Forensic staff attitudes towards men who have sexually offended: a general public comparison

Abstract

Objectives: To explore the attitudes towards men who have sexually offended (MSO) between the general public and professionals and paraprofessionals in forensic settings.

Background: Existing research demonstrates a number of different factors that appear to be important in the development, maintenance and deterioration of attitudes towards MSO. The exploration of such factors requires further exploration.

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

Results: Gender was not found to have any impact on the attitudes individuals held towards MSO. The general public were found to have significantly more negative attitudes when compared to those exposed to MSO at work (professional and paraprofessional staff). Duration of employment did not make attitudes any more or less positive.

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

Introduction

There has been an increase in the prevalence rate of sexual offending in England and Wales in the last year. Because the increase is at a new high (Office for National Statistics, 2018), it seems important that research about men who sexually offend (MSO) continues. In particular, this involves exploring the way in which society and staff working with MSO think and feel about this perpetrator group. An increased understanding of attitudes towards MSO will help to consider whether changes to current societal and institutional policies and procedures need to take place to enhance positive rehabilitation and reintegration. This may include where MSO are housed following discharge, or registration policies such as Megan's Law (e.g. Levenson, 2005) used in the United States of America. Alternatively, media coverage may benefit from changing the way in which MSO are portrayed (Willis, Levenson & Ward, 2010). However, such policies and practices have intended and unintended consequences that require careful thinking. Understanding required changes to policies and procedures could support the adequate management and rehabilitation of MSO both in society and within institutions.

Exposure to offenders and men who sexually offend

Research has explored the impact that exposure to ex-offenders has on the development and maintenance of attitudes towards offenders, and what factors are important (e.g. Maruna & King, 2009; Harper, Hogue & Bartels, 2017). Whilst many studies focus on a particular type of offence, some research explores general offending behaviours. Hirschfield and Piquero (2010) gathered data from an ethnically diverse sample of residents across four American states to analyse attitudes towards ex-offenders. They concluded that exposure to ex-offenders softens the view towards offenders in general and that exposure was the strongest predictor of more positive attitudes. Furthermore, Kjelsberg, Skoglund and Rustad (2007) suggested that gender, age, socioeconomic status, crime victimisation and education were all important factors that positively and negatively affected attitudes towards offenders. Hirschfield and Piquero (2010) confirm the relevance of these factors. The results showed that age was negatively related to stigmatising attitudes and urban residents had more positive attitudes than suburban residents.

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

number of factors to take into account when comparing attitudes towards general offending. Therefore, it is expected that there are a number of factors to take into consideration when exploring attitudes towards MSO.

Factors thought to affect attitudes towards MSO

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

Exposure to men who sexually offend

Exposure has been found to be important in the development of attitudes towards general offender populations (e.g. Hirschfield & Piquero, 2010) as well as MSO (e.g. Simon, 2010). The literature clearly highlights the complexity of the exposure relationship; however it is consistently represented as being important in attitudinal development, maintenance and change (e.g. Ferguson & Ireland, 2006; Simon, 2010). Simon (2010) also acknowledges that although exposure was found to increase positive attitudes, these attitudes can deteriorate after 20 years of exposure to MSO. The current research therefore aims to explore the relationship between length of time working with MSO and attitudinal development further.

Occupation

Linked to exposure, occupation has also been found to be an important factor in the development and maintenance of attitudes towards MSO. It

is thought that those who have a therapeutic input with MSO, such as nurse therapists or psychologists have more positive attitudes (e.g. Sanghara & Wilson, 2006). Whereas, those who have less contact with MSO such as police officers (although dependent on jurisdiction), are said to have more negative attitudes (e.g. Johnson, Hughes & Ireland, 2007). The current research aims to further explore the impact of professional role on attitudes towards MSO.

Gender

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

MSO specific factors

Other important factors highlighted in the literature include beliefs about capacity to change offending behaviours through treatment and rehabilitation (e.g. Dooley, 2009), levels of empathy (e.g. Marshall, 2005), victimisation (e.g. Nelson, Herlihy, & Oescher, 2002) and access to training (e.g. Craig, 2005). Exploration of all the factors highlighted was beyond the scope of the current research.

