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Comparison Of Empathy, Burnout, And Attitudes Toward Sex Offender Treatment Among Mental Health Professionals

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ABSTRACT

With a recent increase in convicted sex offenders and mandated treatment for sexual offending there has been an increase in the number of mental health professionals providing this treatment. Little empirical research has been devoted to this group of mental health professionals and how they may differ from other mental health professionals. The present study explored how mental health professionals in correctional settings, community-based settings, and those providing sex offender treatment differ on levels of empathy, burnout, and attitudes toward sex offender treatment. Moreover, the study explored whether there was a relationship between empathy, burnout, and attitudes toward sex offender treatment among mental health professionals that provide sex offender treatment. Two hundred nineteen mental health professionals that had at least one year of licensed experience in correctional settings, community-based settings, or providing sex offender treatment participated in this study. Those that provide sex offender treatment had more positive attitudes toward sex offender treatment, but had similar levels of burnout and empathy compared to the correctional mental health providers. Additionally, among sex offender treatment providers more positive attitudes toward sex offender treatment were related to higher levels of empathy, lower levels of depersonalization, and higher levels of personal accomplishment. Despite the lack of research about sex offender treatment providers within the psychological literature, the results of the present study will provide some clarity, potentially providing ideas for further areas of research about this group of providers. The concept of this study was formulated based on prior research on mental health professionals generally and attempted to fill the gap in the research on sex

offender treatment providers. This will help understand whether sex offender treatment providers require more training or emphasis on self-care due to the difficult clients that they are working with. As there is more of a push for sex offender treatment, this area of research will continue to be important in the future.

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CHAPTER 1

INTRODUCTION

According to the National Center for Missing and Exploited Children (2014), there were 747,408 registered sex offenders and 265,000 incarcerated sex offenders in the United States in 2014. Additionally, it is estimated that an average of 68% of sexual assaults that happened between 2008 and 2012 were not reported; thus, many additional sex offenders have likely not been apprehended (Bureau of Justice Statistics, 2012). Moreover, there has been an increase in sexual offense convictions in recent years. According to the Legal Dictionary the term *sexual offender*, or sex offender, is defined as all people who are convicted of crimes of a sexual nature. This can include crimes like rape, sexual harassment, pornography production or distribution, molestation, sex trafficking, or sexual assault. Between December of 2001 and December of 2002 the number of total inmates grew by 30,088, and between 1995 and 2001 violent offenses, which include rape and sexual assault, were responsible for 63% of the growth of incarcerated individuals in the United States (Harrison & Beck, 2003). The number of sexual crimes reported on U.S. college campuses increased by over 50% over the past decade (Bureau of Justice Statistics, 2013). Sexual offending is clearly a problem in the United States, and many of these offenders are involved in voluntary or involuntary treatment.

Recently, research has sought to determine whether mental health professionals have more positive attitudes toward sex offenders than does the public, and overall, the research suggests that mental health professionals have more positive attitudes than other groups of individuals (Brown, 1999; Craig, 2005). However, this does not suggest that they always have

an overall positive attitude toward sex offenders. In one study, sex offender treatment providers had a more positive attitude compared to other groups, but they mostly viewed their clients neutrally (e.g., on a Likert scale from 1-5 they score around a 3, indicating a neutral attitude; Nelson, Herlihy, & Oescher, 2002). There were some demographic differences, however those with more experience, men, and those over the age of 35 had the most positive attitudes (Craig, 2005; Hogue, 1993; Nelson et al., 2002). Although there are studies examining attitudes toward sex offenders, few studies have examined more specific attitudes, such as attitudes toward sexual offender treatment. Generally, the public believes that sex offenders should receive treatment in a punitive setting rather than in a community setting (Fortney, Levenson, Brannon, & Baker, 2007) and that treatment should only be provided when it accompanies punishment (Brown, 1999). For example, in one study over 50% of the participants favored castration as a primary treatment modality; likewise, when given a choice from a 0 to 99-year prison sentence, 99 years was the most common choice (Fortney et al., 2007). There are currently no studies that examine mental health professionals' attitudes toward sex offender treatment; however, there is some research discussing the importance of the therapist on sexual offender treatment. Studies found the best predictors of success in sex offender treatment were therapists' level of empathy and warmth (Marshall, 2005; Marshall et al., 2003; Marshall et al., 2002). However, some studies found that mental health professionals' empathy is not a static factor, but changes over time and may be compromised by working with sex offenders (Farrenkopf, 1992; Tyagi, 2006).

Decreased level of empathy, however, is not the only negative result that has been associated with working with sex offenders. Individuals working in mental health professions, in general have a higher risk for burnout due to the nature of their work (Maslach & Jackson, 1986). Moreover, mental health professionals who work in public agencies typically have the

highest rates of burnout (Maslach, 2003). Those who work in correctional environments have high rates of burnout and turnover, likely due to the difficulty of their clients in addition to organizational factors (Dignam, Barrera, & West, 1986; Shaufeli & Peeters, 2000). Studies of those who work with sex offenders as their primary clientele found that these individuals typically have higher rates of burnout than those in other treatment settings. In fact, those who work treating sex offenders in a community setting had higher rates of burnout than those who work in a correctional setting with other offender groups (Shelby, Stoddart, & Taylor, 2001).

There are currently no studies that examine attitudes toward sex offender treatment, level of empathy, and level of burnout in sex offender treatment providers. Additionally, there is a dearth of research comparing sex offender treatment providers to other mental health professionals in terms of burnout, level of empathy, and attitudes toward sex offender treatment, hence the purpose of this study.

