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Clinical Treatment Provider Attitudes Toward Sexual Offender Management within an Outpatient Treatment Center : Treatment Provider Attitude Survey

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Dissertation Approval

This is to certify that the thesis presented to us by Dustan A. Barabas on the 30th day of May, 2007, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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ABSTRACT

The present study's foundation is based on research suggesting that the attitudes of clinicians regarding their clients have profound effects on therapeutic alliances, empathy, and staff burnouts, which may contribute to treatment barriers. Because professionally appropriate behavior often conceals stigma, misconceptions, and negative feelings that clinicians may have toward sexual offenders, an anonymous survey of attitudes, job burnout, and empathy was conducted in an outpatient setting. The survey instruments tap into some latent factors concerning the attitudes of clinicians, their perceptions of burnout, and their abilities to empathize with their clients. This research focused on describing a population of clinicians who work with sexual offenders in an outpatient setting in Pennsylvania. In this study, using anonymous surveys, data was collected from clinical staff who work with sexual offenders. Each packet of surveys contained a demographics questionaire, a survey developed for this study entitled, Attitudes Regarding Sexual Offenders, the Balanced Emotional Empathy Scale, and the Maslach Burnout Inventory. Using SPSS statistical software, frequency distributions and item percentages were calculated for each of the survey question as a discriptive measure of this population. The results are descriptive in nature of the staff at this perticular agency. Significant finding are presented and treatment implications are discussed.

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Chapter 1: INTRODUCTION

Statement of the Problem

Treatment programs for the rehabilitation of convicted sexual offenders living in Pennsylvania require clinical staff from a broad range of specialties to adapt both their expertise and their attitudes for working with this distinctive population. Specialized programs for treatment of sexual offenders involve a complex and demanding continuum of focused treatment, collaborative case management, supervision, detailed monitoring and challenging caseloads. Sexual offenders represent a diverse population of individuals who have significant variations in their backgrounds and needs. Likewise, clinical personnel diverge regarding their personal histories, education, and experiential work with people who have committed sexual offences.

It is well recognized that a clinician's thoughts, feelings, behaviors, and general attitudes toward the population with whom they are working has a profound effect on treatment outcomes, job performance, client satisfaction, and employee morale (Maslach, 1982). Stigma and misconceptions about sexual offenders is pervasive and apparent in our society, but these are typically inconspicuous in clinical staff, primarily because of professionally appropriate behavior. During program development for sexual offenders it is often assumed that clinicians who volunteer or who are selected to work with sexual offenders, are conscious of their beliefs and are aware of the particular demands of working with the sexual offender population. Attitudes incongruent with sexual offender management may lead to treatment barriers, staff burnout, poor treatment outcomes, and programmatic problems.

Purpose of the Study

Because professionally appropriate behavior often conceals stigma, misconceptions, and negative feelings that clinicians may have toward sexual offenders, conducting an anonymous survey of attitudes, job burnout, and empathy in an outpatient setting, taps into some latent factors of the mind-set of clinicians, including their perceptions of burnout and their ability to empathize with their clients. It is hypothesized that attitudes well matched with the demands of sexual offender treatment are likely to result in decreased job burnout, better treatment outcomes, reduced misconceptions and less stigma associated with sexual offender treatment, which ultimately contribute to increased therapy success rates. The anonymous surveys examined the attitudes of clinical staff working with sexual offenders, as well as clinicians' thoughts, feelings, and behaviors. Recognizing the attitudes, which may impede or facilitate effective treatment of sexual offenders, may lead to methods for increasing treatment program success and for developing a better match of particular clinician characteristics for working with this difficult population.

This research was designed to shed light on questions related to attitude and personal feelings. These may include the following questions: Do therapists at this agency worry about sexual offenders harming their (therapists') families. Do they feel irritation toward sexual offenders in general? Would they be distressed if they found out a convicted sex offender was living near their homes? Do they think they could recognize a sex offender if they met one? If they found out a coworker had a criminal record of a sexual offense, would their behavior toward that co-worker change? Do

they believe sexual offenders can be rehabilitated? Should adults, who commit sex crimes, be managed, be treated, and be supervised differently from other criminals? Can people who have committed a sexual offense in the past go on to live law abiding lives? Is the discomfort a sex offender may experience because of public notice justified? Does routine work with this population affect clinicians' empathy levels and perceptions of burnout? Is there more empathy or less empathy among these clinicians as compared to the general population?

Very little research has been conducted to explore the kinds of clinician attitudes that exist, or to explore burnout among therapists working with this population. Likewise, there has been very little research on empathy, or lack of empathy resulting from their work with this population. Because of this void in our understanding, exploratory research was conducted at an agency that exclusively treats sexual offenders across three separate sites. Some insights are offered for the abovementioned questions; these insights enhance scientific understanding of three critical aspects of clinician perceptions about this publicly sensitive population. In addition, the resultant research provides valuable information about existing staff attitudes, beliefs, empathy levels, and job perceptions concerning burnout for one particular agency. This research may lead to enhanced program development for sexual offenders by providing a basis for further study.

Definition of a Sex Offender

According to the Pennsylvania Board of Probation and Parole, "sex offender" is a generic term for all persons convicted of crimes involving sex, including statutory sexual assault, rape, molestation, sexual harassment and certain forms of pornography production or distribution. Sex crimes are forms of human sexual behavior that are crimes and someone who commits these crimes is said to be a sex offender. Many sexual offenses are motivated principally by power and control issues, rather than by sexual desires. A number of sex crimes are crimes of violence that involve sex. Others are violations of social prohibitions, such as indecent exposure or exhibitionism. According to Pennsylvania law, a "sex offender" is an individual required to register under "Megan's Law." Juveniles are not considered "sex offenders" unless they are convicted in adult court or unless they are required to register as a sex offender in another jurisdiction. The Pennsylvania Board of Probation and Parole's procedure requires that all offenders who have been convicted of an offense(s), current or prior history, which involves engaging in an overt sexual act(s), or behavior(s), be designated as a sex offender (Pennsylvania Board of Probation & Parole, 2005).

The fourth addition of the Diagnostic and Statistical Manual of Mental disorders (DSM-IV-TR) lists Paraphilias among the psychological disorders. Paraphilias are described as recurrent, intense sexual urges, fantasies, or behaviors that involve unusual non-human objects, the suffering or humiliation of oneself or one's partner, or engaging children or non-consenting individuals, which cause distress or impairment in social, occupational, or other areas of functioning. The term sexual offender is not used typically by psychiatry or psychology as a diagnostic term. Classified Paraphilias

include Exhibitionism (exposure of genitals), Fetishism (use of nonliving objects), Frotteurism (touching or rubbing against a nonconsenting person), Pedophilia (focus on prepubescent children), Sexual Masochism (receiving humiliation or suffering), Sexual Sadism (inflicting humiliation or suffering), Transvestic Fetishism (cross dressing), and Voyeurism (observing sexual activity) (DSM-IV, 2000). Very often, individuals have more than one Paraphilia.

Individuals who do not have a consenting partner to act out their sexual urges often purchase the services of prostitutes or may act out their fantasies with unwilling victims. Some individuals with a Paraphilia obtain employment, do volunteer work, or develop a hobby that brings them into contact with the desired stimulus (e.g. selling woman's shoes [Fetishism], working with children [Pedophilia], or driving an ambulance [Sexual Sadism]). Characteristically, many selectively view, read, purchase, or collect photographs and films, which depict their preferred type of paraphilic stimulus. A number of individuals claim that their behavior causes them no distress and that their only problem is social dysfunction resulting from the reaction of others. Others report extreme guilt, shame, and depression at having to engage in sexual activities that are socially unacceptable or that they regard as immoral. Several fantasies and behaviors associated with Paraphilias often begin in childhood or early adolescence but become better defined and greatly elaborated during adolescence and early adulthood. The behaviors often increase in response to psychosocial stressors, in relation to other mental disorders, or with increased opportunity to engage in the Paraphilia. The disorders tend to be chronic and lifelong, but both the behaviors and fantasies diminish with advanced age in adulthood (DSM-IV, 2000).

Chapter 2: LITERATURE REVIEW

Early Sexual Abuse and Perpetrator Correlation

Early childhood sexual victimization does not automatically lead to sexually aggressive behavior. Although sex offenders have higher rates of sexual abuse in their histories than those estimated in the general population, the majority were not abused. However, some types of offenders, such as those who sexually offend against young boys, have even higher rates of child sexual victimization in their histories (Becker and Murphy, 1998). Although past sexual victimization can increase the likelihood of sexually aggressive behavior, most children who were sexually victimized never perpetrate against others. Among adult sex offenders, approximately 30% have been sexually victimized. Recent studies show that rates of physical and sexual abuse vary widely for adolescent sex offenders; however, 20 to 50% of these youth experienced physical abuse and approximately 40% to 80% experienced sexual abuse (Hunter and Becker, 1998).

Although many adolescents who commit sexual offenses have histories of being abused, the majority of those adolescents do not become adult sex offenders (Becker and Murphy, 1998). Research suggests that there are certain relevant factors that determine reasons why some sexually abused adolescents go on to perpetrate sexually and others do not. These include the age of onset of sexual abuse, the number of abuse incidents, the time elapsing between the abuse and its first report, perceptions of how the family responded to the disclosure of abuse, and exposure to

domestic violence (Hunter and Figueredo, in press). Someone known to the child or to the child's family abuse approximately 60% of boys and 80% of girls who are sexually victimized (Lieb, Quinsey, and Berliner, 1998). Relatives, friends, baby-sitters, persons in positions of authority over the child, or persons who supervise children are more likely than strangers to commit a sexual assault. Additionally, studies indicate that females commit approximately 20% of sex offenses against children (ATSA, 1996). Males commit the majority of sex offenses but females commit some, particularly against children. It is important to note that not all sex crimes are solved or result in arrest and only a fraction of sex offenses are reported to police.

Sexual Offender Recidivism

Recidivism rates for sex offenders are lower than for the general criminal population. A study of 108,580 non-sex criminals released from prisons in 11 states in 1983 found that nearly 63% were rearrested for a non-sexual felony or serious misdemeanor within three years of their release from incarceration; 47% were reconvicted; and 41% were ultimately returned to prison or jail (Bureau of Justice Statistics). Persons who commit sex offenses are not a homogeneous group, but instead fall into several different categories. As a result, research has recognized significant differences in re-offense patterns from one category to another.

One large-scale analysis examined reconviction rates independently; (Hanson and Bussiere, 1998) reported the following differences: child molesters had a 13%

reconviction rate for sexual offenses and a 37% reconviction rate for new, non-sex offenses over a five-year period. Rapists had a 19% reconviction rate for sexual offenses and a 46% reconviction rate for new, non-sexual offenses over a five-year period. Another study found reconviction rates for child molesters to be 20% and for rapists to be approximately 23% (Quinsey, Rice, and Harris, 1995). Individual characteristics of the crimes further distinguish recidivism rates. For instance, victim gender and relation to the offender have been found to impact recidivism rates. In a 1995 study, researchers found that offenders who had extra familial female victims had a recidivism rate of 18% and those who had extra familial male victims recidivated at a rate of 35%. This same study found a recidivism rate for incest offenders to be approximately 9% (Quinsey, Rice, and Harris, 1995).

The reliance on measures of recidivism as reflected through official criminal justice system data (i.e., rearrested or reconviction rates) obviously omits offenses that are not cleared through an arrest (and thereby cannot be attributed to any individual offender) or those that are never reported to the police. For a variety of reasons, many victims of sexual assault are reluctant to invoke the criminal justice process and do not report their victimization to the police. For these reasons, relying on rearrest and reconviction data underestimates actual re-offense numbers. The rate of reported rape among women decreased by 10% from 1990 to 1995 (80 per 100,000 compared to 72 per 100,000) (Greenfeld, 1997). In 1995, 97,460 forcible rapes were reported to the police nationwide, representing the lowest number of reported rapes since 1989. Statistics indicate that the majority of women who have been raped knew their assailant. A 1992 study estimated that only 12% of rapes were reported (Kilpatrick, Edmunds, and Seymour, 1992). Many women who are sexually assaulted by

associates, friends, or acquaintances do not report these crimes to police. Instead, victims are most likely to report being sexually assaulted when the assailant is a stranger, the victim is physically injured during the assault, or a weapon is involved in the commission of the crime. When examining slightly different measures more recently, it appears that rates have continued to drop. The arrest rate for all sexual offenses dropped 16% between 1993 and 1998. In 1998, 82,653 arrests were logged for all sexual offenses, compared to 97,955 arrests in 1993 (Federal Bureau of Investigations, 1997 and 1998).