Clinical and Societal Implications

The Good Lives Model (GLM; Ward & Stewart, 2003) outlines the importance of having access to goods that are considered necessary to live a 'Good Life'. The GLM's basic premise is that offenders, like all humans, value a number of things in life that are defined as 'primary goods', including healthy living, hobbies, intimacy, spirituality and knowledge. Within treatment, the GLM is used to provide offenders with the knowledge, skills and competencies to obtain primary goods in a pro-social manner upon discharge to maintain a harm-free life. The GLM is considered as complimentary to the Risk-Need-Responsivity Model (RNR; Andrews & Bonta, 2006), which suggests that treatment should be proportionate to the offender's risk, should target their criminogenic need and should be tailored to their individual needs in order to promote responsivity. There is evidence to suggest that taking a strength-based approach to treatment has the potential to increase engagement and motivation whilst also addressing risk management (Ward & Maruna, 2007). Mann, Webster, Schofield and Marshall (2004) found that offenders were more motivated and goal-orientated at the end of a programme based on the GLM. The continually emerging evidence for the effectiveness of the GLM is promising. There is also evidence to suggest that programmes adhering to the RNR principles in treatment are effective for reducing recidivism in MSO (e.g. Hanson, Bourgon, Helmus & Hodgson, 2009). Whilst the literature criticises both of the theoretical approaches to therapeutic treatment, it is suggested that incorporating both models into treatment programmes for MSO has the potential to

improve treatment outcomes (e.g. Andrews, Bonta & Wormith, 2011; Ward, Yates & Willis, 2012).

In addition to therapeutic treatment outcomes, acceptance into society and access to primary goods after release are key factors in successful reintegration and maintenance of desistance (Laws & Ward, 2011). More successful reintegration can encourage desistance and provide support for the offender (Levenson, Brannon, Fortney & Baker, 2007). If a community has collectively more positive attitudes towards MSO, they are more likely to gain employment and seek accommodation. Primary goods such as these can support more successful reintegration. However, it appears that the general consensus regarding MSO is that they cannot be rehabilitated and that society holds a stereotypical view due to their perceived dangerousness (Quinn, Forsyth & Mullen-Quinn, 2004). This highlights the importance a greater understanding of the attitudes that the general public have towards MSO.

Finally, attitudes amongst individuals who work with MSO may have clinical implications for their care, treatment and rehabilitation. Kjlesberg, Skoglund and Rustad (2007) found that individuals who are involved in delivering therapy as part of a rehabilitative programme are more likely to have positive attitudes, in comparison to individuals who are responsible for the day-to-day management of MSO, such as prison officers or healthcare staff. Marshall (2005) found that therapists who are empathic

and warm produce more positive treatment induced changes. Confrontation has been found to be counter-therapeutic (Jennings & Deming, 2017). Historically, treatment programmes that were explicitly designed to overcome denial (e.g. Marshall, Thornton, Marshall, Fernandez & Mann, 2001) used confrontational approaches. However, taking into account the GLM and strength-based approaches to treatment, it is recommended that therapists are non-confrontational to prevent disengagement. Confrontation has been found to have a strong negative correlation with the effectiveness of sex offender therapy groups (e.g. Marshall, Burton & Marshall, 2013). Furthermore, research into negative attitudinal climates highlights the similar significance of attitudes. Zimbardo (1971) has described the potential for negative attitudes to provide a fertile base for the misuse of power, the neglect of client needs and ultimately (and potentially) a culture of abusive care. This would suggest that it is important to explore attitudes of those working with MSO in different capacities, rather than simply focussing on those with a direct therapeutic role.

Purpose of the present study

We have seen that attitudes may have an impact on the readiness or ability of MSO to successfully engage in treatment (e.g. Marshall, 2005) and successfully reintegrate into society (e.g. Laws & Ward, 2011). Understanding the nature of these attitudes is therefore a significant research interest in the context of reducing recidivism and preventing

further abuse (Willis, Levenson & Ward, 2010). The purpose of the present study is to explore differences in attitudes between three population groups; general public, paraprofessionals and professionals. Within this, additional factors (gender and duration of occupation with MSO) will also be explored to determine any possible impact on attitudes.