The purpose of the proposed study is to investigate attitudes toward sex offender treatment among mental health professionals working in community settings, those working in correctional settings, and those who specifically provide treatment to sex offenders. In addition, these professionals' levels of burnout will be measured to determine the difference between the groups and how these attitudes may interact with levels of burnout. Lastly, levels of empathy will be measured to examine differences between groups and how it relates to levels of burnout. This will contribute to filling a gap in the current literature and establishing a foundation for future research. Recognizing whether those who treat sexual offenders have more positive attitudes toward sexual offender treatment than other mental health professionals, and whether working with these clients can impact the therapists themselves (e.g., burnout, level of empathy) is vital in providing the best treatment and understanding if these mental health professionals are

at higher risk for negative consequences. This research will potentially assist mental health professionals in maintaining positive attitudes toward sexual offenders and could help aid in effective clinical treatment.

CHAPTER 2

LITERATURE REVIEW

Burnout

People often choose their career path because they enjoy something about the work. However, when people become exhausted or are confronted with parts of their job they do not enjoy, they can experience burnout. Freudenberger (1981) originally introduced the term burnout in the 1980s as people became exhausted and unmotivated in their working environment. Burnout can lead to psychological symptoms like exhaustion, depersonalization, and decreased accomplishment (Maslach & Leiter, 1997). The concept of burnout was expanded by qualitative research with health care workers to identify common themes of burnout (Maslach, Schaufeli, & Leiter, 2001). Thanks to Maslach's initial qualitative research, burnout has been the subject of a large amount of empirical research.

Burnout is often described as feelings of being overworked and exhausted in one's employment. Burnout can occur in all professions; however, Maslach placed a large research focus on those who work in human and health services. A formal definition of burnout among this group is "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who 'do people work'" (Maslach & Jackson, 1986, p.1). Three dimensions, as defined by Maslach, characterize burnout: emotional exhaustion, depersonalization, and personal accomplishment. Emotional exhaustion occurs when an individual's emotional resources are exhausted by the continuous needs of clients, agencies, and coworkers. Emotional exhaustion is typically caused by demands out of the

person's control and often has to do with agency and client demands. This is considered the most typical and straightforward symptom of burnout because it is characterized by reacting to increasing job demands that result in a feeling of being overwhelmed (Maslach et al., 2001). Depersonalization is caused by depletion of emotional investment, leading to emotional and cognitive dissociation from one's work. In doing this, an individual adapts an indifferent attitude toward work and clients in order to reduce conflict and exhaustion. This can negatively affect one's relationship with their clients and can produce negative attitudes toward clients and the work place (Maslach et al., 2001). Lastly, reduced personal accomplishment describes a professional's decreased confidence in their capabilities. Someone who is suffering from burnout faces overwhelming, constant job demands, and loses confidence in their ability and efficacy. Maslach et al. (2001) explained that burnout is often the result of "too many demands with too few resources" (p.2). Additionally, Leiter and Harvie (1996) found the three dimensions of burnout to be correlated with the increased probability of psychotherapists leaving the profession within the next five years (Leiter & Harvie, 1996). There is a significant amount of research that examines burnout among mental health providers.

Burnout among Mental Health Professionals

There are many studies examining burnout rates of mental health professionals working in different treatment settings. Maslach and Jackson (1981) reported that psychologists are apt to have a higher risk for burnout as compared to other mental health professionals because of the personal involvement that is required for their career and the clientele with whom psychologists work. Burnout among psychologists who provide therapy has been associated with negative attitudes, depression, isolation, lack of empathy, and changing careers (Medeiros & Prochaska, 1988; Rupert & Morgan, 2005; Rzeszutek & Schier, 2014; Skorupa & Agresti, 1993).

There are a number of factors that are related to burnout among mental health professionals. For example, several demographic characteristics have been examined to identify which individuals are more susceptible to burnout. Gender is not a consistent predictor of burnout. However, some studies have found women working in public agencies to have higher rates of burnout than men in these settings (Rupert & Kent, 2007; Rupert & Morgan, 2005). However, Maslach et al. (2001) suggested that these studies largely overestimate women's prevalence of burnout because women experience burnout differently than men. For example, women have higher rates of emotional exhaustion and experience burnout more intensely than men (i.e., their personal life and satisfaction suffers more); however, men have higher rates of depersonalization and indifference toward their clients (Maslach, 2003). Additionally, other studies have found that gender is not a significant predictor of higher burnout rates (Ackerley, Burnell, Holder, & Kurdek, 1988)

Age has the most consistent findings related to burnout risk among mental health professionals. Early-career professionals and those who are younger have the highest rates of burnout (Ackerley et al., 1988; Bearse, McMinn, Seegobin, & Free, 2013; Kadambi & Truscott, 2003; Maslach, 2003; Rosenberg & Pace, 2006). However, it is possible that these findings may be confounded by work experience, in that older individuals who have more experience may have developed better coping skills and adequate skills for their employment (Maslach, 2003; Maslach et al., 2001).

Ethnic minorities are grossly underrepresented in the research on burnout. Many of the studies focus on the Caucasian experience, and do not have enough minority participants for analysis. Studies that have enough participants to examine racial differences find that ethnic minority status is not a predictor of higher burnout among mental health professionals (Lent &

Schwartz, 2012; Maslach 2003). Maslach (2003) found that Asian Americans have similar levels of burnout to Caucasians, and African Americans experience less burnout than other ethnic groups.

Another demographic feature that has been studied related to risk of burnout is marital status. Those who are unmarried have higher rates of burnout than those who are married, possibly because married individuals have more emotional support (Maslach, 2003). Additionally, mental health professionals who do not have children have higher rates of burnout than those with children (Maslach, 2003). However, Maslach posits that individuals who are married and have children are likely to be older, so it is difficult to determine if it is family support alone, or if family support in combination with older age are protective factors against burnout. However, Ackerley et al. (1988) found that the support of a significant other is not a predictor of lower rates of burnout.

