were analysed to determine whether results were clinically significant using the Reliable Change Index (RCI); a measure of significance based on the reliability of the tool. RCI is calculated using the following formula:

$$RCI = \frac{x2-x1}{\sqrt{2(s1\sqrt{1-\mathrm{rxx})2}}}$$

Where $x^1$ represents the participant's pre score, $x^2$ represents post score, $s^1$ represents the standard deviation and $r_{xx}$ is the test-retest reliability of the tool. RCI scores provide a measure of change, the direction of that change and whether the change is reliable. An RCI of $\geq$1.96 indicates clinically significant change (Jacobson & Truax, 1991) beyond what would be expected by chance.

*Perceptions of Sex Offenders Scale (PSO)*

Table six provides an overview of the pre and post scores obtained for each participant on the PSO, along with the RCI. Higher scores on the PSO indicate more punitive perceptions of the case studies; therefore, a negative RCI indicates positive change.

| | Pre | Post | RCI |
|---|---|---|---|
| **Participant 1** | 47 | 29 | -11.18 |
| **Participant 2** | 41 | 33 | -6.47 |
| **Participant 3** | 32 | 21 | -7.48 |

Table 6. PSO results.

All participants indicate a clinically significant change in their attitudinal scores, indicating a positive attitudinal change.

*Attitudes Towards Sex Offenders Scale 21 (ATS-21)*

Table seven provides an overview of the pre and post scores obtained for each participant on the ATS-21, along with the RCI. Higher scores on the ATS-21 are indicative of more positive attitudes, therefore a positive RCI indicates positive change.

| | Pre | Post | RCI |
|---|---|---|---|
| **Participant 1** | 29 | 50 | 9.72 |
| **Participant 2** | 58 | 69 | 22.97 |
| **Participant 3** | 45 | 53 | 23.39 |

Table 7. ATS-21 Results.

All participants' results indicate a clinically significant change in attitudinal scores from the ATS-21, suggesting that using a narrative humanisation approach contributes to an improvement in attitudes.

## Qualitative Data

Data were analysed independently by each facilitator using a thematic-informed analysis (Braun & Clarke, 2006) described in a previous section. An overview of the themes is provided in table eight. Each stage will be discussed in turn, considering the themes at each stage.

| Stage of Intervention | Name of Themes |
|---|---|
| Stage One – Referral Letter | Theme 1 – 'Us' |
| | Theme 2 – 'Us' vs. 'Them' |
| | Theme 3 – Family |
| | Theme 4 – Risk Averse Care Planning |
| Stage Two – Letter from Sister | Theme 5- 'Them' moved to 'Him' |
| | Theme 6 – Responsibility |
| | Theme 7 – Positive Risk Care Plans |
| Stage Three – Integrative Formulation | Theme 8 – Trauma Informed Care Planning |
| | Theme 9 – Enabling / Re-Parenting |

Table 8. Overview of Themes.

*Stage One – Referral Letter*

It becomes clear from the initial thematic analysis that during stage one, perceptions were centred on the negative thoughts and feelings towards the offender.

*Theme 1 – 'Us'*

Participants voiced negative perceptions relating to their role as a staff member after reading Mr X's referral letter. They struggled to see the service user as a person and just saw their offences; evidencing difficulties in putting aside the label; a common theme found in previous research (e.g. Harris & Socia, 2014). Thoughts regarding the referral included *"it's just another sex offender"; "I didn't train for this";* or *"why can't he stay in prison".* In terms of personal feelings, participants felt *"nervous"* because of the unknown; there were feelings of repulsion, fright and fear, sickness and feelings of *"contamination".* One participant worried about what working with this client group said about them; *"what does this say about me? What do other people think about what I do?"*

*Theme 2 – 'Us' vs. 'Them'*

Negative perceptions continued when participants began to think about the offender as a person. It focussed on the divide between staff and offender, enhanced by the use of language including; *"monster"* and *"predator".* Characteristics associated with the offender group were *"manipulative"* and *"untrustworthy".* Negative beliefs were also held regarding the offender's admission to hospital as an alternative to prison. Participants felt that having a diagnosis was a *"passport"* for a hospital admission. This was predicted to have

a negative impact on the ward dynamics as a result of the *"chronic and diverse"* offending behaviours described in Mr X's referral letter.

*Theme 3 – Family*

Considerations were also given to the family within discussions. This included questions being posed such as *"why haven't his family disowned him?", "has he learnt this behaviour from other family members?"* and *"has he been victimised by his own family?"* There was clearly evidence of suspicion towards the family and thoughts regarding their role in the offending. On the other hand, participants *"feel sorry"* for the parents and assumed they would experience *"shame"* and *"disappointment".*

*Theme 4 – Restrictive Care Plans*

In terms of the initial care plan constructed by participants in preparation for admission of Mr X, this was restrictive and risk focussed. Initially, participants stated Mr X should not be admitted due to his perceived heightened risk level. Participants' placed Mr X on enhanced 15 minute observations to ensure the perceived risk he poses to staff and peers could be adequately managed. In addition, participants limited any access to the internet due to fears he may contact his victims. They highlighted that telephone contact should also be monitored by staff to prevent any victim contact. Finally, participants felt that Mr X *"should never be let back out into the community".*

From the analysis of discussions held after the presentation of Mr X's referral letter, it becomes noticeable that participants held a problem-focussed perception of Mr X, and had significant difficulties seeing beyond his label of a 'sexual offender'. Care plans were heavily risk focussed and there was a general reluctance to consider any positive or protective factors relating to Mr X.

*Stage Two – Sister's Letter*

Following the presentation of the letter received from Mr X's sister, a shift was observed from focusing on personal thoughts and feelings, to considering Mr X beyond his label, with more positive additions to his original care plan.

*Theme 5 – 'Them' moved to 'Him'*

Participants began to consider alternative explanations for Mr X's offending behaviours at this stage of the intervention. Consideration was given to internal factors; *"he has insight and an ability to show remorse, disgust and guilt"* and *"he has difficulties in regulating his emotions which may have impacted on his ability to consider the consequences"*. Discussions were also held around the external factors that may offer explanations; *"he has had adverse childhood experiences"* and *"he may have been searching the internet for images to make sense of his own victimisation"*. Participants discussed the personal qualities that emerged from the letter,

including; compassion, consideration, reflexive, humble, problem-solver, a survivor and kind.

There was very little emphasis on personal thoughts and feelings towards Mr X at this stage of the intervention. All participants agreed that they were *"wrong"* about Mr X and began to consider him in a more positive light; therefore 'us' became a redundant theme.

*Theme 6 – Responsibility*

A shift became apparent from thinking that the family were in some way responsible, to now recognising it was the offender's responsibility. Discussions were held around whether they had let him down by not monitoring him enough. Alternatively, participants felt that the family were very supportive and this acts as a protective factor for Mr X, however emphasis was placed more heavily on his responsibility for his offending.

*Theme 7 - Positive Risk Care Plans*

The care planning at this stage took a more strength-based approach, looking at the activities Mr X enjoys, his protective factors and how these can be built into his care plan to promote rehabilitation. This included his motivation to engage, his ego dystonic feelings and his supportive family network. In addition, emphasis was placed on not being able to *"change"* Mr X's sexual preference, but to provide him with education around sex and the law to encourage independent risk

management. The care plan becomes less risk-focussed, and begins to build on a strength-based approach to his rehabilitation.

*Stage Three – Integrative Formulation*

After the final presentation of futher humanised information in the form of an integrative formulation, the personal feelings towards Mr X had taken a somewhat softer approach and participants spoke about a need to consider the wider perspective. Feelings included *"sympathy for what he has been through"* as a result of him being *"damaged".* Participants felt that Mr X required *"TLC"* as a result of his own victimisation.

*Theme 8 – Trauma-Informed Care Planning*

Again, the care planning took a different approach in the final stage of the intervention, with a much heavier emphasis on skill development and identification of a clear treatment pathway within the context of Mr X's historical trauma. Consideration was given to his relationships; participants felt that avoiding the use of a male care team initially was important, as was the consideration given to the female care team; it was felt that a *"maternal"* approach was important, whilst remaining *"confident, consistent and boundaried"*. In an attempt to overcome the artificial safety in secure settings, participants highlighted the need for positive risk taking, graded Section 17 leave, reduced observations and unescorted family visits.