Aims

The study aims to explore differences in attitudes towards MSO. Attitudes will be compared between two groups of staff working in forensic healthcare settings who are exposed to MSO in their jobs in different capacities, and the general public. Forensic staff will comprise of professional and paraprofessional staff. For the purpose of this study, paraprofessional staff is defined as anybody who works with MSO but does not have a professional qualification. This includes healthcare assistants, assistant psychologists and students. Professional staff is defined as staff who have attained a professional qualification. This includes occupations such as nurses, psychologists, psychiatrists, occupational therapists and social workers. The distinction between the two groups of staff is important due to the potential differences in exposure, for example types of therapy being delivered or length of exposure (e.g. 12 hour shift compared to one hour therapy session). The study also aims to determine whether gender plays a role in attitudes. Additionally, it explores whether the length of time one has worked with MSO has an impact on positive or negative attitudes.

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

- Do attitudes towards MSO differ between males and females?
- Does being exposed to MSO at work have an impact on attitudes, and if so, is level of profession (i.e. professional or paraprofessional) important?
- Does length of time working with MSO impact on attitudes?

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

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

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

seemed less likely that staff would have worked in the environment for a longer period of time.

Method

Materials

The cross-sectional study sought participants through convenience sampling. Participants were recruited from the general public and forensic healthcare organisations in the East Midlands, England. Emails were sent out via global distribution lists in forensic healthcare organisations, including both the public and private sector. In addition, social media platforms including LinkedIn and Facebook were utilised.

The research was conducted using the Attitudes Towards Sex Offenders Scale (ATS; Hogue, 1993) which is adapted from the Attitudes Towards Prisoners Scale (ATP; Melvin *et al.,* 1985). Hogue (1993) replaced the word 'prisoner' with 'sex offender'. Total scores range from 0-144 and higher scores indicate more positive attitudes. The ATS has been validated as a reliable method of measuring attitudes towards sex offenders (Hogue, 1993; 1995) and has excellent internal consistency; Cronbach α .92 (Nelson, Herlihy and Oescher, 2002).

Data Collection Procedure

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

Standardised emails were sent out to the communications department of each hospital and emails were distributed to all employees via a global distribution list. Social media posts were also standardised and posted on a fortnightly basis to recruit participants from the general public. If the participant chose to partake, they were directed to the ATS on Bristol Online Surveys. First, participants were required to read the information sheet to ensure they provided informed consent. Participants were also required to give demographic information, including their age range, gender and participant category (i.e. professional, paraprofessional or general public). After completion of the ATS, respondents were redirected to a debrief sheet. Anonymity was maintained throughout the study and participants were informed of their right to withdraw at any time.

Ethical Approval

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

Participants

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

A total of 557 participants were recruited to the research study. Four participants were excluded due to incomplete data sets; therefore the total number of participant's data included in the analysis was 553. A significant proportion of the participants (66.2%, *n*=365) were female, which is likely due to the composition of gender within forensic services. 32.9% (*n*=182) of the participants were male, whilst 0.9% (n=5) chose not to specify their gender. Gender frequencies are displayed in Figure 1.

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

INSERT FIGURE 1 HERE

Figure 1. Gender Frequencies.

A total of 282 participants (51%) were members of the general public. 124 were paraprofessional forensic staff (22.4%) and 147 were professional forensic staff (26.6%). The distribution of participant categories is displayed in Figure 2.

INSERT FIGURE 2 HERE

Figure 2. Participant category distribution.

Of the 244 total forensic staff, almost half had worked with MSO for between one and five years (43.8%, *n*=114), whilst 25% had worked with MSO for more than 10 years (*n*=65). The distribution of length of time working with MSO is displayed in Figure 3.

INSERT FIGURE 3 HERE

Figure 3. Length of time working with MSO.

Data Analysis

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

Results

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

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

Attitudes towards MSO: Gender

Two participants were excluded from the independent t-test as they did not specify their gender; therefore 551 participants were included in this analysis. No significant differences (t (545) = 1.067, p =.640) in attitudes towards MSO were found between male participants (M = 66.64, SD = 24.69) and female participants (M = 68.93, SD = 23.12)

Attitudes towards MSO: Exposure

A one-way ANOVA was conducted to explore differences in ATS scores between the general population, paraprofessionals and professionals. Results of the one-way ANOVA indicate a significant difference between mean ATS scores of the three participant groups; F(2, 550) = 24.64, p = .000. A Newman-Keuls post-hoc analysis was conducted as it is considered to have more power than other post-hoc tests.

The Newman-Keuls analysis indicates that paraprofessionals (M = 63.97, SD = 20.03) and professionals (M = 73.99, SD = 23.28) have significantly more positive attitudes (p = .000) towards MSO in comparison to the general public (M = 58.40, SD = 23.18). No significant differences were found between the attitudes of professionals and paraprofessionals.