Treatment Effectiveness

Several studies present positive conclusions about the effectiveness of treatment programs that are empirically based, offense-specific, and comprehensive (Lieb, Quinsey, and Berliner, 1998). Meta-analysis of treatment outcome studies have found a small, yet significant treatment effect, an 8% reduction in the recidivism rate for offenders who participated in treatment (Hall, 1995). Research also demonstrates that sex offenders who fail to complete treatment programs are at increased risk both for sexual and for general recidivism (Hanson and Bussiere, 1998). One year of intensive supervision and treatment in the community can range in cost between $5,000 and $15,000 per offender, depending on treatment modality. The average cost for incarcerating an offender is significantly higher, approximately $22,000 per year, excluding treatment costs. Effective sex offender-specific treatment interventions can reduce sexual offense recidivism (Hanson and Bussiere, 1998). Because of the tremendous impact of these offenses on their victims, any reduction in the re-offense

rates of sex offenders is important.

Although sex offenders constitute a large and increasing population of prison inmates, most are eventually released to the community. Some 60% of those 265,000 convicted sex offenders noted above were supervised in the community, whether directly following sentencing or after a term of incarceration in jail or prison. Short of incarceration, supervision allows the criminal justice system the best means to maintain control over offenders, to monitor their residence, and to require them to work and participate in treatment. As a result, there is a growing interest in providing community supervision for this population as an effective means of reducing the threat of future victimization. In 1994, less than 1% of all incarcerated rape and sexual assault offenders were female (fewer than 800 women) (Greenfeld, 1997). By 1997, however, 6,292 females had been arrested for forcible rape or for other sex offenses, constituting approximately 8% of all rape and sexual assault arrests for that year (FBI, 1997).

A 1998 National Violence against Women Survey revealed that among those women who reported being raped, a current or former husband, a live-in partner or date victimized 76% of these women (Tjaden and Thoennes, 1998). A Bureau of Justice Statistics study found that nearly 9 out of 10 rape or sexual assault victimizations involved a single offender with whom the victim had a prior relationship as a family member, intimate, or acquaintance (Greenfeld, 1997). The National Crime Victimization Surveys conducted in 1994, 1995, and 1998 indicate that only 32% of sexual assaults against persons 12 or older were reported to law enforcement. (No current studies indicate the rate of reporting for child sexual assault, although it generally is assumed that these assaults are equally under-reported.) The low rate of reporting leads to the conclusion that the approximate 265,000 convicted sex offenders

under the authority of corrections agencies in the United States (Greenfeld, 1997) represent less than 10% of all sex offenders living in communities nationwide. In view of the fact that professionally appropriate behavior often conceals stigma, misconceptions, and negative feelings clinicians may have toward sexual offenders, it is valuable to conduct an anonymous survey of attitudes and job burnout among treatment providers who work with sexual offenders. Anonymous surveys tap into these latent factors and increase understanding of how a therapist's mind-set may influence treatment. This research was exploratory in nature, proposing to investigate attitudes, job burnout, and empathy among treatment providers working with sexual offenders in an outpatient treatment facility in Pennsylvania. Because of this research, more specific hypothesis may be developed to guide future research involving treatment providers working with sexual offenders in an Outpatient treatment facility.

Treatment Approaches

The majority treatment programs for sex offenders in the United States and Canada now use a combination of cognitive-behavioral treatment and relapse prevention (designed to help sex offenders maintain behavioral changes by anticipating and coping with the problem of relapse). Offense-specific treatment modalities generally involve group and/or individual therapy focused on victimization awareness and empathy training, cognitive restructuring, education about the sexual abuse cycle, relapse prevention planning, anger management and assertiveness training, social and interpersonal skills development, and changing deviant sexual arousal patterns.

Different types of offenders typically respond to different treatment methods with varying rates of success. Treatment effectiveness is often related to multiple factors; these include the type of sexual offender (e.g., incest offender or rapist); the treatment model being used (e.g., cognitive-behavioral, relapse prevention, psycho-educational, psycho-dynamic, or pharmacological); the treatment modalities being used; and related interventions involved in probation and parole community supervision. The Cognitive-behavioral therapies are among the few empirically validated Models of psychotherapy. Among the Cognitive-behavioral theories are Ward & Hudson's integrated Pathways Model, PHASE Model, and Good Lives Model.

Without the option of community supervision and treatment, the vast majority of incarcerated sex offenders would otherwise serve their maximum sentences and return to the community without the internal (treatment) and external (supervision) controls to manage their sexually abusive behavior effectively. Managing those offenders who are amenable to treatment and who can be supervised intensively in the community following an appropriate term of incarceration can serve to prevent future victimization and save taxpayers substantial imprisonment costs (Lotke, 1996). Outpatient Psychotherapy has been an integral part of community management. Because of the high cost to society and to the victims of re-offence, the demand for improved treatment outcomes is essential. However, only a handful of studies have examined therapist factors such as attitudes, beliefs, and behaviors that could impact treatment. The attitudes of professionals toward their clients undoubtedly affect their work with them, specifically attitudes that facilitate behavioral changes in offenders (Bordin, 1994). Unfortunately, stigma, misconceptions, and strong negative attitudes exist among clinical staff, as it does with the general population, although these

attitudes are often inconspicuous because of professionally appropriate behaviors.

Cognitive Behavioral Therapy (CBT) with sex offenders is typically a lengthy, labor-intensive process, which puts high demands both on the therapist and on client, often with unpredictable outcomes. CBT is the most predominant form of therapy for this population (Byrne, 2004). Psychotherapy with a reluctant population, such as sexual offenders is stressful for many therapists. The majority of offenders, and particularly sexual offenders, are distrustful of the motives of professionals including treatment providers because of negative interactions involving the legal system. Offenders often expect professionals to see them as unacceptable because of their offense histories and therefore, anticipate rejection; this determines the way offenders process any remarks made by professionals, all of which are interpreted as signs of rejection. This is particularly true of sexual crimes (Marshall & Serran, 2004).

Trust in the therapist has proven crucial in generating change in clients with various mental health problems (Marshall, 2003). Offenders, like other clients, are often concerned about being judged or rejected. Social stigma, and the demoralization that goes with it, can imply to psychotherapy patients that they have personal defects, even immutable ones (Beck et al., 1979). Consequently, it takes time and skill for therapists to surmount this distrust and establish effective working relationships with offenders (Marshall & Serran, 2004). The CBT perspective recognizes the fact that the offender requires education, and that his or her thinking is in need of restructuring or altering, by the application of techniques. Distorted beliefs or ''errors in thinking'' are identified primarily by the therapist and techniques are applied to attempt to change those beliefs and the behaviors they are thought to drive. The therapists and interventions in this approach are relatively detached from the offenders, as opposed to

alternative models, such as social constructionism or constructivism. Although CBT is collaborative and recognizes the need for the recipient to take an active part in therapy, the language used often implies that the offender is relatively passive (Byrne, 2004). This can lead to the erroneous assumption that therapists are simply adhering to a treatment script or applying "canned" interventions. To the contrary, treatment is usually complex, demanding, and frequently uncertain. Widespread adoption within the sexual offender field of highly manualized, psycho- educational programs, which reduce the influence of the therapist has been counterproductive for a thorough examination of how therapist attitudes impact treatment.

Beliefs about sexual offenders in this culture, particularly when victims are children, are at perhaps the highest moral level. This can cause conflicted feelings within therapists; they are generally taught that they have a duty to protect children. Remaining objective becomes difficult when thinking about victims and considering the perpetrators at the same time. Therapists must be self aware enough to respond when these issues naturally come up by being willing to question their personal, professional, and cultural attitudes. Beliefs about the nature of the task that clinicians are trying to accomplish and the perceived contexts within which they work, have profound effects on the way they conduct therapy and deal with interpersonal feelings (Byrne, 2004).

The main treatment focus for therapists who work with offenders is reducing the harm these offenders cause society. In addition to attempting to instill various skills and alter various cognitions, many CBT therapists attempt to achieve this goal by having the client develop a list of situations, of people, and of behaviors to be avoided. This is fundamentally relapse prevention as it has been used with sexual offenders

(Marshall & Serran, 2004). Research has shown that avoidance goals are more difficult to achieve than are approach goals; the former have been the customary(???) practice of offender treatment (Mann et al., in press). Working toward avoidance goals puts the therapist in the position of continually reinforcing the behaviors that the offender should not be doing, places where he or she should not go, and with whom he or she should not have contact. This may create an inequality in the therapeutic relationship, which, may feel not only condescending from the client's perspective, but may also shift the therapist's attitude away from neutral objectivity to the frame of mind consistent with an evaluator or authority figure (Marshall & Serran, 2004).

Therapist-Client Relationship

The client therapist relationship is arguably the most important characteristic predicting treatment outcomes. According to Horvath and Greenburg, 1994, three clusters of predisposing characteristics appear to be important to alliance formation and development. The first cluster involves the client's ability and willingness to form a close attachment with another person. In order to do this, clients would likely need to have had at least some positive attachment experiences in their lives. A second client cluster entails the ability to cooperate.(collaborate)?? Clients must be willing to collaborate, or must at least not have such a high degree of opposition that agreement on goals and tasks would be impossible. The final cluster of predisposing characteristics pertains to clients' sense of self-efficacy. Clients must believe that they

can benefit from therapy and that they themselves are capable of growth through this treatment. In the absence of such a sense, it may be difficult for clients to invest themselves in the relationship. The working alliance is an interactive concept, to which both the client and the therapist must contribute (Horvath and Greenburg, 1994).

According to Gaston & Marmor, 1994, the working alliance influences treatment in three fundamental ways. One, the alliance appears to have an effect in and of itself, beyond the therapist's technical interventions. Two, the alliance fosters the client's receptivity to the therapist's interventions. Thus, when the alliance is strong the client is more likely to complete homework assignments or be receptive to the therapist's interpretations. Three, the alliance affects treatment by serving as a buffer against the inevitable strains that naturally occur in the therapy relationship (Gaston & Marmor, 1994). Advocates of a motivational interviewing approach with offenders, stress the need for therapists to be respectful and supportive of their clients (Miller and Rollnick, 2002). However, few have attempted to appraise the issue empirically.

According to Carl Rogers (1957), the therapist's contribution to this collaborative relationship is equally important to initiation and maintenance of positive rapport and treatment outcomes. He asserts that most fundamentally, therapists need to possess and exhibit attitudes, which he considers necessary and sufficient for constructive personality change in therapy: empathic understanding, unconditional positive regard (or at least positive regard), and genuineness (Rogers, 1957). Research has shown that, therapists who have a history of at least some solid and positive relationships in their lives are more likely to form positive and strong working alliances with their clients. Other difficult qualities to measure probably include therapists' abilities to form alliances, binding investment in the work, commitment to the client,

and overall skillfulness (Henry & Strupp, 1994). Despite current literature arguing against Rogers's position that these therapist qualities are "necessary," most, admit they are important. Empathy in particular has been documented, empirically, to contribute both to alliance and to outcome (Horvath & Greenberg, 1994). In considering the importance of these necessary attitudes that Rogers theorized, it is difficult to conceive of a sound working relationship developed by a therapist with little or no empathy, with low regard for the client, and with a lack of genuineness. Despite this, some therapists, who do not have these important attitudes, engage in work with clients who have committed acts they perceive as repulsive and disgusting. Therapists may not like the client, may have little empathy and may have negative attitudes, which undermine treatment, yet they may portray an outward appearance of competence and professionalism.

Marshall, Serran, Fernandez, Mulloy, Mann and Thornton (2003) investigated the relationship between therapist characteristics and treatment-induced change in sex offender-treatment programs in English prisons. They reviewed 12, two-hour video tapes of treatment sessions depicting between five and eight sex offenders and two and three therapists, and rated each therapist's styles. They examined therapist features and incidence of change. They identified 10 therapist features that predicted beneficial changes in coping skills. The ten therapist features are empathy, warmth, and rewarding, directive, appropriate amount of dialog, appropriate voice tone, asking open-ended questions, perspective-taking, encouraging participation, and appropriate body language. These findings are consistent with other researchers who found that the actions of the therapist have an influence on behavior change beyond that induced by the specified treatment. A confrontational style exhibited by the therapist relates

negatively to perceived competence to coping with the client (Beech & Fordham, 1997).

Job Satisfaction and Burnout

Working with sex offenders is demanding and intensive work for which therapists and care staff interacting with this client group are at risk of emotional burnout (Shelby, Stoddart, & Taylor, 2001). According to Maslach (1982), burnout affects the way in which therapists view clients and themselves, as well as the way in which they interact during treatment sessions. He suggests that feelings of ineffectiveness, worthlessness, and depersonalization lead therapists to choose maladaptive strategies, which result in a client's negative perception of his or her therapist. Clients who perceive their therapists in a negative light are much less likely to participate in treatment and to behave resistively to therapeutic intervention. Therapists who are burned-out often exhibit behaviors, which are interpreted by clients as substandard care. Burnout is characterized by emotional exhaustion, depersonalization and reduced productivity. Emotional exhaustion is the feeling of being emotionally drained by one's job; depersonalization is a negative, cynical attitude toward the client, and reduced productivity is typically a result of feeling ineffective in one's professional role (McCarthy & Frieze, 1999). It is relatively common for these feelings to be hidden by professionally appropriate behavior.