In terms of Mr X's treatment pathway, participants identified the need for skills development, suggesting referrals to group work including assertiveness skills, self-esteem work and integrated trauma informed care. In addition, participants highlighted the need for Mr X to engage in occupational activities in order to develop practical skills and encourage a sense of purpose, consistent with the GLM. In the longer term, participants highlighted the need for Mr X to engage in a Sex Offender Treatment Programme designed to deconstruct his offending and to promote exploration and understanding.

*Theme 9 – Enabling / Re-parenting*

Finally, participants were invited to consider the role they play in working with MSO. There was a feeling that *"we need to instil hope and filter this down to the service users"* and *"see the person, not just the crime or the label".* Participants also highlighted the need to look at the bigger picture and give their commitment to rehabilitation using a more positive approach. Participants were keen to be perceived as *"enablers"* to rehabilitation, rather than *"disablers"* and to take on a 're-parenting' role.

## Discussion

The case study aims to provide an evaluation of the effectiveness of using a narrative humanisation approach with staff who work with MSO and self-identify difficulties in working with such a client group. A measure of RCI provides encouraging results that indicate positive change in attitudes based on clinical significance. The approach evidences that people go through a process of change in attitudes and this lays the foundation for more thoughtful and person-focussed care and treatment.

Within the qualitative analysis, it was clear from the beginning that participants were taking a problem-focussed stance on care planning and in the sharing of their personal thoughts and feelings, likely to have been informed by cultural myths. Thin narratives were privileged and often used derogatory language such as *"predator"* and *"monster"* to describe Mr X. However, throughout the course of the intervention, narratives became increasingly informed by the humanised information provided at each stage. This encouraged participants to identify that they needed to see the bigger picture concerning MSO. Within this, participants began to consider alternative explanations for the reasons why men commit sexual offences, including internal factors such as poor emotional regulation and external factors such as adverse childhood experiences, which influence future behaviour and relationships. Participants reported

feeling less distressed personally, as they shifted their focus from the *"bad bits"*.

**Unintended Consequences**

A potential unintended consequence of this type of intervention is the potential for differences in approaches to care between staff who have and have not engaged. The results have shown positive changes in approaches to working with MSO which may become inconsistent between staff. Those who have not engaged in the narrative humanisation approach may continue with a heavily risk-focussed approach, whilst those who have may be more inclined to take positive risks. Not only could this result in inconsistent management approaches, it could also have the potential for MSO to see opportunities to split teams.

**Reliable Change Index**

Using the RCI as an alternative to statistical analysis was deemed appropriate in this case due to the small sample size and the need to measure individual, rather than group change. According to Zahra & Hedge (2010), the RCI excels in conditions of very small samples in comparison to typical non-parametric statistical options, which are more difficult to implement on small sample sizes. One critique of using the RCI is the potential for practice effects to occur when measures are repeatedly administered. However, this was not believed to be an issue within the current case study as measures

were not repeatedly administered. In such cases, the RCI formula can be corrected if a control group is used to estimate practice effects (Chelune, *et al.,* 1993).

**Strengths and Limitations**

There are limitations to consider when delivering such an intervention that requires an open and honest forum. In order to maintain ethical principles, an intervention of this type requires participants to self-refer based on their own acknowledgment of their difficulties in working with MSO. Although the original invitation email was sent to twenty-seven staff, only six responded to the email, despite professional observations on the ward indicating that many more staff struggle in their work with this client group. This suggests that some staff were reluctant to refer themselves to an intervention which requires such a level of openness and honesty. It requires staff to acknowledge and accept that they find their work difficult, which is not an easy admission for many of us. It may also be difficult for staff to challenge their personal views in order to maintain professional integrity. However, it is hoped that positive feedback from the current participants may increase future numbers in staff based interventions.

Furthermore, although this intervention evidences that some staff are willing to acknowledge their difficulties and attend an intervention to challenge this, it is not always feasible to assume that staff can be

released from wards. In the current climate within healthcare settings, financial budgets are reducing and staffing levels are influenced by this in a way that means it is difficult for managers to release staff from the wards. This is highlighted by a number of failed attempts to deliver the intervention prior to the day that it was delivered.

As the results demonstrate, attitudes shifted from more negative attitudes to more positive attitudes. It may have been that the humanised information provided at each stage influenced this too much and results may have been more reflective of participant's true feelings if the information at each stage had incorporated both negative and positive attributes. It may be unrealistic to assume that participant's attitudes had completed shifted to entirely positive following the one-day workshop and therefore the information provided may have biased results somewhat.

In addition, the researchers acknowledge the limitations of using Finkelhor's (1984) dated model to explain the cycle of sexual offending. The model does not provide an adequate explanation for all types of sexual offence perpetrators and therefore alternative explanations may have been more suitable. However, Finkelhor's model provides a simplistic explanation that can be easily understood by all, thus it was utilised in this instance.

The main strength of the intervention was the open forum for exploration of thoughts, feelings and attitudes towards MSO. Control and leadership was passed over to the participants, allowing them to direct the intervention to meet their own needs as participants engaging in a targeted intervention. Participants have commented on the effectiveness on a personal level, but also with respect to their ability to work with this client group. In the longer term, the positive effects gained from the intervention have the potential to improve the implementation of least restrictive care and enhance person-centred working. The intervention evidences the value in taking a narrative humanisation approach to working with staff to understand their attitudes and perceptions towards MSO, rather than delivering traditional training, which has been found to have little effect in increasing positive attitudes (Craig, 2005).

The intervention has one major limitation that would require revisions if it were to be delivered again. As the researcher designed, delivered and evaluated the workshop, there is potential for researcher bias to have been present. This has an impact on the validity of the intervention. To overcome this in the future, it would be beneficial to have different people completing each stage of the case study. In addition, a more reliable qualitative analysis may have been possible if the researcher had audio recorded the entire day.

Testing participants on the post-intervention measures on the same day as the intervention may serve as another limitation for the case study. This lack of follow-up does not allow for staff to return to their duties to determine how effective the intervention has had on their clinical practice. If a follow-up period had been utilised, the post-intervention results may have differed from those presented. Follow-up periods should be utilised where possible to enable effective evaluation of intervention upon clinical practice.

**Clinical Implications**

The intervention highlights the importance of encouraging staff to acknowledge and challenge their own attitudes and perceptions towards MSO. From a professional practice perspective, it is hoped that interventions of this kind may help to limit the use of restrictive practices informed by a service user's index offence and prevent the use of punitive practice. MSO require a positive and collaborative treatment approach that is person-centred, holistic and least restrictive. However, as highlighted in the initial stages of the intervention, this may be compromised by the attitudes held by some members of staff. The study evidences the efficacy of implementing an intervention to challenge punitive narratives and the restrictive practice that can flow from such narratives. Furthermore, the study highlights the potential for new narratives to emerge along with more person-centred practice.

From a care planning perspective, the intervention evidences the positive impact that increased knowledge and alternative perspectives can have on care plans. During the intervention, there was a shift from restrictive, heavily risk-focussed care plans, to person-centred; skills-based care plans that evidenced a clear treatment pathway. Initially, there was a feeling within the room that Mr X should *"never be let out"* and this was reflected in the heavily restrictive initial care plan. However, the final care plan began to consider discharge planning and the therapeutic treatment requirements for the service user to engage in. The final care plan considered existing strengths and ways in which these could be built upon, as well as equipping Mr X with new skills. This evidences the importance of working with staff to explore the way they perceive MSO to place less emphasis on unreliable subjective feelings, but to triangulate their 'gut' feelings with more objective data (e.g. Offence Paralleling Behaviours) to provide a more systematic approach.

For MSO themselves, it is hoped that the outcomes from the intervention with staff filters down to instil increased feelings of self-worth as a result of the increased positivity in those who support them. By taking a skills-based, discharge planning approach to treatment pathways and care planning, this may instil hope for each of the men and encourage them to think about discharge from the point of admission. The importance of hope in forensic patients has been highlighted within the literature (e.g. Hillbrand & Young, 2008)

and emphasises hope as being a primary goal in line with the GLM (Ward & Stewart, 2003).