Attitudes towards MSO: Duration of Exposure

The general population participants (n = 282) were excluded from this analysis as they are not applicable to the research question. A one-way

ANOVA was conducted to determine whether there are any differences in attitudes between those who have worked with MSO for different periods of time. No significant differences were found between the duration of exposure to MSO and ATS scores; $F(3, 259), = .193$, $p = .901$. Table one demonstrates the mean ATS scores of each duration of exposure.

INSERT TABLE 1 HERE.

Discussion

The aim of this study was to explore how attitudes towards MSO differ depending on gender, type of exposure and duration of exposure.

Gender

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

The findings from this study are consistent with other research studies (e.g. Nelson, Herlihy & Oescher, 2002; Kjelsberg & Loos, 2008; Simon, 2010) where it has been reported that gender did not impact on attitudinal scores. Contrary to this, some studies have found significant differences between gender and attitudinal scores (e.g. Craig, 2005; Ferguson & Ireland, 2006), although these results were in opposite directions. Craig (2005) found that males had more positive attitudes than females, whereas Ferguson & Ireland (2006) found females to have more positive attitudes than males. There may be many reasons for the

conflicting evidence between research studies. In addition, idiosyncratic or personal factors are not disclosed within the research but may warrant further investigation. Such factors that may impact more significantly on attitudes towards MSO include age, victim experiences or cultural background. Women, individuals under the age of 24, single individuals, women with disabilities, students and women without children have all been found to be at higher risk of being the victim of a sexual assault (Office for National Statistics, 2018). This evidences the extent to which other variables can impact on an individual's attitudes towards MSO. A limitation of the current study may be the lack of demographic information collected. Therefore, future research may benefit from gathering more demographic information, such as the factors discussed above, to conduct a more in-depth analysis of the factors that impact an individual's attitudes towards MSO.

Exposure

Participant's exposure to MSO based on their participant category (i.e. general public, paraprofessional or professional) was also examined. The general public had significantly more negative attitudes in comparison to paraprofessionals and professionals who are exposed to MSO in their occupational roles. This supports the hypothesis that being exposed to MSO at work relates to having less negative attitudes. These findings are also consistent with previous research which has evidenced similar findings within a range of different professions, including forensic

healthcare staff (Ferguson & Ireland, 2006; Hogue, 2003), police officers (Johnson, 2007), counsellors (Nelson *et al.,* 2002) and psychologists (Sanghara & Wilson, 2006; Simon, 2010).

The current research found no significant differences between paraprofessional and professional's attitudes towards MSO. Previous research has indicated a difference in attitudes towards MSO between professionals who are or are not involved in the therapeutic treatment of MSO (e.g. Simon, 2010). The present study did not differentiate between those who were or were not involved in treatment; therefore this cannot be included as an important factor. The findings suggest that regardless of involvement with MSO, being exposed to them within the workplace results in less negative attitudes in comparison to the general public. Future research may wish to replicate the current study and include a distinction between those working primarily with MSO and delivering treatment, compared to those who are not. Additionally, assessing therapist's attitudes prior to their involvement in the delivery of therapy to MSO may be an important consideration. This will not only determine suitability of therapists for the role, it will also allow the monitoring of the impact of delivering sex offender treatment over a period of time. This will provide further information regarding the hypothesis that working with MSO for over 20 years causes a decline in positive attitudes. It would also provide evidence to explore whether therapists have more positive attitudes and are therefore attracted to the role, or whether it is

therapeutic exposure that promotes more positive attitudes. All factors to be considered would have important clinical implications.

As there are no significant differences evidenced between paraprofessionals and professionals, this may indicate that education or training are not important factors in the development of attitudes. The lack of significant difference between professional and paraprofessional staff suggests it may be that regardless of training and education, being exposed to MSO and interacting with them in different capacities is the important factor. Such interactions may increase insight into the factors that contribute to a man committing a sexual offence, which in turn may increase empathy and understanding. Therefore, it would seem that all staff, irrespective of job role, plays an important role in promoting integration into therapeutic climates and future reintegration into the community.