How Attitudes Impact Treatment

Attitudes are psychological "predispositions," because they predispose individuals to act in a certain way toward the objects of their attitudes. The attitude comes before behavior, affecting the way a person will act. Attitudes in general are enduring and change only occasionally when additional information, experience, or new perception the object of the attitude is acquired. Attitudes always focus on some object, a person or group, or an idea or issue. They are composed of three parts: what the individual knows, believes or thinks about the topic, how the person feels about the topic, and the likelihood the person will behave or take action based upon their frame of mind. An attitude change will bring about change in any or all of the components.

The attitudes held by therapists toward their client groups are fundamental to the therapists' behaviors as they influence the change processes during treatment. Farrenkopf (1992) found that therapists working with sex offenders for long periods are often discouraged about client change, experience emotional hardening, anger, frustration with the correctional system, and become increasingly suspicious of their clients. Proof indicates that positive attitudes expressed by therapists and correctional officers were found critical to successful community rehabilitation (Glaser, 1969). Therapists who work with difficult and resistive clients may unconsciously develop negative attitudes toward their clients, primarily because of the characteristics of these types of populations.

Detachment is an attitude regarding the degree to which therapists retain detached neutrality in their dealings with clients or become personally involved and allow their own primary thoughts and feelings to become part of the therapeutic process. The ends of this continuum can be represented by the views of Carl Rogers (1957), when he emphasized the importance of experiencing and encountering clients, and in the early writings of Freud, (1913), which stated that the therapists' carefully calculated neutrality was essential if client projections and transference were to be complete and uninterrupted.

Clients are often disliked because they do not change. Resistive clients by definition, go against the therapeutic process, are characteristically not motivated toward treatment, and are typically engaged in therapy for reasons other than personal growth or change. Among these difficult and resistive populations are sexual offenders and various criminal and personality disordered clients. Often these types of clients will do or say things that undermine the therapeutic process. They often create power struggles, manipulate, and frequently do not comply with treatment efforts. In some cases, these strategies by the client cause the therapist to introvert into his or her own issues, compromising the therapist's empathy. Some difficult clients are extremely alert to a therapist's desire that they (the client) improve, and will react to that desire by attempting to frustrate the therapist (Bordin, 1994). Many difficult clients have learned sabotage skills long before meeting the therapist, perhaps because of their interactions with those who oppressed them or who denied them in their families, schools, and other environments. The client may be viewed as a threat to the therapist's self-esteem; if the client does not change, then the therapist may fear he or she is ineffective (Hanna, 2002). If a therapist is open and not aspiring, egotistically, for a particular outcome,

and is not defending his or her ego or competence, a difficult client has no "hook" or "tug" on a therapist that can draw the change process off course (Hanna, 2002).

Empathy is an important attribute affecting the entire therapeutic process. Empathy training is often a central focus during sexual offender treatment, because of the tendency for this population to have difficulty understanding and having compassion for others. An inability to experience empathy can understandably become a barrier to achieving positive rapport and a collaborative working relationship. Some clients are uncomfortable with empathy and are adept at discouraging it in a therapist. It is recommended that therapists be alert for this phenomenon the moment the client is making the attempt to undermine rapport and to recognize how and why one's empathy begins to dissipate (Margulies,1989). Once empathy is lost it must be must be recalled, re-established, and maintained through a conscious act of will. Empathy does not always occur naturally and automatically. According to Magulies (1998), empathy will tend to break down to the degree that one's own unresolved issues begin to emerge. He also emphasizes that empathy breaks down to the degree that the other person presents with viewpoints or perspectives that seem strange or foreign. When either of these conditions manifest, empathy requires an act of will in order to be maintained (Margulies, 1989).

Empathy can also degenerate when a therapist is deeply affected, emotionally, by a client's stories of abuse and tragedy. This, as noted earlier, is typical for sex offenders. Therapists can be caught up in feelings of disapproval, sympathy, resentment, and righteous anger toward those who hurt the client or toward those whom they have hurt; this can interfere with the therapist's ability to see, empathically, the world from a client's perspective (Horvath & Symonds, 1991). When a therapist

genuinely cares for the client but lacks empathy and is authoritarian and intrusive, not only is change unlikely, but also such attitudes can disempower a client. Caring and empathy are different. A therapist can show caring toward a client and still cause the client to deteriorate (Lambert, Bergin, & Collins, 1977).

As noted earlier, it is common for therapists to feel discouraged, disgusted, hopeless, angry, and resentful when working with difficult clients. Although confronting is a technique often used with sex offenders, confronting with compassion and empathy is difficult to do if these emotions are not genuinely felt. It can be extremely hard to care about some difficult clients, such as those who are cruel, insulting, or who make sexist or racist remarks. Some difficult clients contradict and deny everything, no matter how obvious or straightforward. The agitated therapist may feel so much hostility or disgust, he or she is afraid that this hostility will reveal itself and therefore, avoids confronting altogether or does so ineffectively (Kiesler, 1998).

Therapists, who routinely work with difficult clients, may become accustomed to, and expect resistance and feel a temptation to confront and challenge before the client is convinced he or she is truly understood. Therapists who, without empathy, push the client too quickly can actually contribute to their clients' uncooperativeness (Kiesler, 1998). These findings are consistent with other researchers who found that the actions of the therapist influence change beyond that induced by the specified treatment program itself (Beech & Fordham, 1997). Kieser (1998), suggests that before engaging in confrontation, the therapist must thoroughly convince the client that he or she is understood through empathic reflections of meaning and feelings to the point at which the client has little choice but to believe that the therapist understands. Then the therapist can make challenges and confrontations that the client will respect and not

immediately disregard. Ideally, it is recommended that a therapist work through any negative feelings in therapy or peer supervision. If this is not possible, a therapist can suspend or bracket those feelings, leaving his or her mind clear to move forward with therapy, knowing that his or her negative reactions to a client are natural and to some degree expected (Hanna, 2002).

Hogue (1995) measured the attitudes toward sex offenders in 81 members of a multi-disciplinary team (including prison officers, probation officers, psychologists and teachers) working within British Prisons before and after receiving training on working with sex offenders (Hogue, 1991). He found participants had a greater belief in treatment efficacy, greater confidence and knowledge necessary to work with sex offenders after receiving training. In addition, participants reported a more positive attitude after their training.

When the therapist's thoughts are unfocused and beliefs and emotions are in turmoil in the presence of a client, the therapist has probably lost his or her feeling of confidence. This may be dangerous, especially when one works with many difficult clients during the same day or week. There may be times when an overworked therapist is so exhausted from working with difficult clients that he or she might create an artificial distance from clients, unconsciously perceiving them as a threat to his or her own sanity or peace of mind. This can be a sign of burnout, and may result from the fear of becoming somehow "polluted" by the negative attitudes and problems of unsavory clients (Hanna, 2002). The literature suggests that strong negative feelings toward a client can create barriers to rapport and collaboration, can negatively influence treatment outcomes, and contribute to burnout rates.

Attitude Measurement

Attitudes are often the topic for survey research. To measure an attitude, three components, thought, feeling, and behavior, must be included in the survey questions (Alreck & Settle, 1985). To measure a thought component, questions need to assess a person's awareness or knowledge about a particular topic. To explore what people know or believe about a topic, respondents should be asked questions regarding acquired information and understanding of that topic. For example, "I think sex offender registration is *not* an effective tool for promoting public safety." The preceding question inquires about a person's attitude based upon his or her knowledge and opinion about the effectiveness of sex offender registration for upholding community protection. People tend to base both their feelings and actions on their knowledge about a particular object. Asking judgment questions about the respondent's experience with a topic, based on the description of a topic's attributes are indicators of awareness. Thought content-related questions typically ask for a response based on knowledge of details concerning the characteristics of the object (Alreck & Settle, 1985).

The behavior or action component of attitude is measured by past, present, and future behavior toward the object. The question assumes the respondent has had or will have an opportunity to act. As an alternative, a set of hypothetical conditions could be specified and a respondent could be asked how he or she would respond under similar conditions (Alreck & Settle, 1985). For example, "Finding out a coworker has a criminal record of a past sexual offense would *not* change the way I interact with him

or her on a daily basis." The preceding question inquires about the degree to which any behavioral change is likely in response to finding out a coworker has a criminal record of a past sexual offence.

How much a respondent likes or dislikes an object encompasses the feeling component of an attitude. People develop feelings about an object primarily in two ways, reward or evaluation. They tend to have positive or negative feelings about an object based on a past experience with it (reward or punishment) or they automatically and often unconsciously compare what they know or believe about a topic with their own personal values. To measure the feeling component both the position and direction on the positive and negative scale, including the intensity of feelings need to be explored. This can be done by measuring the direction and amount of like or dislike for a topic (Alreck & Settle, 1985). In this case, sensitivity is explored by asking a neutral question about an emotion or feeling, including a corresponding degree of intensity scale (e.g. strongly agrees, agree, disagree, and strongly disagree). According to Babbie (1990), survey research refers to a particular type of empirical social research. Surveys attempt to explain the reasons for and sources of observed events, characteristics, or correlations for making descriptive assertions about some population. Individuals and organizations often seek survey information to discover the needs, wants, and desires of the consumers they serve, or to discover the underlying human conditions that make their goods useful and valuable to others (Alreck, & Settle, 1985).

Chapter 3: METHODS

The purpose of this chapter is to discuss the processes involved in the research, including, the design, participants, data collection procedures, and the instruments used in data collection. This section outlines how the study was conducted and the procedures involved in gathering and analyzing the data. The research design is exploratory in nature conducted to

1) Investigate attitudes among treatment providers working with sexual offenders in an outpatient treatment facility.

2) Investigate job burnout among treatment providers working with sexual offenders in an outpatient treatment facility.

3) Investigate empathy among treatment providers working with sexual offenders in an outpatient treatment facility.

3) Investigate correlations between burnout, attitudes, and empathy among treatment providers working with sexual offenders in an outpatient treatment facility.

Design

The research design is a cross sectional cohort study. In this study, by means of an anonymous survey, data were collected over a three week period from a population of clinical staff who work with sexual offenders. The anonymous surveys are made up of four basic questionaires put together in a packet. Included in each packet was a demographics questionaire, a survey of attitudes regarding sexual offenders, the Balanced Emotional Empathy Scale, and the Maslach Burnout Inventory. Clinicians in the study are employed at three different service locations of the same sexual offender treatment agency in Pennsylvania. Using SPSS statistical software, frequency distributions and item percentages were calculated for each survey question in the attutude assessent survey, the Maslach Burnout Inventory-Human Survices Survey (MBI-HS) and the Balanced Emotional Empathy Scale (BEES), as a discriptive measure of this population. The results are descriptive in nature of the staff at this perticular agency.

Participants

The participants represent thirty (N=16) Bachelor, Master and Doctoral level therapists who work with sexual offenders across three different service locations for the same outpatient agency. All of the clinicians employed at this agency (N=30) were included in the study, making up the total empirical population. Although thirty survey packets were distributed to the clinical staff, sixteen participants returned completed surveys. Six declined the survey, but responded that they did not wish to participate

because they work for this particular facility on a part time consulting basis, do not do not engage in direct therapy with sexual offenders, and perceived participation in the study as a conflict of interest. Eight clinicians did not return the survey packet, indicating that they did not wish to participate.

Data Collection Procedure

Members of the dissertation committee reviewed and approved the research proposal. The Philadelphia College of Osteopathic Medicine Institutional Review Board (PCOM) then reviewed the proposal. The PCOM institutional review board appraised the proposal to be safe and adequate in its design and gave approval to collect data. The director of the treatment facility reviewed the proposal and permitted data collection. A cover letter was developed and attached to each survey form, explaining the survey's intended purpose, identification of the principal investigator(s), estimated completion time, associated risks, and notification that participation is voluntary (see appendix A). Prior to beginning the research, the principal investigator held meetings with the director of the facility and clinical staff to encourage participation in the study, to answer questions, and to discuss the data collection process. The department head and the principal investigator informed the employees that their participation was requested; however, participation was voluntary, anonymous, and in no way affected their employment. The clinicians were informed that they would be receiving a packet of surveys; they were told that there was a predetermined amount of time to complete the packet of questionnaires, and they were directed to the place in which to deposit the completed packets.