Additional demographic variables that have been examined in the burnout literature are education level and personality characteristics among mental health professionals. Level of education has yielded inconsistent findings. Some studies have found that mental health professionals with higher levels of education (Doctoral degrees v. Master's degrees) have higher levels of burnout (Kruger, Botman, & Goodenow, 1991; Wilkerson & Bellini, 2006). Other researchers have found that those with higher levels of education have higher levels of emotional exhaustion, but also have higher levels of personal accomplishment (Nayoung, Eun Kyoung, Hyunjung, Eunjoo, & Sang Min, 2010). Furthermore, Maslach (2003) found that those who have college degrees, but no postgraduate education have the highest levels of burnout because of the lack of options to change positions or earn promotions with bachelor degrees in social

work and psychology. Thus, the findings on the relationship between burnout and education level are mixed.

Personality features have also been measured to examine which types of individuals may be at higher risk of suffering from burnout. Capner and Caltabiano (1993) examined whether there was a difference in paid or volunteer mental health professionals' burnout in community mental health settings. They found that, regardless of paid or unpaid position, individuals with Type A personality types had higher rates of burnout (Capner & Caltabiano, 1993). Maslach et al., (2001) also found that those with Type A personalities had higher rates of burnout. Additionally, those with higher levels of neuroticism and lower levels of agreeableness have higher rates of burnout (Lent & Schwartz, 2012). Other research has found that individuals with low self-esteem and low self-worth have higher rates of burnout (Maslach, 2003). Other personality characteristics that are related to higher rates of burnout are excessive need for control, impatience, high levels of empathy, and chronic overachievement (Maslach et al., 2001; Maslach, 2003). Although there is evidence of a relationship between burnout and personality type, it is not clear which personality features reliably impact burnout.

In addition to individual factors, there are also client factors that influence risk for burnout. Having clients that are highly demanding and time-consuming are associated with higher rates of burnout (Scarnera, Bosco, Soleti, & Lanciani, 2009). Additional client factors that are related to burnout are lack of motivation, violence, resistance, hostile transference, and clients with personality disorders, specifically those with Cluster B personality disorders (Norcross & Guy, 2007). Maslach (2003) suggests there is a widely held belief that clients with high symptom severity are related to higher levels of burnout; however not all research supports this. For example, Devilly, Wright, and Varker (2009) found that clients' exposure to traumatic

events was not related to their therapists' level of burnout. Other research has replicated these findings, suggesting that client symptom severity is unrelated to burnout (Schultz, Greenley, & Brown, 1995). However, other studies found that symptom severity, specifically negative symptom (e.g., flat affect, lack of speech, catatonia) severity of serious mental illness, is related to burnout in caregivers and mental health professionals (Kokurcan, Ozpolat, & Gogus, 2015). In light of the mixed research there is no clear connection between specific client factors and burnout in mental health providers.

Lastly, organizational factors have been researched as indicators of risk for burnout. Large caseloads that create pressure on mental health professionals are related to higher rates of burnout. Large caseloads result in less time for services, less time spent with clients, decreased rapport, and lack of continuity with clients (Maslach, 2003; Maslach, Jackson, & Leiter, 1996; Rupert & Morgan, 2005). Organizational policies and lack of autonomy are also related to higher rates of burnout (Maslach, 2003). Much of the research suggests that many of the organizational factors related to burnout are typical for those working in public agencies versus independent practices. Those in public agencies have more role ambiguity, less autonomy, higher workload, and more clients with severe psychopathology (Ackerley et al., 1988; Carroll & White, 1982; Farber, 1985; Maslach, 2003; Raquepaw & Miller, 1989; Shin, 1982; Vredenburgh, Carlozzi, & Stein, 1999). Maslach and Leiter (1997) suggest that organizational characteristics related to burnout can be reduced to six factors: values, workload, fairness, control, community, and reward. They indicate that higher levels of burnout occur when there is a large discrepancy between the mental health professionals' characteristics and the job characteristics on these six factors.

The interplay between organizational, individual, and client characteristics in predicting burnout could prove to be complicated. There is a paucity of research exploring these interactions and, therefore, it is difficult to speculate what combination of factors is related to the highest rates of burnout. Correctional settings are known to be highly stressful environments, so examining burnout among correctional mental health providers is covered next.

Burnout among Those Working with Offender Populations

Mental health professionals working in correctional environments tend to have higher rates of burnout than those working in other environments. Senter, Morgan, Serna-McDonald, and Bewley (2010) examined the effects of being employed in corrections as a psychologist. They compared 203 doctoral level psychologists who were employed in Veteran's Affairs (*N*=56), Counseling Centers (*N*=49), Public Psychiatric Hospitals (*N*=54), and Correctional (*N*=44) settings. Senter et al. (2010) used the Maslach Burnout Inventory – Human Services Survey (MBI-HSS; Maslach & Jackson, 1981) and found that those in a correctional setting had the highest levels of burnout on all three indices (emotional exhaustion, depersonalization, and personal accomplishment). One other study has explicitly measured burnout among mental health providers in correctional settings. Gallavan and Newman (2013) surveyed 101 practicing mental health providers working in correctional settings about their attitudes toward an offender population. They also utilized the MBI-HSS and the Attitudes Toward Prisoners Scale and found that correctional psychologists reported high rates of burnout, and those with more negative attitudes toward offenders had the highest rates of burnout.

There was limited research prior to Senter et al.'s (2010) study that examined factors in correctional settings that could impact levels of burnout among psychologists. For example, a survey by Boothby and Clements (2000) on the job satisfaction of 830 correctional psychologists

found that the respondents desired fewer administrative duties, less focus on psychological evaluations, and more time to spend counseling and providing psychotherapy in correctional environments. Additionally, Otero, McNally, and Powitztky (1981) surveyed 2,527 full-time and part-time mental health providers in Canadian and U.S. prisons about the structure of mental health services and the roles of mental health providers. Both Boothby and Clements (2000) and Otero et al. (1981) found that correctional mental health providers reported dissatisfaction with opportunities for advancement, large caseloads, and lack of autonomy regarding decision-making. However, neither study measured burnout specifically. When considering all of these factors, it is not surprising that psychologists in correctional settings experience high levels of burnout.