The significantly more negative attitudes held by the general public must also be considered within the context of society. It may be that these negative attitudes are a protective factor in some instances, as fear instilled by the media may encourage the general public to be more vigilant. In turn, this has the potential to alert the threat system; therefore increased awareness may help the general public to protect themselves (Levenson, Brannon, Fortney & Baker, 2007). On the other hand, paraprofessional and professional's views on MSO may be more positive whilst they are working with them in forensic establishments

where risk is mitigated and they pose a smaller risk to the community whilst incarcerated. Additionally, the general public are at higher risk of being influenced by what is reported in the media (e.g. Harper & Hogue, 2016), whereas direct exposure is likely to be more influential on staff attitudes.

Duration of Employment

No significant differences were found between the duration of employment of paraprofessionals and professionals and their attitudes towards MSO. This suggests that regardless of the length of time an individual works with MSO, their attitudes do not appear to significantly differ. It is possible that the decline in attitudes may happen later than explored in this research, as previous research has suggested that a decline begins to occur after 20 years of working with MSO (Simon, 2010). The current study does not support the hypothesis that positive attitudes would increase over time of employment. It also did not provide evidence of deterioration of attitudes within the group of staff who had been employed for more than 10 years, although this may be dependent upon job role.

It may be that individuals who work with MSO in forensic establishments are drawn to such roles because they have less negative attitudes prior to seeking employment. There is no evidence from the results in this study to suggest that attitudes at the start of employment are more negative in comparison to those who have worked with MSO for longer. Neither is

there evidence to suggest that attitudes deteriorate after years of being exposed to MSO. Reasons for the lack of significant difference may be that paraprofessionals and professionals are adequately supported in their roles through clinical supervision and reflective practice. Such practices may prevent burnout or compassion fatigue and allow a safe space for personal exploration of the emotional and cognitive impact of working with MSO regardless of occupational role. Research has suggested that inadequate supervision and support can lead to an increased risk of burnout which is likely to have an impact on attitudes (Moulden & Firestone, date). Sheela (2001) found that team supervision is one of the most effective ways of coping at work. It is therefore recommended that team reflection and supervision is consistently offered to continue to adequately support those working with MSO at any professional level.

This may prevent negative attitudes manifesting in the first place or prevent deterioration over time. Alternatively, those who do experience deterioration in their attitudes towards MSO may opt to leave their job role to prevent further decline or burnout.

Differences in ATS Scores

The current research reports lower total ATS scores in comparison to Hogue's (1993) original published data (table 2). The current results are compared only to Hogue's original data as he reports that many studies have not followed the specific scoring criteria (T. Hogue, personal communication, June 2016). Some studies have not conducted the

reverse scoring and some have not subtracted the constant of 36 to obtain accurate scores.

INSERT TABLE 2 HERE

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

In addition, the ATS scores may be lower than Hogue's (1993) reported data as a result of the specific sample of participants within the current study. Forensic staff were recruited from forensic healthcare settings, which differs from Hogue's participants (probation officers, prison officers and prison psychologists). Different professions working with MSO with

different presenting problems may impact on the way in which attitudes develop and maintain.

Clinical Implications

It is important to consider staff attitudes towards MSO within establishments that support this population. Attitudes have the potential to impact on the way in which care is delivered, how risk is perceived and how individuals are treated (e.g. Marshall, 2005; Kjlesberg, Skoglund & Rustad, 2007). Therefore, it seems important to note that healthcare professional's attitudes, such as nursing staff, have an impact on the care provided which should be non-biased, regardless of the individual's offence history. According to Peplau (1991) nursing should be non-confrontational and non-opinionated.

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

Alternatively, staff with extremely negative attitudes towards MSO may be equally as problematic. Negative attitudes may result in harsh and punitive behaviours towards MSO with an emphasis on risk aversion. This can prevent the development of therapeutic alliance which has implications for treatment (Marshall, 2005). As discussed previously, therapists with warm and empathic characteristics provide MSO with optimism and hope which has positive influences on treatment induced changes (Marshall, 2003). Negative staff attitudes may reduce treatment compliance and therefore reduce the likelihood of positive treatment outcomes and reduced recidivism rates. Aside from therapeutic environments, staff with negative attitudes working in secure hospital wards or prison wings risk their attitudes manifesting into culture of abusive care if they negatively influence other staff. Focus on strength-based approaches such as those incorporating the GLM and RNR models are important.