Data collection occurred over a three week predetermined time. Each of the clinical employees has a mailbox at the main service location; they check and retrieve their mail on an average of twice per week. The surveys were distributed to the clinical staff by placing them in these employee mailboxes. One file folder for survey collection was kept in the head secretary's office. The head secretary monitored the data collection process, assuring that the data was secure and confidential. The clinicians retrieved the packet of surveys from their mailboxes. The participating employees completed the surveys in their spare time and gave the completed packet to the head secretary, who deposited them into the secure file folder throughout the three-week period of data collection. At the end of the three week predetermined time, the principal investigator collected the file folder with the completed surveys inside.

Instruments

Four instruments to collect data were utilized: a demographics questionnaire, a survey designed exclusively for this study entitled, Attitudes Regarding Sexual Offenders, the Maslach Burnout Inventory, and the Balanced Emotional Empathy Scale. Seven categories of demographic data were gathered on a one page questionnaire: age, gender, length of time working with sexual offenders, highest academic degree obtained, where clinicians received training for treating sexual offenders, what percentage of work time is spend in various employment activities, and whether or not respondents feel their salaries are appropriate to their positions. Gender identification was indicated by circling either male or female. Age was responded to by filling in the blank. Length of time working with sexual offenders has six discrete

intervals of time; the respondent circled one. Highest academic degree obtained was responded to by circling one of five responses. The places where they received training for treating sexual offenders has 4 options to circle; the percentage of time spent in work related activities has a fill in the blank response section, and whether or not they feel their salaries are appropriate to their positions is assessed by a likert scale, with a range of strongly agree to strongly disagree.

Validity Assessment of Attitudes Regarding Sexual Offenders Survey

The Attitudes Regarding Sexual Offender Survey was developed exclusively for this study and is included in the packet. The items in the survey were created with the specific assessment of latent variables, i.e. cognitive (thought/perception), behavioral, and emotional or feeling in mind. Each of the items making up the scale reflects one of these latent variables. Therefore, the content of each item represents the construct of interest. The initial instrument consisted of twenty-five items, which were reviewed by psychologists with specialized training in the field of sexual offender and paraphilia treatment, and who have worked extensively with the constructs included in the questionnaire to corroborate content validity. To assess validity, five licensed psychologists who have specialized training in sexual offender treatment and work directly with this population were asked about the relevance of each item to the construct it was intended to measure. The final version of the survey instrument consists of items in which the psychologists were easily able to determine which questions correspond to a particular construct.

The item format used is a likert scale, because the likert scale is one of the most widely used survey formats for measuring beliefs, opinions, and attitudes (DeVelis, 2003). Likert scales are used when the items are presented as declarative statements, followed by response options that indicate varying degrees of agreement with or endorsement of the statement, as is the case with this instrument. An equal number of scale items were positively and negatively worded to avoid bias responses either in a positive (supporting) or in a negative (discouraging) direction. Psychologists agreed consistently about the construct that each item measured, i.e. thoughts, feelings, or behaviors.

The reviewers also evaluated the items for clarity and conciseness. In an effort to keep the survey succinct, six of the items were discarded from the item pool because of content redundancy. It was decided that little or no advantage would be gained by including the additional items and they may perhaps deter subjects from participating because of the increased length of the instrument. A number of factors determined the overall survey length. Investigation into similar surveys conducted with this particular population and setting, revealed that a one-page instrument was optimum for an adequate response rate. To increase the probability of survey completion, unessential items were excluded, keeping the final survey length to one page and one-half pages. The questions are intermixed on the survey, in a random manner, in order to avoid a response bias. The actual items included in the survey are listed below under the construct that is solicited. Each item is scored separately and the data(?) collected is a score, which corresponds to agreement or disagreement on the likert scale, resulting in cumulative percentages for all respondents for each item on the survey. Each item on the survey is presented under the construct with which it corresponds.

Constructs and Corresponding Items:

Opinion or Thought Related Items

- I think people who have committed a sexual offense in the past can go on to live law abiding lives.
- I think that any discomfort a sex offender may experience because of public notice is justified.
- I think sex offender registration is *not* an effective tool for promoting public safety.
- I think sex offenders *do not* want to change their sexual behaviors.
- I find it hard to think about a sexual offender committing the offence.

Belief Items

- I believe sexual offenders can *not* be rehabilitated.
- I believe released sex offenders should be allowed to live undisturbed in the community.
- A person found guilty of a serious sexual offense should always be imprisoned.
- Adults who commit sex crimes should be managed, be treated, and be supervised differently from other criminals.
- Because Paraphilias and other sexual dysfunctions are recognized as "mental disorders," sexual offenders should not be held responsible for their sexual behavior.

Anticipated Behavior Items

- If I were living near a sexual offender I would make inquiries about their offences.
- Finding out a coworker has a criminal record of a past sexual offense would *not* change the way I interact with him or her on a daily basis.
- I could *not* recognize a sex offender if I met one.
- I would choose not to work with a sexual offender.
- I would avoid a known sexual offender.

Feeling and affective Items

- I would feel distressed if I found out a convicted sex offender was living near my home.
- I worry about sexual offenders harming my family.
- Sexual offenders don't bother me.
- I feel irritation toward sexual offenders.
- I would love to work with sexual offenders.

Limitations of the Instrument

Instrumentation and response bias may adversely affect the reliability and validity of the survey. Instrumentation bias exists when questionnaire instructions, questions, scales or response options introduce bias. A great deal of effort and consideration went into the design of each survey question in terms of content, placement, and its relationship to other questions in order to reduce both instrumentation and response bias. According to Alreck, & Settle (1985), respondents have a tendency to report what is socially acceptable when personal preference, opinions, or behavior deviate from what is socially prescribed or they respond, based on the respondent's perception of what would be desirable to the sponsor. An important limitation to questionnaires is that they report what people say and not necessarily, what they do.

Social desirability presents a serious problem when answering survey questions, which deal with sexual deviation. In order to reduce a social desirability bias, the phrasing of each question within the survey was worded in as neutral a manner as possible and stated as specifically as it was reasonably possible. To avoid generating a mental set bias, a problem whereby previous items influence the response to later ones, the latent content of specific types of questions dealing with behaviors, feelings, thoughts and implicit knowledge were distributed equitably throughout the survey. The order and sequence of the questions were mixed to decrease a mental set bias. When the attitudes or predispositions of the respondents are introduced into the survey, based on its construction, this is referred to as response bias (Alreck, & Settle, 1985). In most of the questions the criterion for answering is clearly indicated by phrases such as; "I

feel," "I think," or "I believe." Ambiguous words were restated by commonly recognized phrasing to make each item comprehensible and applicable to the majority respondents.

The Maslach Burnout Inventory (MBI)

The Maslach Burnout Inventory (MBI) was included in the packet of instruments to assess each clinician's self-assessment of burnout. The Maslach Burnout Inventory is among the most widely used measures to research burnout and is generally regarded as the measure of choice for any self-reported assessment of the syndrome known as "burnout," (Kazuko, Hideaki, Masao, Yuchi, and Higashiyma, 2004). The MBI-Human Services Survey measures burnout as it manifests itself in staff members in human services institutions and in health care occupations such as nursing, social work, psychology, and ministry. The MBI-HS is designed to assess three components of the burnout syndrome: emotional exhaustion, depersonalization, and reduced personal accomplishment. There are 22 items, which are divided into three subscales. The MBI-HS, which generally takes about 10 to 15 minutes to fill out, is self- administered, and contains complete instructions for the respondent. The MBI-HS is designed to be used anonymously.

The items are written in the form of statements about personal feelings or attitudes (e.g., "I feel burned out from my work," "I don't really care what happens to some recipients"). The items are answered in terms of the frequency with which the respondent experiences these feelings, on a 7-point, fully anchored scale (ranging from 0, "never" to 6, "every day"). This is to minimize any reactive effect of such personal

beliefs or expectations, which may bias results. For this reason, the test form is labeled MBI Human Services Survey rather than Maslach Burnout Inventory. The nine items in the Emotional Exhaustion subscale assess feelings of being emotionally overextended and exhausted by one's work. The five items in the Depersonalization subscale measure an unfeeling and impersonal response toward recipients of one's service, care, treatment, or instruction. Both for the Emotional Exhaustion and for the Depersonalization subscales, higher mean scores correspond to higher degrees of experienced burnout. Essentially, the higher the score in each category, e.g. Emotional Exhaustion and Depersonalization, the more of that particular construct. The higher the score for Personal Accomplishment, the more satisfied and content the respondents feel. The scores for each subscale are considered separately and are not combined into a single, total score; thus, three scores are computed for each respondent and then coded as low, moderate, or high by using the numerical cutoff points listed on the scoring key.

The Balanced Emotional Empathy Scale (BEES)

Emotional Empathy, as defined by Mehrabian (1997), is one's vicarious experience of another's emotional experience; i.e., to feel what another person feels. In the context of personality measurement, it describes individual differences in the tendency to have emotional understanding with others. Emotional Empathy has been found to relate generally to healthy and adjusted personality functioning and to reflect interpersonal positiveness and skill. Some individuals tend generally to be more empathic in their dealings with others; they typically experience more of the feelings that others feel, whereas others tend to be generally less empathic.

The Balanced Emotional Empathy Scale (BEES) measures components of Emotional Empathy (i.e., vicarious experience of other's feelings, an interpersonal positiveness) in an objective manner. The current version of the BEES was abbreviated, based on a substantial amount of research evidence derived from a previous edition the Emotional Empathic Tendency Scale (EETS). An important feature of the BEES is that it relates negatively (r = -.50) to interpersonal violence and thus, may be useful (as an indirect and subtle measure) for identifying persons who may have a potential to behave in highly aggressive or violent ways (Mehrabian, 1997) Mehrabian (1997), reported validity data for the Balanced Emotional Empathy Scale (BEES). Alpha internal consistency of the BEES was .87 (Mehrabian, 1997). Experimental work, reviewed by Mehrabian, Young, and Sato (1988) yielded the findings for the earlier empathy scale, the 1972 Emotional Empathic Tendency Scale (EETS). The listed validity evidence can be attributed to the newer BEES (Mehrabian, 1996) because the BEES assessment tool has exhibited a very high positive correlation

of .77 with the 1972 EETS (Mehrabian, 1997). Findings showed the Abbreviated BEES to be a positive correlate of emotional success (i.e., general emotional well-being), relationship success (i.e., healthy and happy inter-personal relationships), career and financial success, and overall life success (Mehrabian, 2000).

Mehrabian's 1997 theoretical analysis of traits that are related to affiliation and sociability (i.e., sensitivity to rejection, empathy, dependency, conformity, popularity, loneliness, and shyness) sheds additional light on the construct validity of the BEES. Evidence reviewed in Mehrabian, Young, and Sato (1988) found the following traits in participants tested with the BEES scales: persons with higher Emotional Empathic Tendency Scale scores, compared with those with lower scores, are more likely to have higher skin conductance and heart rate to emotional stimuli. They are more likely to be emotional, as evidenced by their tendency to weep; they most likely had parents who spent more time with them, displayed more affection, and were more explicit verbally about their feelings. They are tolerant of an infant crying and less abusive toward children (only mothers tested), are altruistic in their behavior toward others and volunteer to help others; they are affiliative, are non-aggressive; they rate positive social traits as important, score higher on measures of moral judgment and have pleasant temperaments.

The BEES test has been translated into French and Spanish. Shapiro, Morrison, and Boker (2004) used the BEES to assess the effectiveness of a training course in empathy for first year medical students. The students participated in 8 sessions involving the reading of poetry and prose dealing with doctors and patients. BEES scores increased significantly from the testing before the training sessions to testing after the empathy training sessions. Macaskill, Maltby, and Day (2002) studied the

BEES in relation to forgiveness of others and to self. Their findings showed that both male and female participants with higher BEES scores were more likely to find it easier to forgive others (but not the self).

The Balanced Emotional Empathy Scale (BEES) is in a questionnaire format and is relatively uncomplicated to administer and score as compared to other empathy measures. Subjects report the degree of their agreement or disagreement with each item using a 9-point agreement-disagreement scale. Administration does not require that the tester to be present. The test format, a 30-item questionnaire, was designed for use with an English-fluent population, ages fifteen and older. It requires approximately 10 minutes for administration. Hand scoring yields a single total-scale score. Scoring and interpretation are automated, by using software. Positive and negative items are summed, yielding two totals. The negative sum is subtracted form the positive sum resulting in a total score. The total score is converted into a Z score; the Z score can be compared to a standard Z score table that corresponds to an interpretation of the respondent's level of empathy. The higher the Z score the higher the respondents level of empathy.

Chapter 4: RESULTS

The purpose of this chapter is to report the outcomes of the study in a concise manner. The data is descriptive in nature of this population and results are representative of this agency. The Demographic Characteristics of the Participants, Attitudes Regarding Sexual Offenders survey, the Balanced Emotional Empathy Scale (BEES), and Maslach Burnout Inventory-Human Service Survey (MBI-HS) are discussed independently.