Levels of burnout among other correctional staff have also been investigated. Studies have shown that burnout levels are high among correctional officers (Castle & Martin, 2006; Keinan & Malach-Pines, 2007). Correctional officers have a high turnover rate, high rates of absenteeism, and poor physical health ratings, which are all related to higher rates of burnout (Harenstam, Palm, & Theorell, 1988). A meta-analysis conducted in 2000 identified 43 empirical studies that examined burnout rates among correctional officers (Schaufeli & Peeters, 2000). In almost all of the studies analyzed, correctional officers were found to score in the "high" range on a measure of burnout.

There are organizational factors that relate to burnout in a correctional setting. Sixty-five to seventy-five percent of correctional officers reported that they have stress related to high workload (Kommer, 1993). Studies have shown that the higher the work load the higher the rate of burnout in correctional officers (Dignam et al., 1986; Schaufeli & Peeters, 2000). In addition, lack of autonomy is also a reported complaint by correctional officers. Correctional officers who

report lower levels of autonomy reported higher levels of stress and lower levels of personal accomplishment as compared to correctional officers who reported higher levels of autonomy (Schaufeli, Van den Erijnde, & Browers, 1994). Role ambiguity and role conflict also have an impact on levels of burnout in correctional officers. In particular, correctional officers who report greater confusion about their role in the rehabilitation of offenders have higher rates of stress (Philliber, 1987). The influx of new professionals in other roles (i.e., mental health, education) creates additional role confusion since correctional officers were traditionally expected to provide these services (Philliber, 1987). This role ambiguity leads to greater perceived stress and higher rates of burnout (Philliber, 1987; Schaufeli & Peeters, 2000). Additionally, correctional officers report that there is a lack of uniformity in policies dealing with inmates (Schaufeli & Peeters, 2000).

The most notable stressor in a correctional environment is safety risk. Higher levels of perceived dangerousness and the perception that employment can endanger the safety of an individual are factors that increase the level of burnout when working with offenders (Lambert & Paoline, 2010). In one study, 75% of correctional officers reported that potential violence was the most stressful feature of their work (Shamir & Drory, 1981). Reported danger and increased exposure to AIDS and hepatitis have been listed as significant concerns for correctional staff (Philliber, 1987; Schaufeli & Peeters, 2000). Over one-third of correctional officers suffered from a significant level of burnout and over two-thirds reported moderate to high stress related to their work (Shaufeli & Peeters, 2000). Additionally, Xanthakis (2009) found that correctional officers who have negative attitudes toward offenders have higher levels of burnout and job related stress.

Although correctional officers were found to have high rates of burnout, other employees in correctional settings prove to have even higher rates of burnout. Carlson and Thomas (2006) found that caseworkers have higher levels of burnout compared to correctional officers. They also found that the turnover rate in caseworkers ranged from 25-62% over a five-year period, providing further evidence of the stress and burnout relating to working in correctional environments. They cited low salaries, stress, and perceived lack of support from management as primary causes of burnout in caseworkers (Carlson & Thomas, 2006). These findings have not been replicated and there is a lack of research examining other positions in corrections apart from correctional officers, but Lambert, Cluse-Tolar, and Hogan (2007) suggested that all staff that work with offenders experience similar job stressors. Therefore, they suggest that job type would not have an effect on rates of burnout because there would be high levels of burnout in most individuals who work in a correctional environment.

Sex Offender Treatment Providers

Mental health providers who work with sex offenders might be at particular risk for burnout given that they work with a group of offenders who have a particularly high level of stigma attached to them. A quote by Salter (1988, p. 88) stated, "The rule must be different with … sexual abuse. It is to be expected that the client will have goals the therapist does not share, and the therapist is expected to override the client's wishes." Working with sex offenders also presents certain demands that are not as prevalent when working with other populations. For example, those providing sex offender treatment are frequently required to confront their clients about their sexual thinking and behaviors (Blanchard, 1995). Additionally, sex offenders' points of view likely do not line up with the therapist's values, and their thought processes often violate values of decency, sensitivity, and fairness (Blanchard, 1995). Other client factors that can

become an issue in clinical treatment are client deception, habitual maladaptive thinking, and the lack of empathy that sex offenders often display regarding their victims (O'Connell, Lesberg, & Donaldson, 1990). Research has found that psychologists working with sex offenders have higher levels of burnout or post-traumatic stress responses from vicarious trauma compared to psychologists working with other populations. Vicarious trauma is defined as an empathetic relationship with those who report or discuss traumatic events that result in loss of perceived meaning or hope (McCann & Pearlman, 1990). Kadambi and Truscott (2003) surveyed 91 therapists whose primary clients were sex offenders and found that these professionals had moderately elevated levels of burnout, which was highly correlated with vicarious trauma. Figley (1999) suggested these vicarious trauma responses could include mistrust, nervousness around sex offenders, and increased concern about sexual assault. Empirical research has supported Figley's hypotheses. For example, Farrenkopf (1992) surveyed 24 therapists who worked only with sex offenders. He found that over one-third of those working with sex offenders report symptoms like hypervigilance, suspiciousness of clients, increased concern for the safety of loved ones, and higher perceived levels of danger, and over one-fourth reported levels of generalized stress, exhaustion, and depression, all of which have been tied to elevated levels of burnout (Farrenkopf, 1992). However, Farrenkopf did not specifically measure burnout. Furthermore, sex offender treatment providers report higher levels of secondary trauma compared to professionals working in other settings (Jackson, Holzman, Barnard, & Paradis, 1997). Secondary trauma, or vicarious trauma, is defined as negative reactions observed in trauma workers who experience symptoms from working with those who report traumatic events. The symptoms of secondary stress are similar to those of post-traumatic stress disorder (Bride, Robinson, Yegidis, & Figley, 2004).