## Conclusion

The narrative humanisation approach provides preliminary evidence for an alternative approach to classroom based training being effective at changing the attitudes that people hold towards MSO. It highlights the potential for such approaches to improve staff attitudes, which in the longer term, has the potential for improvements in clinical practice in forensic services.

# Chapter Six

# Conclusion

The thesis aimed to explore and expand on the existing knowledge base of attitudes towards men who have sexually offended (MSO). The thesis was motivated by an on-going stigmatisation of MSO in society and within the forensic establishments that work to rehabilitate this population (Harper, Hogue & Bartels, 2017). We have seen that existing research (e.g. Craig, 2005; Ferguson & Ireland, 2006) details a number of different factors that are related to attitudes towards MSO. Therefore, the thesis aimed to further explore and amalgamate existing findings, provide more evidence to the literature base and explore the clinical and practical implications of the factors.

To achieve the thesis aims a number of different methodological approaches were employed. Existing knowledge was explored, critiqued and synthesised using a systematic approach. Evidence was synthesised and a narrative of the synthesised data demonstrated the factors that influence attitudes within the three domains; cognitive, affective and behavioural. A comparison of attitudes towards MSO between the general public and forensic staff was explored using a quantitative approach. Participants responded to the ATS (Hogue, 1993) using Bristol Online Surveys. Data were analysed using parametric statistics (t-test and ANOVA) and post-hoc tests

(Newman-Keuls). The psychometric properties of the ATS (Hogue, 1993) were critiqued within chapter four due to its wide use within the research literature. Finally the efficacy of a narrative humanisation approach designed to support forensic nursing staff to build more person-centred narratives regarding MSO is explored in chapter five as an alternative to traditional classroom based training.

## Summary of Findings

**Chapter Two.** The aim of chapter two was to systematically review and synthesise existing evidence that explored staff attitudes towards MSO. Primarily, the evidence explored factors relevant to the nature of staff attitudes towards MSO and how these attitudes relate to the care and treatment provided to MSO by forensic services. Thirteen quantitative studies met the inclusion criteria for the review and were subject to rigorous quality assessment before data were extracted. All of the studies reported findings which could be synthesised within the three attitudinal domains discussed in chapter one; cognitive, affective and behavioural attitudes. The review provided findings consistent with those from a recent non-systematic review (Harper, Hogue & Bartels, 2017). Three key factors arose from the data, which appeared to be relate to staff attitudes towards MSO. Levels of exposure to MSO is a complex relationship, however four of the included studies provided evidence in support of increased exposure through job role and more positive attitudes (Ferguson & Ireland,

2006; Johnson *et al.*, 2007; Simon, 2010; Sanghara & Wilson, 2006). Secondly, levels of empathy were an important factor relating to positive attitudes towards MSO. Some studies only suggested this in the context of gender, and therefore it is suggested that this requires further exploration in future research. Finally, the behavioural aspect of an individual's job role was related to the nature of attitudes. Control and containment roles such as police and prison officers is reported to be related to more negative attitudes, whilst therapeutic job roles such as psychologists are reported to be related to more positive attitudes (Ferguson & Ireland, 2006; Higgins & Ireland, 2009). It is unclear from the systematic review whether these differences are due to the different types of exposure or whether the attitudes pre-exist.

The systematic review highlighted a number of different factors that influence the nature of attitudes towards MSO. These factors were considered within the context of providing MSO with care and treatment in forensic services. Some important clinical implications arose as a result of the synthesis. These included the monitoring of staff wellbeing to prevent burnout and compassion fatigue when working with MSO, as research suggests that attitudes can deteriorate over time (Simon, 2010). Furthermore, the possibility of services considering ways to assess the characteristics and competencies of therapists before working with MSO was a suggestion. More specifically, the potential to assess therapist's levels

of empathy is considered, as Marshall (2005) suggests that therapist features are more important for positive treatment outcomes than manualised procedures. Due to inconsistent findings regarding the effectiveness of training to work with MSO, it was suggested that the content of the delivery format of such training may require revisions to provide more positive outcomes.

The systematic review concludes that the way in which various factors relate to attitudes is a complex relationship. There are a number of different factors that seem to be important and vary in the significance of the relationship. Whilst clinical implications are highlighted and recommendations are made, the area warrants more research to examine the relationships further.

**Chapter Three.** Based on the findings from chapter two, this empirical research chapter aimed to further investigate some of the factors thought to influence attitudes towards MSO. The aim of the research was to investigate whether the general public and forensic staff had different attitudes towards MSO, and whether attitudes differed based on gender, exposure to MSO and duration of exposure, as these appeared to be the most significant factors based on the results of chapter two. No significant differences were found between men and women; therefore, the hypothesis that women would have more positive attitudes was rejected. It is possible that gender is not the important factor, but rather it is about people's personal

experiences that influence attitudes. As suggested in chapter three, other idiosyncratic factors such as victim, marital or parental status may be more important than gender. The general public were found to hold significantly more negative attitudes towards MSO in comparison to professional and paraprofessional staff who were exposed to MSO. This finding was in support of the hypothesis that exposure to MSO relates to more positive attitudes, albeit lower than published comparisons. It seems that having a lived experience of working with men who have committed sexual offences and the ability to develop knowledge and understanding about them is an important factor in the nature of attitudes held. Finally, the hypothesis that staff attitudes would improve over time, but evidence deterioration after 10 years of working with MSO was rejected as no significant differences were found. Therefore, length of exposure does not appear to influence attitudes in positive or negative ways, despite Simon (2010) suggesting a deterioration after 20 years. Other factors such as personal and professional support may affect this.

Whilst the findings from chapter three support the exposure relationship that was discussed in chapter two, the empirical research also highlights the difficulty in determining the significance of individual factors that may influence attitudes. It became apparent upon analysis of the research, that findings may have been more meaningful if more demographic information had been sought.

Beyond the factors that were considered within chapter three, other important demographic data could have provided more scope to answer different research questions and improve the quality of the research study. The Office for National Statistics (2018) reports facts regarding likelihood of being a victim of a sexual offence, which include marital or parental status. As a result, including demographic factors such as age, employment or educational status, victim experiences, marital and parental status may have allowed a more in depth analysis.

Nevertheless, there are important clinical implications arising from the research. Although it is recognised that staff working with MSO generally have more positive attitudes, these need to be balanced with awareness of appropriate risk management. Having extremely positive attitudes may cause staff to become vulnerable if they are less vigilant about risk. On the other hand, if risk is at the forefront and positive factors are ignored, risk management can be too restrictive. This would have longer-term implications for rehabilitation if MSO are supported in an overly restrictive manner. Equally, too few restrictions may contribute to a less successful rehabilitation, if transitions are not managed in a manner that is commensurate to risk level. In a societal context, attitudes are important considerations when planning the re-integration of MSO upon discharge from forensic services. The Good Lives Model (Ward & Stewart, 2003) suggests the primary goods that offenders require

to support desistance, however without support from the community to attain primary goods such as housing and employment, risk of recidivism increases.

The research strengths and limitations are discussed with recommendations for future research. The study concludes that some factors appear to be more important in relation to the nature of attitudes held towards MSO; however, it is difficult to determine a causal effect. It provides further evidence for the importance of understanding the relationship to ensure that MSO are provided with effective support to maintain desistance.

**Chapter Four.** The aim of chapter four was to critically evaluate the psychometric properties of the Attitudes Towards Sex Offenders Scale (ATS; Hogue, 1993). The tool has been criticised for oversimplifying the adaptation by replacing the words 'prisoner' in the ATP with 'sex offender' and for using a reductionist label. This is likely to immediately impact on the way in which the person completing the ATS perceives the 'sex offender' they have in mind. Therefore, it was not considered to be sensitive to tap into attitudes specific to sexual offenders. The ATS was criticised for continuing to measure attitudes towards general offenders (Willis *et al.,* 2010) based on the simplistic adaptation. Chapter four recognises that as a result of this, the ATS has poor face validity and lacks specificity.

The ATS has excellent levels of internal consistency with alpha coefficients ranging from .86 (Craig, 2005) to .96 (Higgins & Ireland 2009). This indicates that questions on the ATS reliably measure the same constructs. Further research is required to determine the test re-test reliability of the ATS.