Within society, MSO require support to reintegrate into the community following successful risk reduction and discharge from forensic establishments. Whilst it is acknowledged that having the general public hold negative attitudes can be perceived to be a protective factor (e.g. Levenson, Brannon, Fortney & Baker, 2007) equally it can have a significant negative impact on the MSO themselves. Negative attitudes held by members of the public are likely to prevent successful reintegration due to reluctance from the community to offer opportunities that are known to promote successful reintegration. These factors are

discussed within the Good Lives Model (Ward & Stewart, 2003), placing an emphasis on the importance of recreational, social and occupational activities, in addition to a primary need for stable housing. A lack of opportunities afforded to MSO upon discharge from forensic establishments is likely to cause feelings of worthlessness and hopelessness. Lack of hope has been found to be higher in MSO compared to the general population (Jeglic, Mercado & Levenson, 2012) and is associated with higher levels of recidivism (Martin & Stermac, 1999). In addition, feelings of worthlessness have been found to be prominent in MSO (Robertiello & Terry, 2007). An increase in such feelings as a result of rejection or stigmatisation compromises MSO's resilience against relapse. In addition, significant factors relating to sexual recidivism include antisocial orientation and sexual deviancy (Hanson & Morton-Bourgon, 2006).

Strengths and limitations

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

participants had a view that they wanted to express and therefore may have skewed the results somewhat. Furthermore, the sample may not be generalizable due to the ratio of men to women. However, this ratio is representative of the gender composition within forensic healthcare. A recent systematic review exploring forensic staff attitudes to MSO found that out of the 13 included studies, seven sampled more female than male participants (Challinor & Duff, 2018). Therefore, although there are large differences, it may be representative of the staff populations at least.

With regards to the staff samples, the study did not ask professionals and paraprofessionals to specify whether or not they were involved in the therapeutic treatment of MSO. This limited the extent to which researchers could draw conclusions about the different types of exposure and professional role impacting on attitudes. Future studies should endeavour to gain as much demographic information as possible, to ensure a thorough analysis of a wide range of important factors can be explored.

Although not necessarily a limitation of the study, it is important to consider whether attitudes may differ depending on the type of offence a MSO has committed. For example, previous research has found that contact offenders were perceived as more dangerous than non-contact offenders (Challinor & Duff, 2017). It is therefore assumed that attitudes towards MSO by a contact offence such as rape would attract more

negative attitudes than a voyeur, for example. It is also possible that the victim profile will impact on attitudes, for example MSO against children may be perceived more negatively than a man who offends against his wife, for example. Future research may wish to consider whether providing specific information regarding offence type and victim profiles has an impact on attitudes towards MSO.

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

Conclusion

Research into the attitudes of different populations towards MSO is imperative to understand the clinical and societal implications required to make positive changes and reduce recidivism. The research has highlighted the differences in attitudes towards MSO based on the level of exposure to the population. Staff who work with MSO were found to have more positive attitudes in comparison to the general public. Attitudes were not affected by participants' gender or the length of time they had worked with MSO. Some of the factors explored appear important; however it is difficult to determine a causal relationship. Sexual offending is an increasing societal problem resulting in high numbers of offenders being placed in forensic establishments. The quality of care and treatment

delivered within these forensic establishments impacts on recidivism rates, alongside the ease of reintegration into the community through support from the general public. Therefore, the importance of further understanding within the area of study is paramount to reduce offending rates and relapse.

References

Andrews, D. A., & Bonta, J. (2006). *The Psychology of Criminal Conduct*. Elsevier.

Andrews, D. A., Bonta, J., & Wormith, J. S. (2011). The risk-need-responsivity (RNR) model: Does adding the good lives model contribute to effective crime prevention? *Criminal Justice and Behavior*, *38*(7), 735-755.

Challinor, L. E., & Duff, S. (2017). Sexual offending hierarchies, personality attributions, and the clinical implications. *Journal of Forensic Practice*, *19*(3), 190-197. DOI: 10.1108/JFP-07-2016-0031.

Challinor, L.E., & Duff, S. (2018). Factors influencing the development of attitudes towards men who sexually offend and the impact on their care and treatment: A systematic review of literature between 1985 and 2015. *Aggression and Violent Behaviour, 41,* 98-107. DOI: 10.1016/j.avb.2018.06.001.

Craig, L. A. (2005). The impact of training on attitudes towards sex offenders. *Journal of Sexual Aggression*, *11*, 197-207. DOI: 10.1080/13552600500172103.