Other studies have reported that mental health professionals that work with sex offenders develop high levels of perceived cynicism and low levels of perceived optimism (Farrenkopf, 1992). Additionally, these individuals can develop professional anger, which Farrenkopf explained as feeling angry toward sex offenders because of long-term exposure to them, frustration with clients, fatigue, and increased substance use among samples of therapists who work with sex offenders (Bird-Edmunds, 1997; Farrenkopf, 1992). For example, Bird-Edmunds (1997) surveyed 276 individuals who provide sex offender treatment and found that 29% reported an increase in emotional, psychological, and physical symptoms in the past year. Additionally, Bird-Edmunds posited that individuals who work with sex offenders are subjected to higher rates of burnout. Steed and Bicknell (2001) found that of 67 therapists who worked with sex offenders, 19% had high levels of burnout. Those who work with sex offenders also report that they become more cautious in romantic relationships and feel more concerned with family safety (Jackson et al., 1997; Shelby et al., 2001). If mental health professionals have such a strong reaction to their clients and their clients' stories, it would likely lead to higher rates of emotional exhaustion, which is a facet of burnout.

In terms of burnout specifically, several studies have measured levels of burnout among those who treat sex offenders. Kadambi and Truscott (2003) found that 23% of those who work with sex offenders scored in the high range on the emotional exhaustion and depersonalization scales on the MBI-HSS, and overall, reported higher levels of emotional exhaustion and depersonalization as compared to those who work with other client groups. Other researchers have studied those who work with or interact with primarily sex offenders (e.g., judges, caseworkers, supervisors, attorneys, treatment providers who specialize in sex offender cases) instead of examining specifically mental health professionals. Thorpe, Righthand, and Kubik

(2001) surveyed 12 mental health professionals, 8 attorneys, 35 caseworkers, 9 administrators, and 5 judges who identified as primarily working with sex offenders. They found that all of these individuals had elevated levels of burnout, regardless of job type (Thorpe et al., 2001).

Additionally, Shelby et al. (2001) surveyed 75 licensed mental health providers who worked in inpatient or prison settings and 75 licensed mental health providers working in outpatient sex offender treatment facilities. Shelby et al. (2001) used the MBI and found that levels of emotional exhaustion and depersonalization were significantly higher in those whose primary clients were sex offenders compared to other mental health professionals. Shelby et al. (2001) also found that those who work in an outpatient setting with sex offenders have higher rates of burnout compared to those working in a prison setting. However, no subsequent studies have compared burnout rates related to working with sex offenders to those in other settings. Additionally, these studies did not examine whether demographic factors have an influence on increased levels of burnout among those who work with sex offenders. One could hypothesize that attitudes a therapist holds toward the clients they are working with would have an impact on their level of burnout.

Attitudes toward Sex Offenders

Attitudes have long been a core concept of psychology. For example, one of the more well-known definitions by Allport (1935, p. 810) stated that an attitude is "a mental and neural state of readiness, organized through experience and exerting a directive and dynamic influence upon the individual's response to all objects and situations with which it is related." A more general definition posits that attitudes are just "summary evaluations" that have a range from positive to negative and allow us to make short cuts and summary evaluations based on past experiences or limited amounts information (Petty, Wegener, & Fabrigar, 1997, p. 611).

Having a negative attitude toward sex offenders can have an impact on how this population is treated or perceived by others.

Public Attitudes

In light of the sexual nature of the crime, sexual offenders are often stigmatized and viewed more negatively than other criminals (Plumm, Nelson, & Terrance, 2012). The United States has enacted a variety of registration statutes and community notification laws for sexual offenders. In 1947, California was the first state to maintain a sexual offender registry that required sexual offenders to provide their address to local law enforcement and to check in annually (Agan, 2011). This was an attempt to provide better public safety and prevent recidivism. The most recent federal legislation, the Adam Walsh Act of 2006, requires all states within the U.S. to maintain a sexual offender registry that is easily accessible to the public (Levenson & Tewkbury, 2008).

Additionally, there has been an increase of media coverage for sexual crimes in recent years (Plumm et al., 2012). Sexual and violent crimes are grossly over-reported by the media compared to minor crimes (Ditton & Duffy, 1983; Marsh, 1991). Violent sexual assaults accounted for .08% of all crimes in 2009, but an average of 10% of crime stories in the media were crimes of a sexual nature (Dowler, 2006; United States Census Bureau, 2012). Moreover, when the literature gives a range of recidivism rates for sexual offenders, the media tend to only report the higher rate of the range (Lotke, 1996). Robbers (2009) reported that disintegrative shaming is often a consequence of current sex offender legislation. Disintegrative shaming is defined as punishment that is meant to be stigmatizing, rejecting, and ostracizing. The combination of publicity, disintegrative shaming, and the way the media sensationalizes the stories of sexual offenses often lead to more negative attitudes toward sex offenders, by not only

the public, but also perhaps individuals who work with sex offenders. This could not only have an effect on the offenders themselves, but also could have a negative impact on those who provide sexual offender treatment (Blanchard, 1995).