As the tool is so widely used, there is also extensive normative data amongst different participant groups to compare ATS scores against. Having said this, Hogue does not identify cut-off points for negative or positive attitudes and therefore it is left to researchers to interpret their results based on published norms. This could lead to misinterpreted data, particularly due to the limitations of the 'undecided' option on the Likert-type discussed within chapter four. In addition, not all of the research studies utilising the ATS have explained their scoring procedure. Therefore, it is difficult to determine which published data has followed Hogue's (1993) scoring instructions and therefore some of the published data is an unreliable comparison.

Chapter four highlights the importance of a psychometrically robust tool to measure attitudes and draw conclusions to inform clinical practice. It was concluded that omitting 'prisoner' and replacing it with 'sex offender' was not adequate. This results in a tool that does not specifically tap into what it claims to. As a result, alternative tools are recommended for future use in the research field; the Perceptions

of Sex Offenders Scale (PSO; Harper & Hogue, 2015). The PSO measures affective judgements rather than knowledge based judgements and thus is a measure of perceptions. In addition to the PSO, recommendations are used to incorporate the revised ATS-21 into a battery of assessments to promote the thorough assessment of attitudes, perceptions and social cognitions. In conclusion, use of the ATS-36 should be replaced with tools that more accurately measure what they describe.

**Chapter Five.** Chapter two concluded that there are inconsistent findings regarding the efficacy of training programmes to support staff to work with MSO. It was recommended that revisions were required to traditional classroom based training methods because findings from chapter two were inconsistent regarding the effectiveness. Therefore, chapter five utilised a narrative humanisation approach to encourage the exploration of existing narratives that staff held regarding MSO. Throughout the day, the narratives were built upon to encourage the privilege of more person-centred narratives to support changes in routine practice. Quantitative data were analysed using the Reliable Change Index calculation to determine whether changes in pre and post training scores were clinically significant. All scores were significant and indicative of clinically significant change in a positive direction. Verbatim notes were qualitatively analysed using a thematic-informed analysis. This evidenced a shift from restrictive care plans

and the privilege of negative narratives to more person-centred care plans, which adopted a trauma-informed approach. Clinically, the intervention evidences the benefits of taking an unconventional approach to staff training and workshops aimed at developing an awareness of MSO. In taking such an approach, it is hoped that these changes in attitudes and perceptions could have a positive impact on the treatment of MSO to promote collaborative, holistic and least restrictive care and treatment for MSO. The limitations of the case study are recognised and recommendations for future delivery include evaluators being independent from the training facilitators and longer-term follow-ups to draw firmer conclusions. In conclusion, narrative humanisation approaches to staff interventions are promising alternatives to traditional training methods and consideration should be given to the efficacy of using such an approach more widely.

**Clinical Implications.** The overarching theme of the thesis focuses on understanding the factors that influence that nature of attitudes towards MSO and how these factors are associated with the effectiveness of rehabilitative practices, including those that operate within community settings and how they are influenced by societal attitudes. As a result, a number of clinical and societal implications have arisen. An important aspect for staff working with MSO is to have a good understanding of the men they are working with and to form positive therapeutic relationships. Attitudes influence how easily

therapeutic relationships can establish. It is clear throughout the thesis that the impact of positive personal characteristics of staff and their role in rehabilitation is important (e.g. Marshall, 2005). As such, it is important that training courses provide adequate information to assist in the development of this understanding and allow a safe space for exploration of personal values and beliefs. Approaches such as the narrative humanisation approach described in chapter five appear to be a promising alternative. This approach should be considered alongside packages with content revisions such as those described in chapter two, which include challenging sex offender myths and taking a strength-based approach in the context of the Good Lives Model (Ward & Stewart, 2003). In addition to training, staff working with MSO require regular clinical supervision and reflective practice as an opportunity to share their personal experiences of working with MSO. As discussed in chapter two, risk of burnout and compassion fatigue is apparent, particularly after working with MSO for a significant period of time (e.g. Simon, 2010). Clinical supervision allows a safe space to share experiences and aims to prevent psychological and emotional difficulties such as burnout and compassion fatigue by acknowledging such difficulties and intervening early to prevent deterioration in attitudes, which may have a negative impact on the care and treatment for MSO. Chapter three highlights the potential unintended consequences of attitudes of either extreme within institutions. Risk management should be

proportionate to the risk posed by the MSO, as described in the Risk Need Responsivity model (RNR; Andrews & Bonta, 2006). However, very negative or very positive attitudes may cause judgements to become clouded and risk management to be disproportionate to an offender's risk. This emphasises the need for ongoing multi-disciplinary risk judgement and risk management through the use of Structured Professional Judgement (SPJ) tools such as the Risk of Sexual Violence Protocol (RSVP; Laws *et al.,* 2003).

**Future research.** The thesis makes several recommendations for future research. Recommendations are aimed at improving the way in which the relationship between different factors and attitudes towards MSO is understood and also what novel approaches can be used to change the way in which staff are supported to work with the population.

It is clear from the findings in chapters two and three that the factors that influence the nature of attitudes towards MSO are wide ranging, inconsistent and complex. Whilst research exists that provides firmer conclusions regarding some factors, there is a need for more research into different demographic factors. Based on the evidence from the Office for National Statistics (2018) regarding the factors that make an individual more likely to be a victim of a sexual assault, future research would benefit from exploring the influence of such factors on an individual's attitudes towards MSO. These factors include victim experiences, marital status, parental status and therapeutic or non-

therapeutic exposure to MSO. Such research would promote further arguments regarding the causal relationship between personal factors and the nature of attitudes held.

Chapter four acknowledges some of the limitations of the original 36-item ATS. As a result, it is recommended that future research make use of the re-imagined tools to measure attitudes and perceptions towards MSO; the PSO and the ATS-21. Having said this, both tools require further exploration of the psychometric properties to determine whether they are a true improvement on the ATS-36. As the tools become more widely used, it is anticipated that more reliability, validity and normative data will become available to allow researchers to determine the robustness of each tool.

Finally, alternative methods to training staff to work with MSO are required, due to such inconsistent findings regarding the efficacy of traditional classroom based methods. Chapter five provides an alternative approach and preliminary data suggests promising results. However, as discussed there were several limitations that require revisions for future research. Longer-term follow-ups are necessary to really determine how effective such training methods are in terms of their clinical implications. In addition, the narrative humanisation approach may be perceived as too intrusive for some individuals as they are required to be open about their own values

and beliefs. There may be more viable alternatives to training methods which require further research.

## Conclusion

The nature of sexual offences and the people who commit them continues to be a controversial topic within society. In addition, MSO are stigmatised within the institutions in which they are detained, therefore an understanding of the ways in which their rehabilitation and re-integration can be made successful is important. As previous research has evidenced, negative attitudinal cultures can lead to a culture of abusive care (e.g. Zimbardo *et al.,* 1971) rather than rehabilitative care with an emphasis on strengths. Therefore, it is important to examine the attitudes and determine ways in which staff can be supported to modify their attitudes with a greater understanding of the people they support.

The attitudes of both staff and the general public are influenced by a broad range of different contributing factors. It is clear from the findings within the thesis that further research is warranted to explore the relationship more thoroughly.

The clinical and societal implications presented throughout the thesis provide recommendations for small changes to the way in which institutions work with MSO. However, by making these *small* changes there is potential for significant changes to the outcomes of

therapeutic treatment and successful rehabilitation. By increasing our understanding of the factors that contribute to the nature of attitudes held, there is the potential to create more treatment enhancing cultures, there is potential to increase successful rehabilitation and reintegration, and ultimately to effect a reduction in rates of re-victimisation. The role of attitudinal development and an understanding of the manifestation of attitudes would seem, on the basis of this thesis, to offer genuine potential.