Dooley, R. L. (2009). *Perceptions of sex offenders' rehabilitation: the differences in perceptions among mental health professionals and the public* (Unpublished doctoral dissertation). Alliant International University, California.

Ferguson, K., & Ireland, C. (2006). Attitudes towards sex offenders and the influence of offence type: A comparison of staff working in a forensic setting and students. *The British Journal of Forensic Practice*, *8*, 10-19. DOI: 10.1108/14636646200600009.

Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: a meta-analysis of recidivism studies. *Journal of consulting and clinical psychology*, *73*(6), 1154. DOI: 10.1037/0022-006X.73.6.1154

Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and Behavior*, *36(*9), 865-891.

Harper, C.A., & Hogue, T.E. (2016). The emotional representation of sexual crime in the national British press. *Journal of Language and Social Psychology, 34*(1)*,* 3-24. DOI: 10.1177/0261927X14544474.

Harper, C.A., Hogue, T.E., & Bartels, R.M. (2017). Attitudes towards sexual offenders: what do we know, are why are they important? *Aggression and Violent Behaviour, 34,* 201-213. DOI: 10.1016/j.avb.2017.01.011.

Hirschfield, P. J., & Piquero, A. R. (2010). Normalization and legitimation: Modeling stigmatizing attitudes toward ex-offenders. *Criminology*, *48*(1), 27-55. DOI: 10.1111/j.1745-9125.2010.00179.

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

Hogue, T.E. (2016, June 21). Email communication.

Hogue, T.E., & Peebles, J. (1997). The influence of remorse, intent and attitudes towards sex offenders on judgements of a rapist. *Psychology, Crime and Law, 3*(4), 249-259. DOI: 10.1080/10683169708410821.

Jeglic, E. L., Mercado, C. C., & Levenson, J. S. (2012). The prevalence and correlates of depression and hopelessness among sex offenders subject to community notification and residence restriction legislation. *American Journal of Criminal Justice*, *37*(1), 46-59. DOI: 10.1007/s12103-010-9096-9.

Jennings, J.L., & Deming, A. (2017). Review of the empirical and clinical support for group therapy specific to sexual abusers. *Sexual Abuse, 29*(8), 731-764. DOI: 10.1177/1079063215618376.

Johnson, H., Hughes, J.G., & Ireland, J.L. (2007). Attitudes towards sex offenders and the role of empathy, locus of control and training: a comparison between a probationer police and general public sample. *The Police Journal, 80,* 28-54. DOI: 10.1350/pojo.2007.80.1.28.

Jones, E. C. (2013). An examination of counselling professionals/paraprofessionals attitudes toward adolescent sexual offenders. *Sage Open*, *3*(3), 1-14.

Kjelsberg, E., & Loos, L. H. (2008). Conciliation or condemnation? Prison employees' and young peoples' attitudes towards sexual offenders. *International Journal of Forensic Mental Health*, *7*, 95-103. DOI: 10.1080/14999013.2008.9914406.

Kjelsberg, E., Skoglund, H. T., & Rustad, A. B. (2007). Attitudes towards prisoners, as reported by prison inmates, prison employees and college students. *BMC Public Health*, *7*(1), 1-9. DOI: 10.1186/1471-2458-7-71.

Laws, D. R., & Ward, T. (2011). *Desistance from sex offending: Alternatives to throwing away the keys*. New York: The Guilford Press.

Levenson, J. S., & Cotter, L. P. (2005). The effect of Megan's Law on sex offender reintegration. *Journal of Contemporary Criminal Justice*, *21*(1), 49-66. DOI: 10.1177/1043986204271676.

Levenson, J.S., Brannon, Y.N., Fortney, T., & Baker, J. (2007). Public perceptions about sex offenders and public protection policies. *Analyses of Social Issues and Public Policy, 7*(1)*,* 1-25. DOI: 10.1111/j.1530-2415.2007.00119.x.

Mann, R. E., Webster, S. D., Schofield, C., & Marshall, W. L. (2004). Approach versus avoidance goals with sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 16*, 65-75.

Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment*, *17*, 109-116. DOI: 10.1177/107906320501700202.

Marshall, W., Thornton, D., Marshall, L., Fernandez, Y., & Mann, R. (2001). Treatment of sexual offenders who are in categorical denial: A pilot project. *Sexual Abuse: A Journal of Research and Treatment*, *13*, 205-216.