The public often views sex offenders as a homogeneous group that cannot be cured (Fedoroff & Moran, 1997). Not surprisingly, most public attitudes toward sex offenders are negative. However, there are some demographic differences in public attitudes toward this population. For example, there is some variability regarding whether men or women have more negative attitudes toward sex offenders. Some studies have found that there are no differences in male and female attitudes toward sex offenders (Brown, 1999; Johnson, Hughes, & Ireland, 2007; Sahlstrom & Jeglic, 2008), whereas other studies found that women have more negative attitudes, endorse more concerns about sex offenders living in their community and are more supportive of community notification policies as compared to men (Caputo & Brodsky, 2004; Harnett, 1997; Lieb & Nunlist, 2008; Rogers, Josey, & Davies, 2007). Additionally, women with minor children have been found to have the most negative attitudes toward sex offenders and feel most strongly that community notification is important (Caputo & Brodsky, 2004). There are also inconsistent findings regarding other demographic variables. In some studies older individuals endorsed less negative attitudes toward sex offenders (Brown, 1999), whereas in others younger individuals have less negative attitudes (Kjelsberg & Loos, 2008). A study by Phillips (1998) found that people in their 30's and 40's had more negative attitudes toward sex offenders than those under 30 and over 50. Phillips hypothesized that these individuals are probably most likely to have young children, which is consistent with other findings. Overall, the findings are mixed, and because there is relatively little research in this area, it is difficult to hypothesize if specific demographic features impact public attitudes toward sex offenders.

Mental Health Professional Attitudes

There is a lack of research examining mental health professionals' attitudes toward sex offenders, but there have been a few studies examining whether those who treat sex offenders have more positive attitudes toward them than other people who come in contact with this group. Hogue (1993), using a scale he created, the Attitudes Toward Sex Offenders Scale (ATSO) found that those who treat sex offenders have more positive attitudes about them than police officers or the public. The ATSO has since been used in many subsequent studies and has proven to have good psychometric properties. Additionally, Nelson et al. (2002) found that counselors who primarily work with sex offenders had more positive attitudes than the public on Hogue's ATSO Scale. Additionally, on a Likert scale with 1 being a negative attitude, 3 being a neutral attitude, and 5 as a positive attitude, those who work with sex offenders as their primary clientele had an average score of 3.21, meaning they have a slightly more positive than neutral attitude (Nelson et al., 2002).

There are also demographic variables of mental health professionals that work with sex offenders that are related to more positive attitudes about sex offenders. Counselors with more experience working with sex offenders and those who were victims of sex abuse, themselves, have more positive attitudes (Nelson et al., 2002). Craig (2005) asked seventy-four residential sex offender treatment providers about their attitudes toward sex offenders using the ATSO, and found that women and those under the age of 35 had the most negative attitudes, greater concern for their safety when working with sex offenders, and more negative attitudes toward sex offenders' abilities to be rehabilitated than other groups. One study altered Hogue's ATSO to compare the attitudes of a public sample, a student sample, and a sample of those involved in the criminal justice system who work with primarily sex offenders. Gakhal and Brown (2011) had

92 members of staff at a local chain store, 20 probation officers who worked with only sex offenders, and 64 undergraduate psychology students take the survey. The probation officers had a more positive attitude than both the student and public groups.

Many of these studies mention the concern that because most people hold such strong negative attitudes toward sex offenders, those who provide treatment to sex offenders may also be perceived negatively by the public. Although research has found mental health professionals who work with sex offenders to generally have more positive attitudes about this population, it is possible that working with sex offenders might result in feelings of isolation, loneliness, and stigma (Blanchard, 1995). These feelings could lead to higher rates of burnout compared to mental health professionals who work in other clinical settings or with other populations.

Attitudes toward Sex Offender Treatment

It is not surprising that the public would hold generally negative attitudes about sex offenders, given their history of criminal behavior. However, it is not clear whether the public supports treatment for this population. Little research exists on attitudes toward sex offender treatment.

Of the few studies that have been done, the results suggest that the public often has conflicted attitudes about sex offender treatment. Brown (1999) sent out 500 questionnaires to individuals who were registered to vote in an attempt to get a snapshot of the public's attitudes toward sex offenders and their treatment and received 312 responses. She created a questionnaire asking about the importance of treatment, what type of treatment should be provided, and where this treatment should take place in addition to other questions about attitudes toward sex offenders. She found that over half of respondents agreed that sex offenders should receive treatment, but only if the treatment occurs in addition to receiving punishment. A

majority of her participants reported that they believed in the "just desserts theory," which suggests that an offender should always receive punishment first and foremost before treatment is even considered an option. Although the public believes that treatment and reducing recidivism are important, they also believe that the offender needs to be incarcerated (Carlsmith, Darley, & Robinson, 2002). Additionally, participants felt as though treatment should only take place in incarcerated settings and not in the community. Similarly, Fortney et al. (2007) found that the public believes treatment is more likely to reduce recidivism if it occurs in a prison rather than a community setting.

Brown (1999) also found that 64% of respondents actively opposed having a sex offender treatment facility in their community. Moreover, these participants stated that they would not only oppose a treatment setting in their community, but would reject sex offenders from returning to their community even if they had received treatment, which has been found in other studies as well (Vallient, Furac, & Antonowicz, 1994).

As stated earlier, the public's attitude toward the treatment of sex offenders tends to favor more punitive than rehabilitative treatments. Fortney et al. (2007) studied 192 Florida community members' attitudes toward sex offenders with a self-report questionnaire and found that over 50% of the respondents favored castration as a reasonable treatment modality. In the same study, participants reported that the average prison sentence for a sexually-related offense should be 39 years, and the most common response given for a recommended prison sentence on a scale from 0 years to 99 years was 99 years (Fortney et al., 2007). What type of treatment the offender received also affects individual's attitudes toward the sex offender. In a vignette study, participants rated that sex offenders were more capable of change when they completed sex offender treatment while incarcerated compared to any other treatment setting or modality (e.g.,

incarcerated v. community setting and sex offender treatment v. car maintenance training; Rogers, Hirst & Davies, 2011). Another study compared attitudes about the perceived treatment amenability of sex offenders among students and mental health professionals (Jung, Jamieson, Buro, & DeCesare, 2012). Treatment amenability in this study was defined as whether treatment would reduce recidivism of child molesters, rapists, and exhibitionists. Responding to a vignette, students and professionals had similar levels of responses, in that they believed that sex offenders would respond somewhat favorably to treatment (Jung et al., 2012). There was no significant difference between students' and professional's ratings of perceived treatment amenability for the groups of offenders; however, professionals viewed treatment amenability slightly more positively than the students (Jung et al., 2012).