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# Appendices

## Appendix A: Quality Assessment Form

### Quantitative Quality Assessment Form

*Adapted from the Critical Appraisal Skills Programme (CASP, 2017)*

| Question | Y (2) | P (1) | N (0) | U (0) | Comments |
|---|---|---|---|---|---|
| **Screening Questions** | | | | | |
| *Did the study address a clearly focussed issue?* | | | | | |
| *Were participants recruited appropriately?* | | | | | |
| **IS IT WORTH CONTINUING?** | | | | | |
| **Detailed Questions** | **Y** | **P** | **N** | **U** | |
| *Was the design appropriate to answer the research questions?*<br>- *Does it identify reasons for that methodology?* | | | | | |
| *Was power reported?* | | | | | |
| *Is the method clear to address the research issue?* | | | | | |
| *Is the measurement tool reliable?* | | | | | |
| *Is the measurement tool valid?* | | | | | |
| *Were ethical considerations taken into consideration*<br>- *Was confidentiality maintained, was ethical approval explained* | | | | | |
| *Are response rates recorded?* | | | | | |
| *Was data analysis sufficiently rigorous?*<br>- *Was the appropriate statistical test used?* | | | | | |
| *Were assumptions of the data tested/reported (e.g. normality, homogeneity)?* | | | | | |
| *Are all the results reported (i.e. significant and non-significant, not bias)?* | | | | | |
| *Is there a clear statement of findings?* | | | | | |
| *How valuable is the research?*<br>- *Does it contribute to existing knowledge considered, do they identify future research needs* | | | | | |

**Total Quality Score:**

## Appendix B: Data Extraction Form

**Date of data extraction:**

**Author(s):**

**Article Title:**

| **Article Characteristics / Inclusion Criteria** | |
|---|---|
| Population: | |
| Exposure: | |
| Outcome: | |
| Environment | Prison Community Forensic Healthcare |
| Statistical analysis used: | |
| **Participant Information** | |
| N = | |
| Mean Age | |
| Gender | |
| Profession | |
| Other relevant information | |
| **Outcomes** | |
| Tool(s) used: | |
| What outcomes were measured? | |
| Was the tool validated/checked for reliability? | |
| Statistical results: | |

**Overview / interpretation of results:**

**Conclusions:**

## Appendix C: Attitudes towards Sex Offender Scale (Hogue, 1993)

**ATS**

Please answer the following statements by indicating the extent to which you agree with each item. To respond, circle the number to the right of each item that describes the extent to which you agree with the statement. There are no right or wrong answers.

**ATS**

| | Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 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 sex offenders more bitter | | | | | |
| 9. Give a sex offender an inch and they'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 a treated 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 rest of us | | | | | |
| 27. I would never want one of my children dating a treated sex offender | | | | | |
| 28. Most sex offenders have the capacity for love | | | | | |
| 29. Sex offenders are 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 sex offenders do well in prison/hospital, they should be let out on parole | | | | | |

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## Appendix D: Participant Information Sheet

### Attitudes Towards Sex Offenders: A comparison of professionals, paraprofessionals in a forensic environment and the general public.

Name of Researcher(s): Laura Challinor (Supervised by Dr Simon Duff)

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I would like you to read through the information sheet thoroughly, to ensure you understand what is being asked of you. If you have any questions before participating, you can find my contact details, and my supervisors contact details at the bottom of the sheet.

### What is the purpose of the study?

The purpose of my research is to investigate whether attitudes of sex offenders differ between the general population, and people who work with sex offenders. I am also investigating whether a person's perception towards sex offenders is affected by the length of time they have worked with a sex offender.

I aim to fill in some of the gaps from previous literature, to give a wider understanding of perceptions towards sex offenders.

### Why have I been invited?

You may have been invited because you work with sex offenders, either in a professional or non professional capacity; therefore you might be a psychologist, or you may be a healthcare assistant, but either way, your participation matters.

You may be somebody who doesn't work with sex offenders at all, and I will therefore be comparing your attitudes towards sex offenders with those who do work with them to see if there are any significant differences.

I aim to get 192 participants altogether and would be very grateful if you can spare a few minutes to help me achieve this goal!

### Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, by clicking onto the next page, which requires you to give some demographic information, informed consent will be

assumed. Furthermore, by responding to each of the questions and then submitting your responses, informed consent will again be assumed.

If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

**What will happen to me if I take part?**

After you have read the information sheet, you will be taken to an online questionnaire.

Firstly, you will be required to fill out a few demographic questions to provide me with some information about yourself; this will all be confidential, and at no point during the study will you be asked to give your name or any personal details.

After filling out the demographic questions, you will be taken to the 36-item questionnaire. You will be required to answer these questions by choosing one of 5 options – ranging from strongly agree, to strongly disagree.

It is expected that you will complete the questionnaire in around 10 minutes.

Once you have submitted your completed questionnaire, your answers will be sent to a University of Nottingham database ready for analysis.

Throughout your participation, your confidentiality will be maintained.

**Expenses and payments**

Participants will not be paid an inconvenience allowance to participate in the study.

**What are the possible disadvantages and risks of taking part?**

No risk should be posed to any participant during the study, as it is a simple online questionnaire.

**What are the possible benefits of taking part?**

We cannot promise the study will help you but the information we get from this study may help to fill the gaps in the current literature on sexual offending. It is hoped that it will give the field a better understanding of people's differences in perceptions, and why they may differ.

**What happens when the research study stops?**

Once the required number of participants have been recruited and the questionnaires are complete, the data will be used for statistical analysis, to see if there are any differences in attitudes. Once all the analyses have been carried out, a paper will be written outlining the research and its findings and practical implications will be discussed.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting the University of Nottingham (contact details at the end of this sheet).

**Will my taking part in the study be kept confidential?**

At no point during the study will you be asked to disclose your name. All demographic information and your answers given in the questionnaire will remain confidential, and data will be stored and accessed in compliance with the Data Protection Act 1998.

Initially your data will be coded by a participant number, however when the data is transferred into a programme for analysis, you will no longer be coded by this participant number and your data will be completely anonymous.

Ethical approval has been sought from the university.

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database.

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your data.

**What will happen if I don't want to carry on with the study?**

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far will be lost when the red X in your internet browser is closed.

**What will happen to the results of the research study?**

The results will be used as part of a Forensic Psychology Doctorate and may be published. If they are published in the future, the research can be obtained by emailing the researcher. It may also become available online.

You will not be identified as taking part in any report or publication.

**Who is organising and funding the research?**

This research is being organised by the University of Nottingham.

**Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Research Ethics Committee.

**Further information and contact details**

Researchers can be contacted by email on;

Lwxlc1@nottingham.ac.uk or simon.duff@nottingaham.ac.uk

Faculty of Medicine & Health Sciences
Room B05 YANG Fujia Building
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

**Appendix E: Participant De-brief sheet**

Thank you for participating in the research, your involvement and time is greatly appreciated.

The study aims to compare whether professionals and paraprofessionals who work with sex offenders have a different attitudes towards them compared to the general population.
It also aims to look at whether the longer time a person has spent working with sex offenders in a forensic environment correlates with more positive attitudes.

Data will be statistically analysed in order to answer these questions, and a paper will be written for the entire study, towards a Forensic Psychology Doctorate qualification.

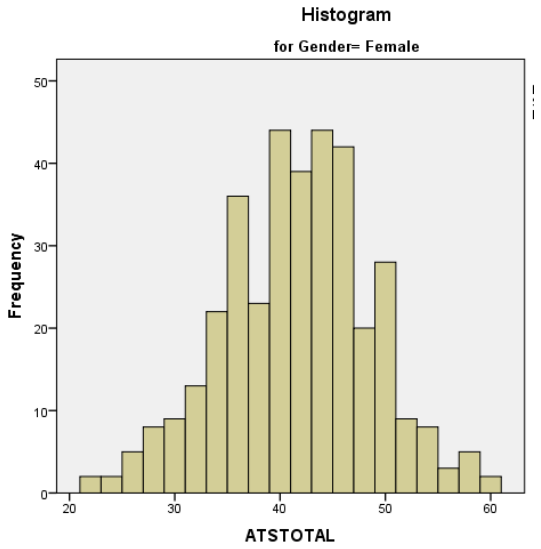
Again, the researchers would like to take this opportunity to thank you for taking the time to participate.