Marshall, W., Burton, D., & Marshall, L. (2013). Features of treatment delivery and group processes that maximize the effects of offender programs. In J. Wood & T. Gannon (Eds.), *Crime and crime reduction: The importance of group processes* (pp. 159-174). New York, NY: Routledge.

Martin, K., & Stermac, L. (2010). Measuring hope: Is hope related to criminal behaviour in offenders?. *International Journal of Offender Therapy and Comparative Criminology*, *54*(5), 693-705. DOI: 10.1.1.845.454

Maruna, S., & King, A. (2009). Once a criminal, always a criminal? 'Redeemability' and the psychology of punitive public attitudes. *European Journal on Criminal Policy and Research*, *15*(1-2), 7-24. DOI: 10.1007/s10610-008-9088-1.

Melvin, K. B., Gramling, L. K., & Gardner, W. M. (1985). A scale to measure attitudes toward prisoners. *Criminal Justice and Behaviour, 12*(2), 241-253. DOI: 10.1177/0093854885012002006.

Moulden, H. M., & Firestone, P. (2010). Therapist awareness and responsibility in working with sexual offenders. *Sexual Abuse*, *22*(4), 374-386. DOI: 10.1177/1079063210382047.

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

Office for National Statistics. (2018). Sexual offences in England and Wales: year ending March 2017. Retrieved April 14, 2018, from https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/sexualoffencesinenglandandwales/yearendingmarch2017#how-prevalent-are-sexual-assaults.

Peplau, H. (1991). *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing*. New York: Springer Publishing.

Quinn, J.F., Forsyth, C.J., & Mullen-Quinn, C. (2004). Societal reaction to sex offenders: a review of the origins and results of the myths surrounding their crimes and treatment amenability. *Deviant Behaviour, 25*(3), 215-232. DOI: 10.1080/01639620490431147.

Robertiello, G., & Terry, K. J. (2007). Can we profile sex offenders? A review of sex offender typologies. *Aggression and Violent Behavior*, *12*(5), 508-518. DOI: 10.1016/j.avb.2007.02.010.

Sanghara, K.K., & Wilson, J.C. (2006). Stereotypes and attitudes about child sexual abusers: a comparison of experienced and inexperienced professionals in sex offender treatment. *Legal and Criminal Psychology, 11,* 229-244. DOI: 10.1348/135532505X68818.

Sheela, R.A. (2001). Sex Offender treatment: Therapists' experiences and perceptions. *Issues in Mental Health Nursing, 22,* 749-767. DOI: 10.1080/01612840152713009.

Simon, S. (2010). *Psychologists' attitudes towards sex offenders* (Unpublished master's thesis). Pacific University, Oregon. Retrieved from http://commons.pacificu.edu/spp/173.

Stinson, J. D., Becker, J. V., & Tromp, S. (2005). A preliminary study on findings of psychopathy and affective disorders in adult sex offenders. *International Journal of Law and Psychiatry*, *28*(6), 637-649.

Ward, T., & Maruna, S. (2007). *Rehabilitation*. Routledge.

Ward, T., & Stewart, C.A. (2003). The treatment of sex offenders: risk management and good lives. *Professional Psychology: Research and Practice, 34*(4)*,* 353-360. DOI: 10.1037/0735-7028.34.4.353.

Ward, T., Yates, P. M., & Willis, G. M. (2012). The good lives model and the risk need responsivity model: A critical response to Andrews, Bonta, and Wormith (2011). *Criminal Justice and Behavior*, *39*(1), 94-110.

Willis, G. M., Levenson, J. S., & Ward, T. (2010). Desistance and attitudes towards sex offenders: Facilitation or hindrance?. *Journal of Family Violence*, *25*(6), 545-556. DOI: 10.1007/s10896-010-9314-8.

Zimbardo, P. G., Haney, C., Banks, W. C., & Jaffe, D. (1971). *The Stanford Prison Experiment*. Zimbardo, Incorporated.

Figure 1. Gender frequency of participants. 553 participants, 365 were female and 182 were male. Five participants chose not to specify their gender.

Figure 2. Participant category frequencies. 282 participants were general public. 124 were paraprofessional staff and 147 were professional staff.

Figure 3. Duration of employment in forensic services for professional and paraprofessional staff. 114 participants had worked

in forensic services between one and 5 years. 65 had worked in forensic services for more than 10 years.