More recently, Wnuk, Chapman, and Jeglic (2006) developed a scale to standardize the measurement of attitudes toward sex offender treatment. The Attitudes Toward Sex Offender Treatment Scale (ATTSO) was used to measure undergraduate students' attitudes. Wnuk et al. (2006) created an initial pool of 35 items based on statements frequently found in the literature and in other scales measuring attitudes toward offenders (ATSO; Hogue, 1993; ATS; Melvin, Gramling, & Gardner, 1985). Following a factor analysis of the scale items, 15 items performed well and measured three factors: Incapacitation, Treatment Ineffectiveness, and Mandated Treatment. In general, their participants had negative attitudes toward sex offender treatment. This scale has only been used once since its creation in a study measuring undergraduate students' attitudes toward juvenile sex offenders. This study used case scenarios, the ATSO, and ATTSO. Generally, the participants viewed juvenile sex offenders and their "treatment amenability" negatively (Sahlstrom & Jeglic, 2008). Although Sahlstrom and Jeglic (2008) did not indicate their definition of treatment amenability, the responses by the participants indicate

that they believe the offenders in the case examples would not respond well to treatment and their likelihood of recidivism would not be reduced by treatment.

There is a dearth of information regarding mental health professionals' attitudes toward the treatment of sex offenders, which is one purpose of this proposed study. Despite the lack of research, there has been research examining the effects of negative attitudes toward clients by treatment providers.

Impact of Negative Attitudes toward Clients

The literature reviewed previously shows the wholly negative attitudes toward sex offenders and negative attitudes toward treatment of sex offenders by the public. Although mental health professionals generally have a more positive attitude toward sex offenders than the public, they do not generally perceive sex offenders positively. Treatment providers' attitudes are particularly important because these attitudes can impact treatment progress.

Many factors impact the therapeutic relationship, and ultimately, an individual's progress in treatment. A task force sponsored by American Psychological Association (APA) was tasked to identify empirical principles for therapeutic change that are generalizable across different clinical groups with differing clinical problems (Sandhu & Rose, 2012). Three variables were identified: participant characteristics, which include both client and therapist variables, relationship factors, and technique factors. In terms of relationship factors, the therapeutic alliance has been found to be positively associated with client outcome. Even when other factors are controlled for (i.e., therapeutic technique, therapist skill level) the therapeutic alliance, itself, is associated with positive change in clients (Martin, Garske, & Davis, 2000). It may be difficult, however, for professionals to create and maintain this alliance with sex offenders, given the nature of the individual, treatment, and offense.

Working with sex offenders can be difficult for many reasons, including that traditional mental health techniques can be ineffective with this population and many sex offenders are receiving treatment involuntarily (Blanchard, 1995). Most research on the effectiveness of sex offender treatment has focused on specific interventions rather than the process of treatment, itself (Sandhu & Rose, 2012). The limited research that has been done on the process of sex offender treatment found that a higher level of empathy toward sex offenders was related to more positive change (Bauman & Kopp, 2006; Marshall 2005; Ware & Bright, 2008). Tyagi (2006) found that empathy and therapist warmth toward sex offenders are sometimes compromised by countertransference and the heinous nature of the crimes committed. Having a negative attitude can have a negative effect on treatment effectiveness (Bauman & Kopp, 2006). Moreover, having a negative attitude toward a client or their treatment amenability creates an atmosphere where the client may be unwilling to engage in treatment (Drapeau, Korner, & Brunet, 2004; McCallum, 1997). Drapeau et al. (2004) found that sex offenders reported that therapists were the most important factor in their treatment.

Robitscher (1980) posits that it is often hard for mental health professionals to work with sex offenders because of negative attitudes from other people within and outside their profession. Both psychotherapy and the justice system can be greatly impacted by the public's attitude that treatment should include punishment, vengeance, and retribution (Robitscher, 1980). There are unique dilemmas that mental health professionals face when treating sex offenders that are not present when working with other clients, including hearing horrendous first-hand accounts of crimes, being concerned about safety, becoming detached and hardened, and a generally negative attitude held by most individuals about their clients (Scheela, 1996; Scheela, 2001). Although the public, justice system, and media call for punishment, mental health professionals also know

that punishment is generally ineffective as a treatment modality (Finkelhor & Lewis, 1988). It can be difficult for therapists to remain objective and empathetic with a population most people believe do not deserve empathy.

The therapeutic alliance is fundamental to the therapeutic process with any client. Blanchard (1995) states that referring sex offenders to mental health professionals who are well skilled and understand the importance of their impact on change can cultivate treatment success more than any technique. If the sex offender feels that they have empathy, respect, and concern from their treatment provider, they will be less hesitant to participate in meaningful therapy (Derlerga, Hendrick, Winstead, & Berg, 1991). The process of sex offender treatment and change requires reciprocation from the therapist (Blanchard, 1995). Self-awareness of attitudes toward sex offender treatment and how working with sex offenders impacts the therapist is not only important for self-care, but allows for the most effective treatment. Understanding whether attitudes toward treatment impacts therapist burnout level and which individuals are most susceptible to having negative attitudes or higher burnout rate allows us to explore how to counteract these effects not only for the wellbeing of the therapist, but also for their clients. One aspect that could be affected is the therapist's level of empathy.