Demographic Characteristic Results

Results are presented in table 1 and table 2 for the demographic characteristics. Descriptive statistics were calculated using SPSS statistical software. Each item of the demographics questionnaire was analyzed for frequencies and percentages, as well as means, modes, medians, standard deviations, and range for certain characteristics. The results are presented in table format and highlights are presented following the table.

Table 1

Demographic Characteristics of the Participant Sample

(N=16)

Characteristic	Mean	Median	Mode	SD	Range
Age	38.0	36.0	38.0	9.26	25-60
Years work with Sex Offenders	1-5	1-5	1-5	.96	1-15
Daily Activities					
% Direct Service	62.6	67.5	60.0	26.46	2-90
% Supervision	8.75	.0	.0	17.74	0-70
% Administrative	14.25	5.0	.0	24.15	0-98
% Assessments	14.06	20.0	20.0	10.36	0-30

Highlights from Table 1

Results indicate that the respondents were 62.5% male and 37.5% female, ranging in age from 25 to 60 years old, with an average age of 38. The majority of the respondents have between 1 and 5 years of experience working with sexual offenders; only a quarter have between 10 to 15 years of experience working with sexual offenders (see table 1).

As seen in table 1, moderate dispersion exists in the data regarding how respondents portion their daily activities among direct service with clients, with supervision, with administrative tasks, and with administering assessments including the report write-up. The time spent in direct services with clients ranges from 2% to 90%; the mean amount of time spent in direct service is 62.6% with a SD of 26.46. The majority of the respondents spend most of their time working directly with clients. Data indicates that 56.3% of the respondents spend 0% of their time in supervision. Among those that get supervision, only 8.75% of their time dedicated to this purpose. One-quarter of the respondents spend 0% of their time on administrative tasks, and another quarter spend 20% or more of their time with administrative tasks. One-quarter of the respondents spend 0% or no time administering assessments and on writing reports. Among those whom administer assessments and write the corresponding report, the total time spent ranges from 5% to 30%, with the majority spending more than 20% of their total time engaged in this activity. This discrepancy is likely due to the percentage of non-qualified clinicians excluded from this activity.

Half of the respondents hold a Masters of Science (MS) or Master of Arts (MS) degree. The majority, 62.5% of the clinicians are Masters level practitioners. Only two of the sixteen respondents hold doctoral degrees (PhD, PsyD, or EdD), as well as Bachelor of Arts (BA) or Bachelors of Science or (BS) degrees. Most of the respondents received their sexual offender-specific training on the job and through other training sources. More than half of the respondents received continuing education. However, the majority of the respondents received their sexual offender-specific training through a combination of on the job training, other training sources, and continuing education. Fourteen of the sixteen respondents did not receive any sexual offender-specific training through their academic programs. It is remarkable that little supervision is occurring at this agency and sex offender-specific training seems to come from an amalgamation of sources. Almost all of the respondent's agreed that their salaries were appropriate to their positions (see table 2).

Table 2

Demographic Characteristics of the Participants (N=16)

Characteristic	N	%
Gender		
Male	10	62.5
Female	6	37.5
Age		
25	1	6.3
30	2	12.5
32	2	12.5
33	1	6.3
34	2	12.5
38	4	25.0
47	1	6.3
48	1	6.3
52	1	6.3
60	1	6.3
Time Working with Sex Offenders		
<1 year	1	6.3
1-5 years	10	62.5
5-10 years	1	6.3
10-15 years	4	25.0
Highest Degree		
BS/BA	3	18.8
MS/MA	8	50.0
MSW	2	12.5
PhD/PsyD/EdD	2	12.5
Other	1	6.3

(Table 2 Continues)

Table 2 Continued

Characteristic	N	%
Sex offender Training		
Academic Program		
Yes	2	12.5
No	14	87.5
On Job Training		
Yes	15	93.8
No	1	6.3
Continuing Education		
Yes	9	56.3
No	7	43.8
Other Training		
Yes	1	6.3
No	15	93.8
Percentage of Total Time Spent in Work Activities		
Direct Service		
2	1	6.3
20	1	6.3
40	2	12.5
50	1	6.3
60	3	18.8
75	1	6.3
80	3	18.8
85	1	6.3
90	3	18.8

(Table 2 Continues)

Table 2 Continued

Characteristic	N	%
Percentage of Total Time Spent in Work Activities		
Supervision		
0	9	56.3
5	2	12.5
10	2	12.5
20	2	12.5
70	1	6.3
Administrative		
0	6	37.5
5	3	18.8
10	1	6.3
20	4	25.0
25	1	6.3
98	1	6.3
Assessments		
0	4	25.0
5	1	6.3
10	2	12.5
20	6	37.5
25	2	12.5
30	1	6.3

(Table 2 Continues)

Table 2 Continued

Characteristic	N	%
Salary is Appropriate to Position		
Strongly Disagree	1	6.3
Disagree	2	12.5
Agree	11	68.8
Strongly Agree	2	12.5

Balanced Emotional Empathy Scale (BEES) Results

The Balanced Emotional Empathy Scale (BEES) is designed to measure one's vicarious experience of another's emotional experiences, i.e. feeling what another person feels. Norms for the general population on the BEES is a mean of 45, with as standard deviation of 24 (Mehrabian, 2000). The mean for this clinician population is 49.9, with a standard deviation of 23.0. This means that the majority of the respondents are within the average range of emotional empathy compared to the general population. The Majority, 68.8% of the respondents had scores in the average to slightly high range of emotional empathy. In general, this population differs very little with the general population, indicating that work with sexual offenders has little to no impact on their ability to empathize with their clients (see table 3).

Table 3

Balanced Emotional Empathy Scale (BEES)

(N=16)

Empathy Level	N	%
Extremely Low	1	6.3
Very Low	1	6.3
Slightly Low	2	12.5
Average	6	37.5
Slightly High	5	31.3
Moderately High	1	6.3

Mean	Median	(N=6) Mode	SD
49.9	50.0	50.0	23.0

Maslach Burnout Inventory-Human Service Survey (MBI-HS) Results

The Maslach Burnout Inventory-Human Service Survey was designed to assess three components of the burnout syndrome: emotional exhaustion, depersonalization, and reduced personal accomplishment. The higher the score in each category, e.g. Emotional Exhaustion and Depersonalization, the more of that particular construct. The higher the score for Personal Accomplishment, the more satisfied and content the respondents feel.

Results of this clinician population indicate inconsistency among the respondents on the three measures of burnout. Although results on the Maslach Burnout Inventory indicated low to moderate levels of burnout, dispersion exists among scores, meaning that some of the clinicians feel burned out, while but others do not. One-quarter of the respondents report high levels of emotional exhaustion, meaning they feel emotionally drained by their work with this population. Notably, most of the clinicians feel low levels of depersonalization, meaning that they take their work personally and invest personal commitment to their clients. In general, clinicians at this agency have low to moderate levels of burnout and moderate levels of personal accomplishment, which could indicate normal variation among the respondents (see table 4).

Table 4

Maslach Burnout Inventory-Human Service Survey (MBI-HS)

(N=16)

Emotional Exhaustion	N	%
Low	7	43.8
Moderate	5	31.3
High	4	25.0
Depersonalization		
Low	9	56.3
Moderate	6	37.5
High	1	6.3
Personal Accomplishment		
Low	4	25.0
Moderate	8	50.0
High	4	25.0

Attitudes Regarding Sexual Offenders Survey Results

Table 3 presents every question on the Attitudes Regarding Sexual Offenders Survey, the number of respondents who answered in a particular way, and the percentage of all respondents to a specific question. Statistics for the responses of the Attitudes Regarding Sexual Offenders survey items (N=16) were examined and significant descriptive information is highlighted following the table.

Table 5

Positively Scored Survey Item Responses of Attitudes Regarding Sexual Offenders Survey.
(N=16)

Question	Response	N	%
1. I think people who have committed a sexual offense can live law abiding lives.			
	Strongly Disagree	1	6.3
	Disagree	3	18.8
	Agree	10	62.5
	Strongly Agree	2	12.5
2. I believe released sex offenders should be allowed to live undisturbed in the community.			
	Strongly Disagree	1	6.3
	Disagree	10	62.5
	Agree	5	31.3
	Strongly Agree	0	0.0
4. I would feel distressed if I found out a convicted sex offender was living near my home.			
	Strongly Disagree	0	0.0
	Disagree	8	50.0
	Agree	7	43.8
	Strongly Agree	1	6.3
5. If I was living near a sex offender, I would make inquiries about their offence.			
	Strongly Disagree	0	0.0
	Disagree	2	12.5
	Agree	12	75.0
	Strongly Agree	2	12.5

(Table 5 Continues)

Table 5 Continued

Question	Response	N	%
6. I think that any discomfort a sex offender may experience as a result of public notice is justified.			
	Strongly Disagree	0	0.0
	Disagree	5	31.3
	Agree	9	56.3
	Strongly Agree	2	12.5
8. A person found guilty of a serious sexual offense should always be imprisoned.			
	Strongly Disagree	0	0.0
	Disagree	3	18.8
	Agree	12	75.0
	Strongly Agree	1	6.3
11. Adults who commit sex crimes should be managed, treated, and supervised differently from other criminals.			
	Strongly Disagree	0	0.0
	Disagree	1	6.3
	Agree	10	62.5
	Strongly Agree	5	31.3
14. I find it hard to think about a sexual offender committing the offence.			
	Strongly Disagree	3	18.8
	Disagree	11	68.8
	Agree	2	12.5
	Strongly Agree	0	0.0

(Table 5 Continues)

Table 5 Continued

Question	Response	N	%
16. I enjoy the work I do with sexual offenders.			
	Strongly Disagree	0	0.0
	Disagree	1	6.3
	Agree	11	68.8
	Strongly Agree	4	25.0
17. I feel anger toward sexual offenders.			
	Strongly Disagree	2	12.5
	Disagree	9	56.3
	Agree	5	31.3
	Strongly Agree	0	0.0
18. Sexual offenders don't bother me.			
	Strongly Disagree	3	18.8
	Disagree	10	62.5
	Agree	3	18.8
	Strongly Agree	0	0.0
20. I worry about sexual offenders harming my family.			
	Strongly Disagree	1	6.3
	Disagree	7	43.8
	Agree	7	43.3
	Strongly Agree	1	6.3

(Table 5 Continues)

Table 5 Continued

Question	Response	N	%
21. Clients and I often agree about the tasks that need to get done in therapy to improve their situation.			
	Strongly Disagree	0	0.0
	Disagree	5	31.3
	Agree	9	56.3
	Strongly Agree	2	12.5
22. I believe my clients like me.			
	Strongly Disagree	2	12.5
	Disagree	4	25.0
	Agree	9	56.3
	Strongly Agree	1	6.3
23. My clients and I typically trust each other.			
	Strongly Disagree	3	18.8
	Disagree	9	56.3
	Agree	4	25.0
	Strongly Agree	0	0.0
24. My clients often have different ideas about what the problems are.			
	Strongly Disagree	0	0.0
	Disagree	2	12.5
	Agree	10	62.5
	Strongly Agree	4	25.0

(Table 5 Continues)

Table 5 Continued

Question	Response	N	%
25. I often feel appreciated by the clients I work with.			
	Strongly Disagree	0	0.0
	Disagree	7	43.8
	Agree	8	50.0
	Strongly Agree	1	6.3
Positively Scored Survey Item Responses Survey (N=16)			
3. I believe sexual offenders can *not* be rehabilitated.			
	Strongly Disagree	3	18.8
	Disagree	9	56.3
	Agree	4	25.0
	Strongly Agree	0	0.0
7. Finding out a coworker has a past sexual offense would *not* change the way I interact with them.			
	Strongly Disagree	2	12.5
	Disagree	6	37.5
	Agree	8	50.0
	Strongly Agree	0	0.0
10. I think sex offender registration is *not* an effective tool for promoting public safety.			
	Strongly Disagree	2	12.5
	Disagree	10	62.5
	Agree	4	25.0
	Strongly Agree	0	0.0

(Table 5 Continues)

Table 5 Continued

Question	Response	N	%
12 Because Paraphilias and other sexual dysfunctions are "mental disorders," sexual offenders should not be held responsible.			
	Strongly Disagree	11	68.8
	Disagree	5	31.3
	Agree	0	0.0
	Strongly Agree	0	0.0
15. If I had other opportunities, I would choose *not to* work with sexual offenders.			
	Strongly Disagree	4	25.0
	Disagree	11	68.8
	Agree	1	6.3
	Strongly Disagree	0	0.0
19. I believe *not* allowing sexual offenders to live near places where children congregate is necessary to reduce re-offences.			
	Strongly Disagree	0	0.0
	Disagree	2	12.5
	Agree	12	75.0
	Strongly Agree	2	12.5

Highlights of Table 5

Significant variation among the respondents is most evident, because no question elicited 100% concurrence among respondents to a particular question or response. Notably, responses to question five indicate that 75% of clinicians agreed that they would make inquiries, if they were living near a sexual offender, about his or her offence. There is about an equally split agreement and disagreement to question twenty about whether or not they worry about sexual offenders harming their families. Responses to question one, shows that 62.5% of clinicians agree that people who have committed a sexual offense in the past can go on to live law abiding lives and as reported on question four, 50% of the clinicians would not be distressed if they found out a convicted sex offender was living near their homes (see table 3).