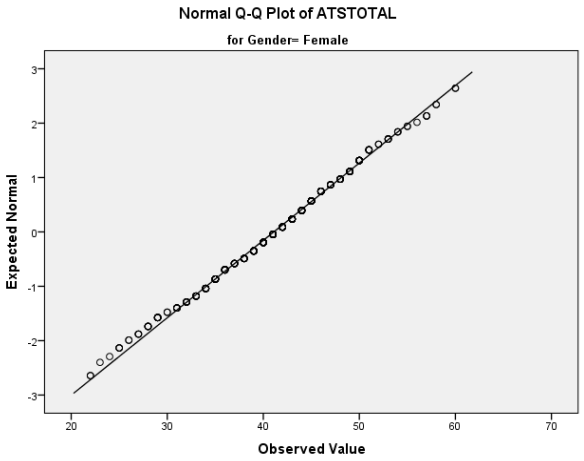
If you have any more questions about the study, please contact;

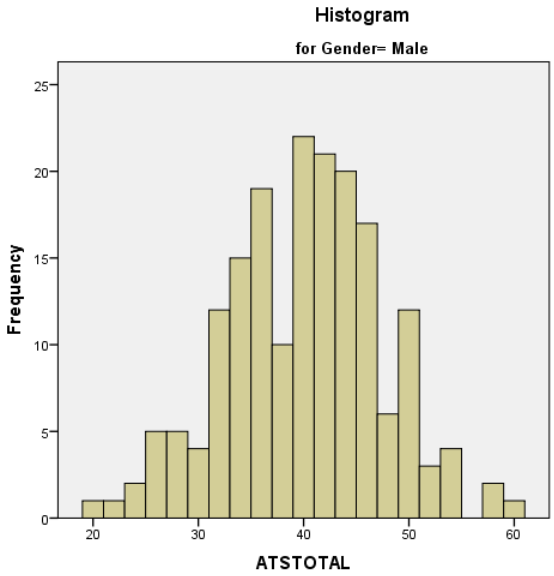
Lwxlc1@nottingham.ac.uk or simon.duff@nottingham.ac.uk

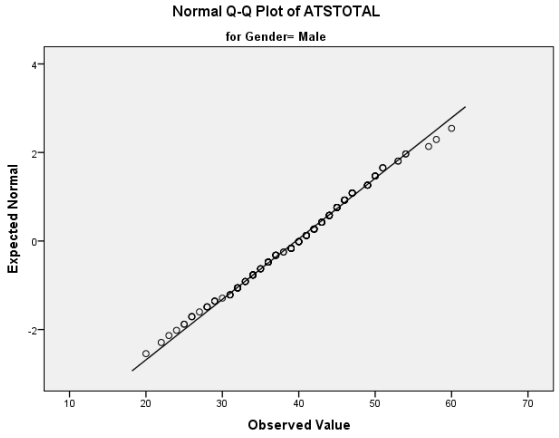
# Thank you

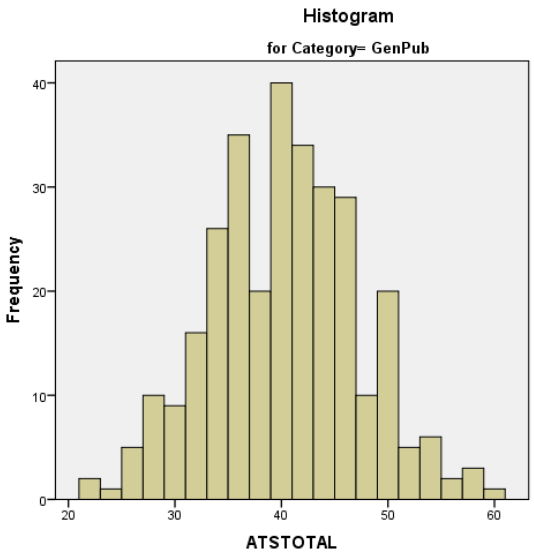
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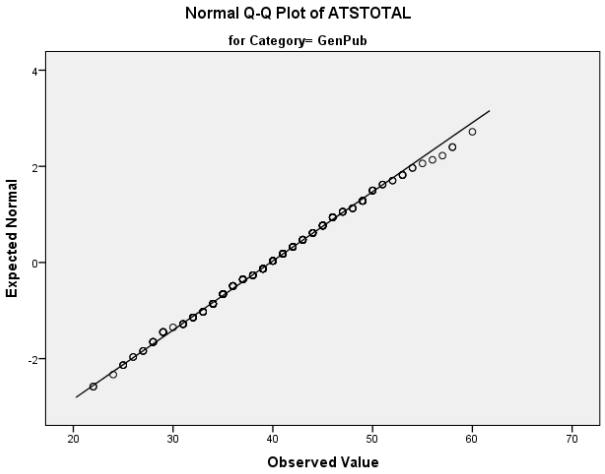


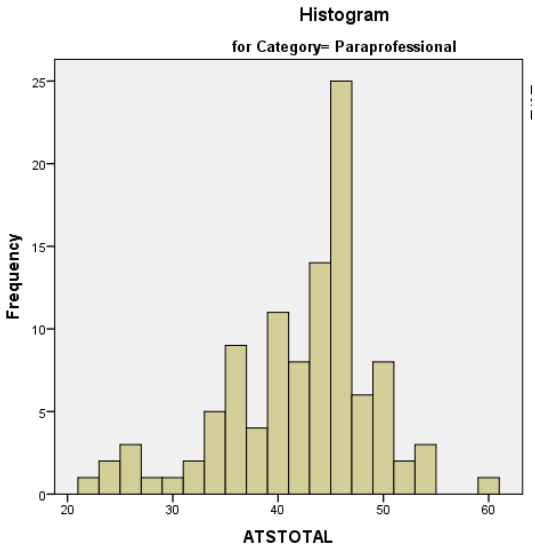



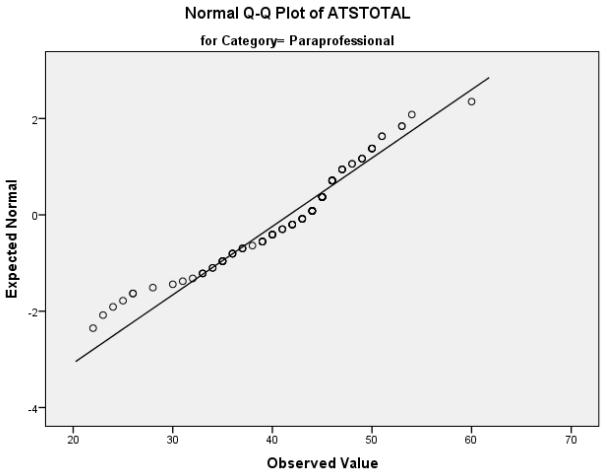



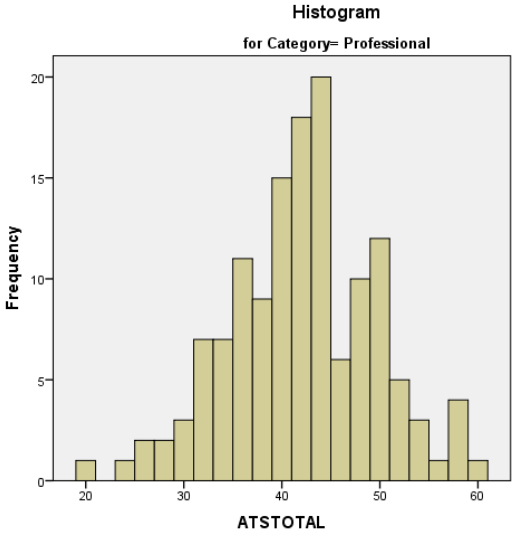



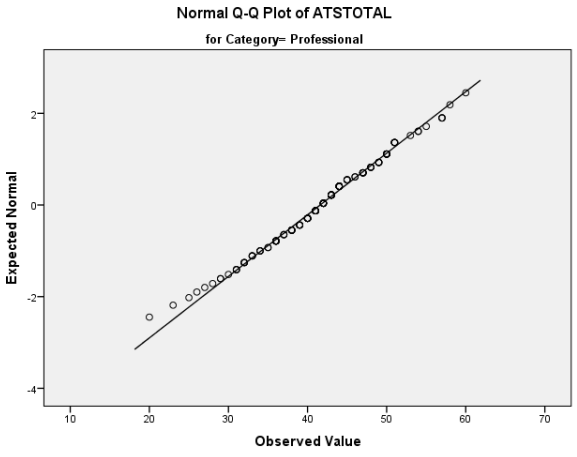

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Frequency
ATSTOTAL

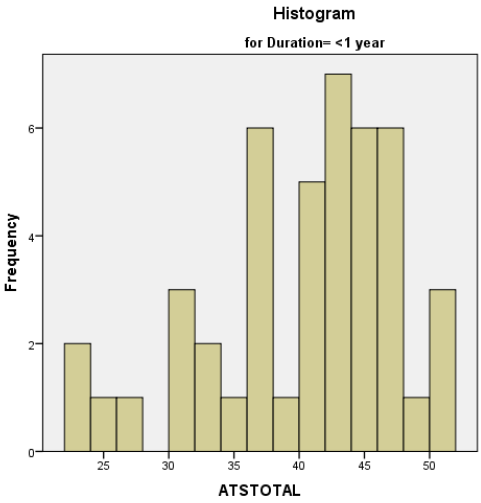

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for Category= GenPub
Expected Normal
Observed Value