The majority of clinicians are in agreement that released sex offenders should not be allowed to live undisturbed in the community and more than half agree that sex offender registration is an effective tool for promoting public safety. The greater number of clinicians is in accord that any discomfort a sexual offender may experience because of public notice is justified. Responses to several questions give the impression that these clinicians are in support of continuous offender monitoring and registration to protect the public, despite their effects on the offenders. Correspondingly, responses to question nineteen shows that 75% of the clinicians believe that not allowing sexual offenders to live near places where children congregate is necessary to reduce re-offences and the majority of clinicians agree that a person found guilty of a serious sexual offense should always be imprisoned.

Although the majority of clinicians are in support of imprisonment, segregation, and public notice, responses to question eleven indicates, 62.5% agree that adults who commit sex crimes should be managed, treated, and supervised differently from other criminals, and more than half agree that sexual offenders can be rehabilitated. Sixty-eight percent strongly disagreed with the statement because paraphilias and other sexual dysfunctions are "mental disorders"; sexual offenders should not be held responsible, so the most of the clinicians at this facility believe that sexual offenders should be held accountable for their behavior despite their diagnosis.

According to responses on questions 16, 17, and 18, 68.8% agree and 25% strongly agree that they enjoy their work with sexual offenders. More than half of the respondents reported that they do not feel anger toward sexual offenders or are not bothered by this population. Results for question 14 indicate that 68.8% of clinicians do not find it hard to think about a sexual offender committing the offence. According to responses on question 7, 50% of clinicians agree that finding out a coworker had a past sexual offence would not change the way they interact with that coworker. Conversely, 37.5% disagreed and 12.5% strongly disagreed with this question, indicating they would interact differently with a coworker if they found out he or she had a past sexual offence.

Survey question numbers 21, 22, 23, 24, and 25 are related to how the clinicians, in general, perceive the therapeutic alliance with their sexual offender clients. The majority, 56.3% of clinicians, agreed that they believe their clients like them and that their clients frequently concur about therapeutic tasks. However, 56.3% of the clinicians feel that they and their clients do not trust each other, and 62.5% think their clients have different ideas about what the problems are. Disparity regarding

feelings of appreciation related to question 25 indicates that 50% of the clinicians feel appreciated by the clients with whom they work, whereas 43.8% disagree that they feel appreciated. No clinicians, 0% strongly disagreed with the statement, "I often feel appreciated by the clients I work with." Responses to question 15 indicate 68.8% of clinicians would choose to work with sexual offenders despite having other opportunities (see table 3).

Data gathered from the Maslach Burnout Inventory, the Balanced Emotional Empathy scale were cross-tabulated using SPSS statistical software to explore the direction and strength of correlations among the instruments. Clinicians who participated in this study do not have more or less empathy than the general population. No significant correlations were evident, upon review of the data, between levels of empathy and feelings of burnout. No distinctive characteristics emerged to indicate this population of clinicians is dissimilar to the characteristics of the general population.

DISCUSSION

This research focused on describing a population of clinicians who work with sexual offenders in an outpatient setting in Pennsylvania. Beliefs about sexual offenders in this culture, particularly in cases in which victims are children, are at the highest moral level; therefore, it is logical to assume that clinicians have similar beliefs. The present study's foundation was based on research suggesting that the attitudes clinicians have toward their clients have profound effects on therapeutic alliance, on empathy, and on staff burnout, which ultimately contribute to treatment barriers. Because there is much variability in the data and the research focus has been relatively unexplored, discussion could be virtually boundless. Therefore, it is important to recognize that the following discussion is biased from a Cognitive Behavioral (CBT) perspective and that it centers on particular highlights presented in the data, on insights from clinical experience, and on relevant literature.

If an archetype were to be composed, based on the demographic characteristics of this group of respondents; the clinician would be 38 years old, male, holds a master's degree, with one to five years of experience working with sexual offenders, and who spends the majority of his time in direct treatment with sexual offenders. No demographic data was found in the literature to compare this archetype to the average clinician working in sexual offender treatment facilities across the country. However, based on anecdotal corroboration, this "average" is probably an accurate reflection of the conceptual population. It was hypothesized that negative stereo typical beliefs about sexual offenders may be hidden by professionally appropriate behaviors. This does not appear to be the case with this population. In general, the group seems to be

optimistic about rehabilitative efforts, perceive effectiveness in the punitive system, and generally like working with sexual offenders.

Personal accomplishment was found to be relatively high for this population. Meaning that the majority found the work they do to be rewarding. Further exploration, may examine the specific aspects that make their work rewarding, bearing in mind that studies indicate this population of offenders is resistant to change and therapeutic interventions are only marginally effective. Clinicians' optimistic attitudes and the beliefs that they can help, as shown in the data as high levels of personal accomplishment, may protect the clinicians form burnout (see table 3). These optimistic beliefs may motivate the clinicians to continue to work with this population because they feel as if they are making a difference in society. The data indicates half of the respondents believe that offenders can be rehabilitated.

A significant problem for clinicians who work with sexual offenders seems to be expectation. Because they are mental health clinicians, or present themselves as therapists, it is understandable that the offenders expect the clinicians to give ethical priority to issues such as the therapeutic relationship, the vulnerability of the client, and the benefit of therapy for the client as an individual. However, it is common for clinicians to have conflicts between matters of ethical concern and other matters for which the therapist is responsible, such as the protection of society, and the need to cooperate with legal authorities, who may have no interest in the client's welfare. Clinicians are required to fulfill two incongruent roles; that of the offender's trusted therapist, and that of the offender's warden. Even the most compatible and sincere therapist may find it difficult to be completely honest with clients about their true motives are for initiating particular interventions. Community safety always takes

precedence over any other therapeutic considerations, including respect for an offender's autonomy or personal opinions. To that end, clinicians may elicit and use information from therapy sessions that could incriminate the offender. The clinician's ability to reconcile apposing perspectives and roles in these instances may be explained by the theory of cognitive dissonance.

Cognitive dissonance is a term which describes the uncomfortable tension that comes from holding two conflicting thoughts at the same time, or from engaging in behavior that conflicts with one's beliefs. More precisely, it is the perception of incompatibility between two cognitions, in which "cognition" is defined as any element of knowledge, including attitude, emotion, belief, or behavior. The theory of cognitive dissonance states that contradicting cognitions serve as a driving force that compels the mind to acquire or invent new thoughts or beliefs, or to modify existing beliefs, to reduce the amount of dissonance (conflict) between cognitions (Thibodeau & Aronson, 1992). It may be hypothesized that clinicians at this facility are able to adapt their perspectives to minimize cognitive dissonance and therefore are able to maintain an optimistic outlook.

To illustrate fundamental relationships types and their basic representations, a reference may be made to the research with physician-patient relations. Thirty years ago, Szasz and Hollender (1956), developed the basic models of the doctor – patient relationships). The first is the Activity – Passivity Model. In this type of relationship, the health professional does something to the patient but the patient is very passive. The patient has no control or no responsibility; the practitioner has absolute control and absolute responsibility. The second model, very common in medical practice and presently accepted as the norm, is the Guidance – Cooperation model. The patient is

aware of what is happening and is capable of following instructions. The practitioner tells the patient what to do, and he or she expects the patient to comply. In this model, the health practitioner decides what is best for the patient and makes the recommendation. The patient is expected to follow the recommendation because "the doctor knows best". The third representation is a "Mutual Participation" model, in which the physician and patient are pursuing common goals of eliminating illness and preserving health. The doctor and patient have equal power and are mutually interdependent; there is shared responsibility, and mutual dignity and respect, and their behaviors must be mutually satisfying for the relationship to continue. The patient's input is continually included in decisions before they are made because there is an open and responsible partnership. This is the model most likely to promote cooperation, as reported in Szasz & Hollender, (1956).

The latter role of mutual participation has been found most important in attempting to facilitate adherence. As Hanson (1986) notes, these changes in the way the physicians communicated resulted in improved patient understanding and contributed to a better adherence record, as well as to clinical outcomes. Several studies indicate that patients who receive information in a manner they expect from a physician are more satisfied with the help they receive, tend to like the practitioner more, and are more likely to follow through on recommended actions (Szasa & Hollender, 1956). Perhaps, offenders are unclear about the role of the therapist in their management as well as in expectations for treatment. The Activity – Passivity Model most closely resembles sex offender treatment, as it exists today. Understandably, offenders are often distrustful of the motives of professionals, including treatment providers, because of negative interactions involving the legal system. This likely

establishes the therapeutic relationship in an unequal manner, putting the therapist in an authority role, rather than in a collaborator role. An approach shift to the Guidance – Cooperation model may benefit both the therapist and the offender, by enhancing the offender's sense of self-efficacy.

Bandura (1994) defines self-efficacy as people's beliefs about their capabilities to produce designated levels of performance to exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave. They include cognitive, motivational, affective and selection processes. People's beliefs about their abilities to cope affect how much stress and depression they experience in threatening or difficult situations, as well as their level of motivation. Perceived self-efficacy to exercise control over stressors plays a fundamental role in anxiety arousal. People who believe they can apply control over threats do not invoke disturbing thought patterns. An efficacious outlook promotes intrinsic interest and deep engrossment in activities. Self-beliefs of efficacy are essential to self-regulation of motivation. According to Bandura, (1994), most human motivation is cognitively produced. He asserts that people motivate themselves and guide their actions anticipatorily by the using forethought. They form beliefs about what they can do. They anticipate likely outcomes of prospective actions. They set goals for themselves and plan courses of action intended to realize valued futures (Bandura, 1994).

Those who believe they cannot manage threats experience anxiety and may dwell on their coping deficiencies. They tend to magnify the severity of possible threats and worry about things that rarely happen. Through such inefficacious thinking, they distress themselves and impair their levels of functioning. The stronger the

feelings of self-efficacy, the more likely people are to take on difficult and threatening activities. A strong sense of efficacy enhances human accomplishment and personal well-being. There is an increasing body of evidence that human accomplishments and positive well-being require an optimistic sense of personal efficacy. This is true because ordinary social realities are full of impediments, adversities, setbacks, frustrations, and inequities. People need a healthy sense of personal efficacy to sustain the perseverant effort required to succeed. Individuals without a strong sense of self-efficacy either abandon or abort endeavors prematurely when difficulties arise and they become cynical about the prospects of effecting significant changes (Bandura, 1994).

The hypothesis suggested that the combined stress of working with a difficult and often resistant population and managing an incongruous role would lead to increased job burnout. Interestingly, this study showed that working with this population in a "dual role capacity," did not have much of an impact on burnout. This discrepancy may be explained by the findings that most of the clinicians like the work they do, are personally invested, and are satisfied with their compensation. About half of the respondents agreed that they feel some amount of appreciation by their clients.

Questions related to the therapeutic alliance indicate the majority of clinicians believe that the tasks that need completion in therapy in order to improve the sexual offenders' situations are often agreed upon with the offender. This may mean that the offenders can acknowledge their circumstances, realize the need for conformity, and comprehend the treatment plan. However, it may not mean the offender and clinician agree on the problems to be focused on in therapy. In fact, 62.5% of the clinicians think the offenders typically have different ideas about what the problems are. It seems that the offender may participate in treatment; however, the alliance is based more on

compliance than on trust. This is consistent with the literature, which reports that sexual offenders, having been treated negatively by the legal system, often perceive the therapist as part of the same punitive structure. More than half of the clinicians indicate there is little trust between them(?) and the provider. (??)

Half of the respondent population does not receive formal supervision. However, no mandatory supervision guidelines are mandated, besides the general ethical and legal standards for general practitioners. Lack of supervision may be a problem, because ineffective treatment methods may go unnoticed and may present potential liability for the agency or for the clinician. The data shows variation among the clinicians regarding their backgrounds and experience, possibly equating to inconsistent treatment methods and approaches. From a fiscal perspective, minimizing supervision allows more time for revenue-generating activities and may promote a sense of autonomy among the clinicians.

Motivational interviewing may be advantageous for those who work with the sexual offender population, from the perspective of the clinician. Motivational interviewing is not a technique or set of techniques that are applied to clients; rather, it is a delicate balance of directive and client-centered components, fashioned by a guiding philosophy and understanding of what activates change. As defined Miller W, & Rollnick S. (2002), motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. It is more focused and goal-directed than exploring, standardized questioning or reflective counseling. The therapist is intentionally directive and the counselor actively seeks the examination and resolution of ambivalence. Miller & Rollnick. (2002), distinguish between the spirit of motivational interviewing and

techniques that are used. They report that there are as many variations in technique as there are clinical encounters. Motivational interviewing relies upon identifying and mobilizing the client's intrinsic values and goals to stimulate behavior change. Motivational interviewing does not rely on coercion, persuasion, constructive confrontation, and the use of external contingencies (e.g., the threatened loss of job or family). This approach explicitly proscribes direct persuasion, aggressive confrontation, and argumentation, which are the conceptual opposite of motivational interviewing. The counseling style is generally a calm and eliciting one.

Direct persuasion is not an effective method for resolving ambivalence. It is appealing to try to be "helpful" by persuading the client of the urgency of the problem and about the benefits of change; however, these tactics generally increase client resistance and diminish the probability of change (Moyers T, Rollnick S. 2002). The clinician does not view each client's "readiness to change" as a client characteristic, but a fluctuating product of interpersonal interaction. The therapist must be extremely attentive and responsive to the client's motivational signs in order to distinguish how prepared a client is to change. This can be done by eliciting and selectively reinforcing the client's own self-motivational statements, expressions of problem recognition, concerns, aspirations and intentions to change, as well as, ability to change. Monitoring a client's degree of readiness for change ensures that resistance is not generated by jumping ahead of the client. The therapeutic relationship is more like a partnership or companionship than it is like expert/recipient roles. The therapist respects the client's autonomy and freedom of choice (and consequences) regarding his or her own behavior (Rollnick S, Kinnersley P, Butler CC., 2002).

For example, Hemphill and Hart (2002) note that treatment effectiveness with psychopathic offenders depends on the necessity of the clients to "establish a positive relationship with a therapist. Similarly, advocates of a motivational interviewing approach with offenders stress the need for therapists to be respectful and supportive of their clients (Miller and Rollnick, 2002). Unfortunately, few have attempted to appraise the issue empirically. Of those who have, Dahle (1997), reports that one factor predicting treatment readiness and commitment was the clients' trust in the intentions of treatment providers. Trust in the therapist has been shown to be crucial in generating change in clients with various mental health problems (Marshall et al., 2003).

Based on a number of survey questions, it appears that the clinicians at this facility seem to agree with the punitive aspects of offender management; however, they seem generally optimistic about intervention and treatment methods. Only 25% of the clinicians believe that offenders cannot be rehabilitated. The remainder believes that rehabilitation is not only possible, but also the majority thinks that offenders can go on to live law-abiding lives. An attitude of optimism and a strong sense of self-efficacy may explain the reasons why most of the clinicians are not feeling burnout from working with this difficult and often resistant population. Perhaps an optimistic attitude, a strong sense of self-efficacy and belief that treatment efforts are valuable, buffer clinicians from feeling as if their efforts are pointless, thus protecting them from burnout.

No baseline data were found in the relevant literature to compare clinician characteristics such as attitudes toward sexual offenders, ability to empathize with offenders, or burnout rates with the research group. The data do not support the conclusion that the clinicians at this facility have higher or lower empathy levels than

the public. No relationship between empathy level and burnout was recognized. The ability to empathize with sexual offenders runs counter to logic, when one considers that the majority of the general population finds the actions of sexual offenders to be repulsive, and as a group, they are generally perceived to be among the most horrible among criminal populations.

The clinicians in this study did not deviate much from the general population regarding their ability to empathize. It is possible to explain the ability to empathize with sexual offenders because clinicians get to know each of their clients as individuals and they are able to judge them on a combination of human characteristics, rather than on their offensive behavior only. In some instances, an offender may have had one offense. One behavior does not necessarily characterize a personality. Additionally, the data does not suggest that clinicians with lower than normal levels of empathy chose to work with this population or are better suited for working with the offender population.

Limitations of the Study

The intention of this research was to explore clinician characteristics within one agency, i.e. a population study. Inherently, a major limitation of this type of study is the inability to generalize beyond this agency. A major issue in exploratory studies involves drawing premature conclusions. This study was designed to provide a "first look," at this population. Relative to the conceptual population of sexual offender clinicians in the United States, the respondents who participated in this study may not be representative; it is also statistically too small to generalize for comparative purposes. However, usable data gathered from the entire population of clinicians provides a solid foundation to discuss the characteristics of the clinicians at this agency. Describing the characteristics of these clinicians provides valuable insights and allows speculation about the conceptual population of clinicians who work with sexual offenders at similar agencies. Bias is characteristically a limitation when studies are conducted in the workplace. Despite the anonymous presentation of the surveys, many employees will not take the chance that their responses could be traced to them, thus reflecting negatively. Therefore, either they do not participate or they answer questions in a socially appropriate manner.

In retrospect, this project is similar to a case study design. The case study is one of several ways of doing social science research. Rather than using large samples and following a rigid protocol to examine a limited number of variables, case study methods involve an in-depth, longitudinal examination of a single instance or event: a case (Yin 2002). Case studies are used to organize a wide range of information about a case and then analyze the contents by seeking patterns and themes in the data. A case

can be individuals, programs, or any unit, depending on what the researcher wants to examine through in-depth analysis and comparison. Yin, 2002, suggests that a case study should be defined as a research strategy, an empirical inquiry that investigates a phenomenon within its real-life context. As a result, the researcher may obtain a better understanding of the reason(s) why an instance happened as it did, and what might become important to observe more extensively in future research. Researchers often undertake exploratory case studies before implementing a large-scale investigation. Exploratory case studies help to identify questions, select measurement constructs, and develop measures, as well as safeguard investment in larger studies in which considerable uncertainty exists about program operations, goals, and results (Yin 2002). Survey research, although only descriptive in nature, can spark curiosity for more controlled experimental studies.

This study produced a wealth of information, although the data obtained is so variable for each question, this leads to a multitude of additional questions. Because thoughts interact with feelings and behaviors, each question, inherently, can be examined from a number of viewpoints, not the least of which is how the attitudes of these clinicians play out as consequences for the sexual offenders.

Recommendations and Future Research

Research in the area of sexual offender management is needed, because so many Americans believe that the only investment in sex offenders should be punitive. Because of the high cost to society and to the victims of re-offence, research in this area is indispensable. There is a need for the public recognize that sexual offenders are not only a criminal justice problems but also public health problems. If this public mid-set begins to change, perhaps more funded research in this area may be delegated. Management of the sex offender population is an ever-growing problem for society and it will continue to demand research endeavors. It is necessary to consider the damage to society and the damage to victims of re-offences; it is necessary so that serious attention may be given to all aspects of treatment efforts, including the therapeutic conditions necessary to increase treatment effectiveness and to decrease recidivism. Because this population is not going away, someone has to deal with this population; therefore, clinicians will continue to be a chief component of effective management strategies.

In Pennsylvania, no sexual offender-specific credentialing is mandated. There are no minimum standards of education for, of training for, or of ethical oversight of clinicians, other than standard practice guidelines and licensure laws. Professional organizations like the American Psychological Association have not yet set ethical and training standards for the many psychologists entering this particular field. As a result, an abundance of professionals who diagnose sexually violent predators has developed in the last two decades, and several hundred psychologists, often with little or no background in treating sex offenders, make a profitable business of recommending who

should be committed to treatment programs and of providing treatment. A way to distinguish specialists with advanced training as authorities in this area may create a new area of expertise for mental health professionals and limit paraprofessionals from damaging the reputations of legitimate experts.

Inconsistent educational experience for managing this population may be a contributing factor to poor treatment outcomes. Future research examining the relationship between education and treatment outcomes may be helpful for determining adequate training and academic standards. This research found that sex offender-specific training for these clinicians came from an amalgamation of sources but that little came from formal education. It is recommended a minimum standard of education and training be established, providing clinicians with appropriate credentials to work within this field. Sexual offender treatment seems to be a distinctive field within psychology, with exceptional demands, and requiring modified ethical standards to recognize the dual role of clinicians.

In this study, inconsistency among the clinicians regarding the time spent on specific work related tasks was reported. This difference among the clinicians is probably due to different proportions of tasks for differing levels of licensure or credentials. For example, Masters level clinicians spend the majority of their time in direct service provision and pass many administrative tasks, such as filing and bookkeeping, to auxiliary staff. Similarly, Bachelors level clinicians are typically assigned a greater proportion of administrative and record keeping tasks, because they are not normally as qualified for more advanced tasks, such as treatment and evaluation. Accordingly, basic qualifications affect the clinicians' daily activities;

therefore, formalizing minimum standards for training should not negatively affect current workflow procedures.

A future study may investigate the offenders' perceptions of similar attitude questions, as those that were asked of the clinicians for this study. Comparing the two perspectives may identify inherent issues for relating with this population. A future study may examine how attitudes affect outcomes. According to the results, a Masters degree is the most common academic degree for this population of clinicians. Academic programs may consider specific training programs or classes for those who treat offenders, as is done for those who treat addictions, eating disorders, children, etc. Possibly a special certification or specialty program could be developed to address this need.

The Attitudes Regarding Sexual Offenders survey could be further developed in order to provide an overall assessment of general attitudes by grouping similar items together or scaling the instrument to produce a total score for "relative attitude." Scaling the instrument would permit comparison between respondents based on a standard scoring method. Respondent A may have a higher score than respondent B; therefore, hypotheses can be developed regarding relative standing and comparisons among the group of clinicians; studies can also be conducted with other instruments. For example, there may be a correlation between "positive attitude scores" and burnout rates. Perhaps a high score on the "attitude assessment tool" can be compared to a high or low score on another instrument. The enhanced Attitude Assessment instrument could also be used as an attitude needs assessment. Further research may find attitudes that correlate with positive treatment outcomes, and ideal clinician characteristics could be matched with this population. This may be considered similar to the way in which

SAT scores predict college success. The a more refined version of the attitude instrument could perhaps be used as a prescreening measure to determine whether or not basic attitudes are present in applicants to aid in personnel selection or this could be used to identify incongruent attitudes so that remedial efforts can be employed. The survey instrument in its current form does not allow for this type of comparison.

This study found that almost all of the respondents felt that their salaries were appropriate to their positions. The responses could have been biased, because of the workplace. It would be interesting to repeat the study by sending the questionnaires to the clinicians' homes, so that the surveys, could, in no way be associated with the agency. However, if the results are an accurate reflection, a future study may compare salary ranges with other client populations or may examine any relationship between remuneration and satisfaction levels.

REFERENCES

Alreck, P. L. and Settle, R. B. (1985). The Survey Research Handbook, Irwin. Homewood, Illinois.

Bandura, A. (1994). Self-efficacy. In V. S. Ramachaudran (Ed.), *Encyclopedia of human behavior* (Vol. 4, pp. 71-81). New York: Academic Press. (Reprinted in H. Friedman [Ed.], *Encyclopedia of mental health.* San Diego: Academic Press, 1998).

Bednar, R. L. & Peterson, S. R. (1995). Unique qualities of the therapeutic relationship; in: Self-esteem: Paradoxes and innovations in clinical theory and practice (2nd ed.). *American psychological Association,* Washington, DC. pp. 233-269.

Becker, J. and Murphy, W. (1998). What We Know and Don't Know about Assessing and Treating Sex Offenders, *Psychology, Public Policy and Law.* 4: 116-137.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: *Theory, Research, and Practice, 16,* 252-260.

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. 0. Horvath & L. Greenberg (Eds.). The working alliance. *Theory, research, and practice pp.* 13-37. New York, Wiley.

Briggs, D. (1994). The management of sex offenders in institutions. In T. Morrison, M.

Byrne, V. S. (2004) Changing people's minds. Journal of Sexual Aggression. Caswell Clinic, Bridgend, UK Vol. 10, 2, 181-192.

Converse, M. J. & Presser, S. (1986). Survey Questions: Handcrafting the Standardized Questionnaire, Sage Publications, Cal.

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

DeVellis, R. (2003). Scale Development: Theory and Applications, (2nd. Ed.) *Applied Social Research Methods Series,* Sage Publications. Thousand Oaks, Cal., Vol. 26.

Erooga, & R. C. Beckect (2001), Sexual offending against children pp. 129-145. London.

Farrenkopf, T. (1992). What happens to therapists who work with sex offenders? *Journal of Offender Rehabilitation* , 8 ,217- 223.

Federal Bureau of Investigations (1997). Uniform Crime Reports for the United States, *U.S. Department of Justice,* Washington, DC.

Freud, S. (1913). On the beginning of treatment: Further recommendations on the technique of psychoanalysis. In J. Strachey (Ed.), *Standard edition of the complete works of Sigmund Freud, pp. 122-144.* London: Hogarth.