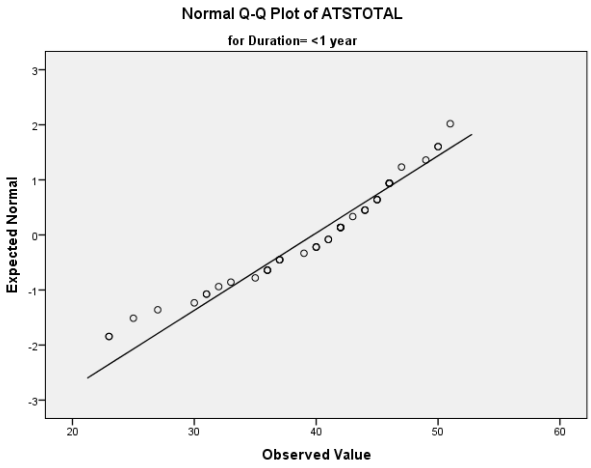

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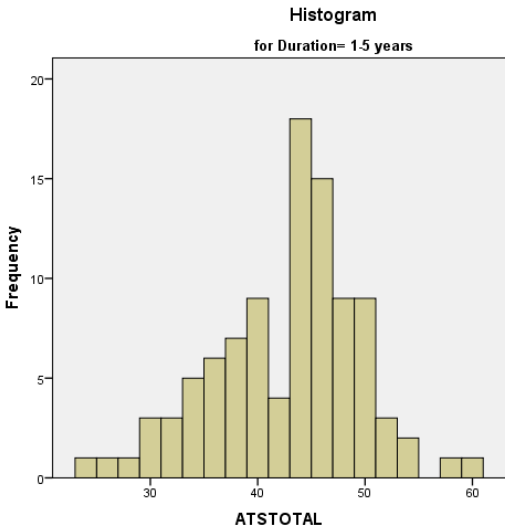

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Observed Value

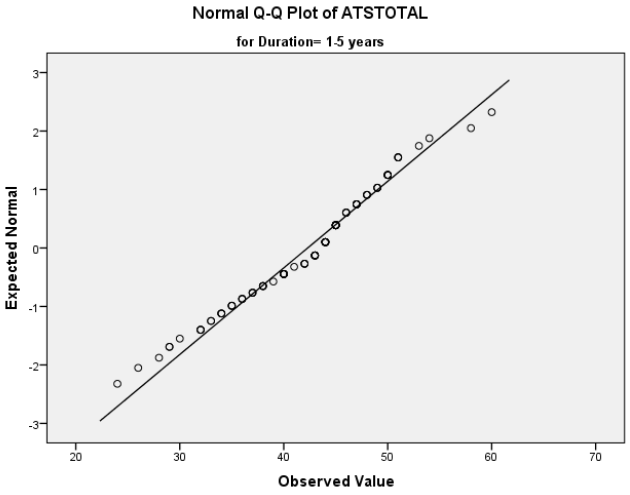

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Frequency
ATSTOTAL

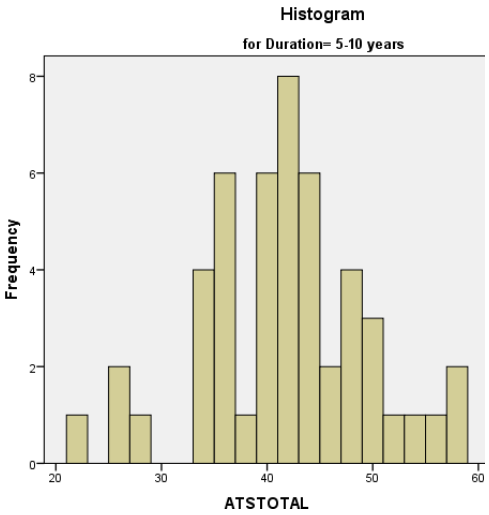

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for Category= Professional
Expected Normal
Observed Value

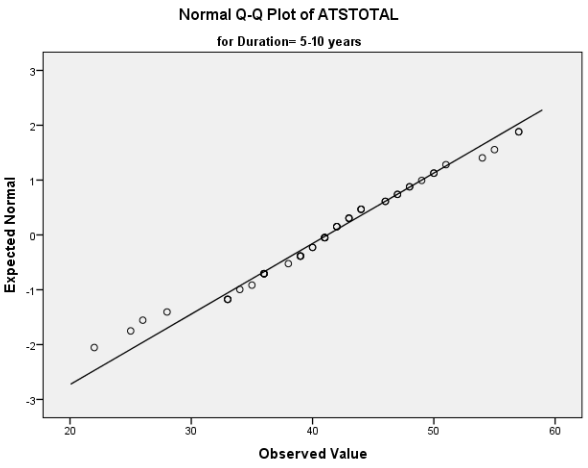

Histogram
for Duration= <1 year
Frequency
ATSTOTAL

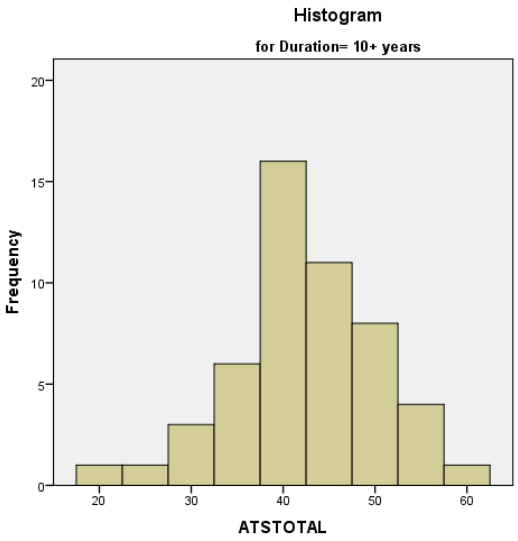

Normal Q-Q Plot of ATSTOTAL
for Duration= <1 year
Expected Normal
Observed Value

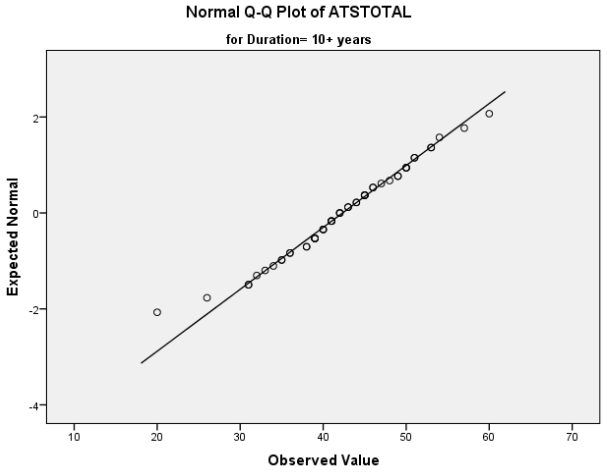

Histogram
for Duration= 1-5 years
Frequency
ATSTOTAL


Normal Q-Q Plot of ATSTOTAL
for Duration= 1-5 years
Expected Normal
Observed Value


Histogram
for Duration= 5-10 years
Frequency
ATSTOTAL


Normal Q-Q Plot of ATSTOTAL
for Duration= 5-10 years
Expected Normal
Observed Value


Histogram
for Duration= 10+ years
Frequency
ATSTOTAL
0
5
10
15
20
20
30
40
50
60


Normal Q-Q Plot of ATSTOTAL
for Duration= 10+ years
Expected Normal
Observed Value
2
0
-2
-4
10
20
30
40
50
60
70

## Appendix G: ATS-21

Please answer the following statements by indicating the extent to which you agree with each item. To respond, tick the circle to the right of each item that describes the extent to which you agree with the statement.