Friedman, S. H. & DiMatteo, M. R. (1999). Development of the Physical Therapy *Physical Therapy*, Outpatient Satisfaction Survey (PTOPS).

Gaston. L., & Marmor, C. R. (1994). The California Psychotherapy Alliance Scales. In A. 0. Horvath & L. Greenberg (Eds.), The working alliance: *Theory, research, and practice pp. 85-108.* New York, Wiley.

Greenfeld, L. (1998). Alcohol and Crime: An Analysis of National Data on the Prevalence of Alcohol Involvement in Crime, National Symposium on Alcohol Abuse and Crime, *U.S. Department of Justice, Bureau of Justice Statistics* Washington, DC April 5-7.

Hall, G. (1995). Sex Offender Recidivism Revisited: A Meta-Analysis of Recent Treatment Studies, *Journal of Consulting and Clinical Psychology,* 63: 802-09.

Hanna, F. J. (2002). Reducing therapist interference and increasing therapeutic wisdom; In: Therapy with difficult clients: Using the precursors model to awaken change. *American Psychological Association,* Washington, DC, pp. 167-180.

Hanson, R. and Bussiere, M. (1998). Predicting Relapse: A Meta-Analysis of Sexual Offender Recidivism Studies, *Journal of Consulting and Clinical Psychology,* 66 348-364.

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L.& Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. Sexual Abuse: A Journal of Research and Treatment , 14, 169-194.

Henry, W. L. & Strupp. H. H. (1994). The therapeutic alliance as an interpersonal process. *Theory, research, and practice pp. 51-84.* New York: Wile.

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

Hogue, T. E. (1995). Training multi-disciplinary teams to work with sex offenders: Effects on staff attitudes. Psychology, Crime & Law, 1, 227-235.

Hogue, T. E. & Peebles, J. (1997). The influence of remorse, intent and attitudes toward sex offenders on judgments of a rapist. Psychology, Crime & Law, 3, 249-259.

Horvath, A. O., Gaston, L., & Luborsky, L. (1993). The therapeutic alliance and its measures. *In N. E. Miller, L.*

Horvath, A. O., & Greenberg, L. (1994). The working alliance: *Theory, research, and practice.* New York: Wiley.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, p38.*

Hunter, J. and Becker, J. (1998). Motivators of Adolescent Sex Offenders and Treatment Perspectives, *Sexual Aggression, American Psychiatric Press.* Washington, DC.

Hunter, J. and Figueredo, A. (2005).The Influence of Personality and History of Sexual Victimization in the Prediction of Offense Characteristics of Juvenile Sex Offenders, Behavior Modification.

Kilpatrick, D., Edmunds, C., & Seymour, A. (1992). Rape in America: A Report to the Nation, *National Victim Center.* Arlington, VA, 1992.

Lea, S., Auburn, T. & Kibblewhite, K. (1997). Working with sex offenders: The perceptions and experiences of professionals and paraprofessionals. International Journal of Offender Therapy and Comparative Criminology, 43 , 103-119.

Lieb, R. Quinsy, V. & Berliner, L. (1998). Sexual Predators and Social Policy, *Crime and Justice.* University of Chicago, 43-114.

Lotke, E. (1996). Sex Offenders: Does Treatment Work? Corrections Compendium 21.

Macaskill, A., Maltby, J., & Day, L. (2002). Forgiveness of self and others and emotional empathy. *Journal of Social Psychology, 142, 663-665.*

Marshall, W. L., Fernandez, Y. M., Serran, G. A., Mulloy, R., Thornton, D., Mann., R. E. & Anderson, D. (2003). Process Variables in the Treatment of Sexual Offenders. A review of the relevant literature. Aggression, and Violent Behavior: A Review Journal , 8, 205-234.

Marshall, W. L., Serran, G. A., Fernandez, Y. M., Mulloy, R., Mann., R. E. & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. Journal of Sexual Aggression , 9, 25-30.

Marshall, W. L. & Serran, G. A. (2004). The Role of the Therapist in Offender Treatment Psychology, Crime & Law, Vol. 10 Issue 3, p309-320, 12

Maslach, C. (1982). Burnout: The Cost of Caring. Eaglewood Cliffs, NJ: Prentice Hill.

McCarthy, C.W. & Frieze, H. I. (1999). Negative Aspects of Therapy: Client Perceptions of Therapists' Social Influence, Burnout, and Quality of Care. *Journal of Social Issues,* University of Pittsburgh, vol. 55, pp 33-50.

McMullin, R. E. (2000). The New Handbook of Cognitive Therapy Techniques. *Norton.* New York.

Mehrabian, A. (1996). *Manual for the Balanced Emotional Empathy Scale (BEES).* (Available from Albert Mehrabian, 1130 Alta Mesa Road, Monterey, CA, USA 93940).

Mehrabian, A. (1997). Analysis of affiliation-related traits in terms of the PAD Temperament Model. *Journal of Psychology, 131,*101-117.

Mehrabian, A., Young, A.L., & Sato, S. (1988). Emotional empathy and associated individual differences. *Current Psychology: Research & Reviews, 7,* 221-240.

Mehrabian, A. (2000). Beyond IQ: Broad-based measurement of individual success potential or "emotional intelligence." *Genetic, Social, and General Psychology Monographs, 126,* 133-239.

Miller W, Rollnick S. (2002). Motivational Interviewing: Preparing People to Change.2nd Edition. New York: Guilford Press.

Pennsylvania Board of Probation & Parole (2005). The Facts Regarding Sex Offenders. *Office of Legislative Affairs and Communications.* Harrisburg, PA.

Quinsey, V., Rice, M. and Harris, G. (1995). Actuarial Prediction of Sexual Recidivism, *Journal of Interpersonal Violence*, 10:85-105.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21, 95-103.* 133-138.

Rollnick S, Kinnersley P, Butler CC. (2002). Context-bound communication skills training: development of a new method. *Family Practice.* Medical Education, 36:377-383.

Shapiro, J., Morrison, E.H., & Boker, J.R. (2004). Teaching empathy to first year medical students: Evaluation of an elective literature and medicine course. *Education for Health: Change in Learning & Practice, 17,* 73-84.

Shelby, R. A., Stoddart, R. M. & Taylor, K. L. (2001). Factors contributing to levels of burnout among sex offender treatment providers. Journal of Interpersonal Violence, 16, 1205-1217.

Szasz, T. S., & Hollender, M. H. (1956). A contribution to the philosophy of medicine: The basic models of the doctor-patient relationship. *Archives of Internal Medicine,* 97,585-592.

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

Tjaden, P. & Thoennes, N. (1998). Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence against Women Survey, *U.S. Department of Justice, National Institute of Justice.* Washington, DC.

Vivian-Byrne, S. (2004) Changing people's minds. Journal of Sexual Aggression *Caswell Clinic, Glanrhyd Hospital*, Bridgend, UK Vol. 10, No. 2, pp. 181-192.

Yin, R. K. (2002). Case Study Research. Design and Methods. Third Edition. *Applied social research method series.* Sage Publications, CA. Vol.5.

APPENDICES

Appendix A

Participant Explanation of study
Philadelphia College of Osteopathic Medicine
Department of Psychology

Dear Participant,

My name is Dustan Barabas and I am currently a graduate student in the Clinical Psychology program at the Philadelphia College of Osteopathic Medicine (PCOM), I am conducting a research project for partial fulfillment of the requirements for the degree of Doctor of Psychology. The project is being supervised by Stephanie Felgoise, PhD., Robert DiTomasso, PhD., and Mike Degilio, PsyD. I will be exploring the attitudes and beliefs of staff who work with sexual offenders.

We believe that the results of the study will provide valuable information pertaining to how the attitudes of staff who work with sexual offenders may impact clinicians. There is not an interest in individual responses; rather the general pattern or trends in the responses of participants will be analyzed collectively. You will be asked to complete a series of surveys regarding your attitude and opinion about sexual offenders, perceptions related to your work, and a few demographic questions. The entire packet should take less than thirty minutes to complete.

You have been asked to participate in the study because you are employed at an agency that treats sexual offenders. Participant responses will be kept confidential. None of your responses will be shared with your employer and participation in no way affects your position. You are free to stop participating at any time without any consequences or penalty. You may indicate that you do not want to participate anymore by not returning the survey to the experimenter.

Please be aware that your participation is completely voluntary. You may withdraw at any point during the study. All information collected during this investigation will be kept strictly confidential and used only for purposes of the study. Consistent with the American Psychological Association (APA) guidelines, all research materials will be stored for a minimum of five years in case any participant or another researcher wishes to access the original files. If any questions arise, you may contact Dustan Barabas, Dr. Stephanie Felgoise, or the Institutional Review Board (IRB) at the Philadelphia College of Osteopathic Medicine (PCOM), through the dept. of Psychology.

* Please be aware, that there are minimal risks associated with participation in this study. These risks may include, a slight negative reaction to all or part of a question you will be asked to respond.

Philadelphia College of Osteopathic Medicine
4170 City Avenue
Philadelphia, PA 19131
215-871-6442

Appendix B

Demographics Questionnaire

Circle or fill in the appropriate response:

Male / Female *age:* _____

Length of time working with sexual offenders:

< 1 year 1 – 5 years 5-10 years 10-15years 15-20 years >20 years

Highest academic degree obtained.

BS/BA MS/MA MSW PhD/PsyD/EdD Other

Where did you get training for treating sexual offenders? (Circle all that apply)

1) Academic degree program

2) Employment (on-job training)

3) Continuing education/seminars

4) Other

What percentage of time do you spend in the following activities?

_____ Direct service

_____ Supervision

_____ Administrative tasks

_____ Assessment and report writing

My salary is appropriate to my position?

Strongly Agree	Agree	Disagree	Strongly Disagree
4	3	2	1

Attitudes Regarding Sexual Offenders

The following survey is being conducted to explore trends in attitude (thoughts, feelings, and behavior) toward people who have committed a sexual offence. Your response is completely anonymous and all survey results will be kept confidential.

Directions: read the following statements. Circle the number which best describes your agreement or disagreement with each question

1. I think people who have committed a sexual offense in the past can go on to live law abiding lives.	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1
2. I believe released sex offenders should be allowed to live undisturbed in the community.	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1
3. I believe sexual offenders can *not* be rehabilitated.	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1
4. I would feel distressed if I found out a convicted sex offender was living near my home.	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1
5. If I was living near a sex offender I would make inquiries about their offence.	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1
6. I think that any discomfort a sex offender may experience as a result of public notice is justified.	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1
7. Finding out a coworker has a criminal record of a past sexual offense would *not* change the way I interact with them on a daily basis.	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1
8. A person found guilty of a serious sexual offense should always be imprisoned.	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1
9. I could *not* recognize a sex offender if I met one.	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1
10. I think sex offender registration is *not* an effective tool for promoting public safety.	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1
11. Adults who commit sex crimes should be managed, treated, and supervised differently from other criminals.	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1
12. Because Paraphilias and other sexual dysfunctions are recognized as "mental disorders," sexual offenders should not be held responsible for their sexual behavior.	**Strongly Agree** 4	**Agree** 3	**Disagree** 2	**Strongly Disagree** 1
14. I find it hard to think about a sexual	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**

offender committing the offence.	4	3	2	1
15. If I had other opportunities, I would choose *not to* work with sexual offenders.	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
16. I enjoy the work I do with sexual offenders.	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
17. I feel anger toward sexual offenders.	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
18. Sexual offenders don't bother me.	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
19. I believe *not* allowing sexual offenders to live near schools, public pools, and places where children congregate is necessary for reducing re-offences.	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
20. I worry about sexual offenders harming my family.	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
21. Clients and I often agree about the tasks that need to get done in therapy to improve their situation.	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
22. I believe my clients like me.	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
23. My clients an I typically trust each other.	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
24. My clients often have different ideas about what the problems are.	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
25. I often feel appreciated by the clients I work with.	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1

Thank you very much for your time!

Responses are completely anonymous and all results will be kept confidential.

Appendix D

Albert Mehrabian, Ph.D.

Date: Nov. 13, 06

Dear Dustin Barabas;

Your are hereby given permission to make hard-copy reproductions of the Balanced Emotional Empathy scale for use with participants who you will be testing in your own experimental studies. Please note you are **not** allowed to reproduce any items of the scale listed above in **any medium** for distribution to others (e.g., dissertation, thesis, written report, journal article, book, computer program, any internet-based communications, or in any other test or test manual). Display of the scale on any web page or inclusion of the scale in email messages to study participants is specifically prohibited.

Others in your department or school who may wish to use the scale listed above need to contact me at the address below for permission to use it.

Sincerely,

Albert Mehrabian

IMPORTANT, PLEASE READ THIS SECTION CAREFULLY!

1130 Alta Mesa Road, Monterey, CA 93940
Telephone: 831 6495710; email: am@kaaj.com

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