There are no right or wrong answers.

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

# Appendix H: PSO

**The Perceptions of Sex Offenders Scale (PSO)**

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

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Somewhat Disagree | Somewhat Agree | Agree | Strongly Agree |

_____1. With support and therapy, someone who committed a sexual offence can learn to change their behaviour.

_____2. People who commit sex offences should lose their civil rights (e.g. voting, privacy).

_____3. The death penalty should be reintroduced for sex offenders.

_____4. People are far too on edge about the risks posed by sex offenders.

_____5. More sex offenders should be given sentences in the community.

_____6. Sex offenders prefer to stay home alone rather than be around lots of people.

_____7. Most sex offenders do not have close friends.

_____8. Sex offenders have difficulty making friends, even if they try real hard.

_____9. The prison sentences sex offenders receive are much too long when compared to the sentence lengths of other crimes.

_____10. People who commit sex offences should be subject to harsh restrictions on their liberty for the rest of their lives.

_____11. Trying to rehabilitate a sex offender is a waste of time.

_____12. Sex offenders should wear tracking devices so their location can be pinpointed at any time.

_____13. Only a few sex offenders are dangerous.

_____14. Most sex offenders are unmarried men.

_____15. It's not <u>if</u> a sex offender commits another crime, it's <u>when</u>.

_____16. Most sex offenders keep to themselves.

_____17. Sex offenders should have all their details announced to local communities.

_____18. Convicted sex offenders should never be released from prison.

_____19. Sex offenders will almost always commit further offences.

_____20. Some sex offenders should be allowed to work in schools.

What type of sex offender were you thinking of? _____

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## Appendix I: Referral Letter

Dear Sir/Madam,

Please accept referral of Mr X, a 25 year old man with a diagnosis of intellectual disability and autism spectrum condition. Mr X has a longstanding history of sexually inappropriate behaviours, including conviction.

Mr X was remanded to HMP Z in June 2015 for the offence of sexual activity against a child. He also has a history of;

- Sexual fantasies about young children
- Rape fantasies of adults and children
- Attempted sexual assault of female staff member
- Accessing pornographic images
- Bestiality (digitally penetrated a dog)
- Engaged in oral sex with male peer
- Sexually touched a three year old girl
- Attempting to re-enact sexually violent games

Mr X has been made subject to a sex offender notification requirement following an offence against a child under 13 in 2013; this is due to expire in July 2018.

Mr X requires admission to a specialist treatment service that is able to provide sex offender treatment specific to those with Mr X's diagnosis.

Yours Sincerely,

Dr Q.

## Appendix J: Sister's Letter

Dear Dr T,

I am writing to you to provide further information about my brother, Mr X, who I understand has recently begun working with you on his offending behaviours. I wanted to give you some more information about Mr X's childhood, in order to inform your work.

Mr X and I grew up together in Derbyshire. We had an extremely happy childhood, living with our parents in a small village where everyone knew each other. There was a group of about 6 children and we used to spend our evenings and weekends in the countryside. It was during this time that I realised that my brother was perhaps a little less 'normal' than the rest of us. He lacked confidence, but he was warm and a good listener, just not much of a talker. Although he came out with us, he would go off on his own and walk for miles and miles, he enjoys this immensely and benefits from being able to have this time alone. My parents were also aware of him being different, and at the age of 8, my brother was diagnosed with an ASC and intellectual disabilities. I made extra efforts to continue to our normal routine to reinforce to my brother that things wouldn't change. We still played out with our friends and we still had lots of fun. My brother enjoys physical activities; things that don't necessarily require him to interact with others.

When my brother started comprehensive school at 12 years old, he became a different person. He struggled to make friends and was isolative, even at home. He was bullied at school by both older and younger children, boys and girls. He did not receive adequate support from the school and eventually stopped going at all. We later found out that my brother had been the victim of sexual abuse at the hands

of a caretaker at the school; we continue to try to get justice for my brother. Despite my parent's attempts to get him out, he remained isolative and often became aggressive when we suggested we all went out. He was constantly on his computer but we assumed he was playing games. He explained to us that he couldn't cope with being 'labelled' with disorders.

It was about 2 years later that my dad looked at my brother's computer and found search histories of child pornographic images and videos. The internet was disconnected. However, my brother found ways to continue to meet his sexual needs, including with animals and children. My parents have tried to get help for my brother, but until his arrest there was nothing anyone would offer him other than short-term sessions with the NSPCC. My brother is disgusted by his sexual pre-occupations, but does not know how to manage his thoughts. He openly speaks about wanting to harm himself to punish himself for what he has done, and what he thinks about doing now. Although I understand a hospital ward is not an ideal place for my brother, he speaks about how grateful he is to be receiving help for his behaviours.

Since his admission, my brother is again like a new person. He speaks about his peers on the ward and the relief at finding other people "more like him". This is the first time in many years we have seen my brother happy and engaging in social conversations with others. His confidence has increased and he is much more susceptible to social interaction.

He speaks of his psychology sessions very positively. He tells me that he has begun to explore his thoughts, and can now understand what triggers his negative thoughts which helps him to manage them

better. He hopes to be able to develop robust skills to manage his thoughts, as he very openly admits he never wants to offend again.

We continue to be a supportive family, we visit my brother every week and do not treat him any differently as a result of what he's done. Obviously we do not like what he has done, but we have to put that aside and remember him as a person, not for what he has done. We struggle sometimes, but we don't let him see that. He feels very positive about his future since his admission, and therefore we reinforce this.

I hope this background information is useful and please do not hesitate to call me if you require anything more.

Yours Sincerely,

Miss X.

## Appendix K: Integrated Formulation

Mr X struggled as a child to establish and maintain any friendships, which has impacted significantly on his level of confidence and ability to develop independence. Due to extended periods of isolation and his parent's attempts to encourage socialisation, Mr X struggles to deal his own anger. He also cannot identify as someone with "diagnoses" and does not wish to be referred to under such a label.

It is likely that this anger is an indirect response to his experience of Mr X's own sexual abuse by someone who was in a position of authority. As a result of this, Mr X prefers to spend time alone so as not to react in an angry way to others. In addition, Mr X copes with his intrusive thoughts by walking, and by having positive interactions with his supportive family. Mr X's family are fully informed about his history of abuse, and about his own offending behaviours, however they do not have open conversations about this in detail, rather, they focus on the future and Mr X's rehabilitation. The family have a very positive outlook and don't dwell on the past.

As a result of Mr X's abuse, he finds it difficult to trust people, particularly adult males in positions of authority. He expresses a view that the outside world is an unsafe place, and whilst in secure services, he is being protected from the dangers of the world. Due to this perception, Mr X has been heavily supported by his family and he is very dependent on them.

Within secure services, Mr X has found a supportive, settled and happier environment which allows him to avoid the stresses of independent life, protects him and provides social contacts and values his caring side. In effect, he may have found himself safety and protection away from the perceived threats of the outside world. He

has a desire to work on his difficulties and learn ways in which to effectively manage his inappropriate thoughts. It is not surprising that the prospect of discharge into the community might seem frightening to him. Discharge means insolation through losing his social networks and Mr X fears this will serve as the onset to re-offending.

It is important not to accept Mr X's own view of himself at face value, and to remember that he has many strengths, including his caring and honest interaction styles, his ability to develop friendships in such a safe environment, and his close relationship with his family. The way forward for him might usefully include a consideration of how he can use these qualities to find work opportunities and a social life away from psychiatric services and triggers to inappropriate thoughts.

If Mr X is successful in developing a robust relapse prevention plan and changing the way in which he thinks about himself, he might be able to develop an alternative model of himself as a man.