Empathy

Rogers (1957) stated there were six common factors that are necessary and sufficient for effective psychotherapy. They include congruence, genuineness, warmth, unconditional positive regard, ability to have empathy, and communication of empathy. Empathy is defined as "a capacity of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts and experiences of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner"

(Merriam-Webster Dictionary, n.d.). However, empathy is an ambiguous construct that can have different meanings and components because of the subjectivity and complexity of the construct (Morse et al., 1992). There are five current conceptualizations of empathy: empathy as a professional state, empathy as a human trait, empathy as caring, empathy as a relationship, and empathy as a communication process (Kunyk & Olson, 2001). Empathy as a professional state is conceptualized as a learned skill that allows therapists to communicate the client's reality and subjective experience back to them. Alligood (1992) stated that trained empathy is a learned clinical skill, but can also be a natural ability. Empathy as a human trait means that empathy is an innate ability. However, even as an innate construct, it can be reinforced and improved (Alligood, 1992). There are additional ways to conceptualize empathy. For example, several researchers conceptualize empathy as caring. These researchers suggest that empathy is a way for an individual to alleviate emotional suffering in others (Hudson, 1993; Sutherland, 1993). The caring actions that psychologists demonstrate are listening, comforting, and talking. There are others who describe these actions and empathy as part of a 'special relationship' between the client and psychologist. This relationship reinforces the clients' coping ability and allows them to reconcile issues in their life (Kunyk & Olson, 2001). Lastly, empathy is conceptualized as a communication process. In this conceptualization the professional is able to perceive the client's situation and emotions and express understanding to the client.

Regardless of the conceptualization of empathy, it is considered one of the core factors in therapy. There is evidence that empathy is related to positive therapeutic outcomes (Duan & Hill, 1996; Patterson, 1984; Truax & Mitchell, 1971). In light of some of the mixed conceptualizations of empathy, researchers suggest that there is difficulty defining and measuring the concept. However, a review of the research suggested that empathy is related to

most theoretical orientations and to positive outcomes in psychotherapy (Feller & Cottone, 2003). In addition, clients rate empathy as an important piece to their therapeutic outcomes. Some research suggests that clients believe psychotherapy is most effective when their therapists express empathy ("Measuring Empathy during Psychotherapy," 2008). There has been quantitative research that shows the positive impact that empathy can have in a therapeutic relationship. Some research found that clients who experience empathy have lower levels of antisocial behavior, less aggression, and better identity development (Eisenberg, Spinard, & Sadovsky, 2005; Hoffman, 2001; Weisner & Silbereisen, 2003). Additionally, mental health professionals' level of empathy is correlated with positive client outcomes such as less resistance in treatment and increased disclosure in treatment (Forrester, Kershaw, Moss & Hughes, 2008). Although research suggests that empathy is important to the therapeutic process, there is a lack of research regarding how clients impact therapists' level of empathy and whether different client populations affect empathy in different ways.

Empathy Fatigue

Empathy fatigue is defined by Stebnicki (1999) as a state of emotional, mental, physical, and occupational exhaustion that occurs when a mental health professional is drained from interactions with their clients. Stebnicki (2007) posits that empathy fatigue interferes with a counselor's personal growth, mental, physical, and emotional wellbeing, and professional development. This would indicate that counselors suffering from empathy fatigue would have a decline in their ability to listen and respond empathetically to their clients (Stebnicki, 2007). There is some research that discussed the relationship between empathy fatigue and burnout. Stebnicki (2000) suggests that empathy fatigue is a precursor to burnout. Some descriptive research also suggests that there are factors that can lead to empathy fatigue. For example,

countertransference or subconscious reactions to clients and their issues could be factors that influence empathy fatigue (Rogers, 1961; Stebnicki, 2000). Additionally, perhaps having deep empathetic reactions to clients results in empathy fatigue (Stebnicki, 2000).

It can be difficult for researchers to measure the constructs of empathy and empathy fatigue. Empathy can be perceived differently by those rating or measuring empathy, and may differ between the client, professional, or the researcher (Stenbecki, 2000). There are currently no measures of empathy fatigue, however, there are multiple measures of empathy.

Sex Offenders' Impact on Therapist Empathy

As explored earlier, there is research that suggests that working with sex offenders can have a negative impact on mental health professionals and several studies have specifically examined whether a professionals' level of empathy might be negatively impacted. Farrenkopf (1992) interviewed 24 therapists who were well trained and experienced in sex offender treatment. Farrenkopf found that empathy did not appear to be constant over time, but was impacted by their work with sex offenders. Therapists reported the highest levels of empathy in their first five years of working with sex offenders, but empathy tended to decrease over time. How empathy was measured was not described in this study. Polson and McCullom (1995) also interviewed individuals engaged in sex offender therapy. They found that therapists reported that if they had higher levels of empathy, they also had more positive attitudes toward sex offenders. In addition, they asked the sex offenders, themselves, about the perceived level of empathy they thought their therapists had. It was found that when offenders thought their therapists had higher levels of empathy the offender felt that they themselves could better express empathy (Polson & McCullom, 1995).

Other studies reviewed tapes of sex offender therapy to assess for level of empathy. These studies all utilized trained observers to code tapes of manualized, or structured, sex offender group therapy with different therapists. A regression analysis, which was replicated in three studies, found that therapist empathy and warmth were the best predictors of success in the program (Marshall, 2005; Marshall et al., 2002; Marshall et al., 2003). However, they did not examine differences in therapists to assess what affected levels of empathy. Ware and Bright (2008) also found that empathy in therapists was related to increases in empathy in sex offenders. However they did not elaborate on how these constructs were measured. Finally, Tyagi (2006) found that empathy could be compromised by attitudes and reactions to sex offenders. Although these studies provide evidence that empathy has an impact on process and outcome in sex offender treatment, very few studies have been done in this area. In addition, the existing studies on therapist empathy in sex offender treatment have found that empathy may not be a static factor, but one that could be challenged or changed by working with sex offenders (Sandhu & Rose, 2012). Examining whether low empathy levels are associated with working with sexual offenders would provide the framework for further research.

Significance of the Study

Previous studies have shown that sexual offender treatment is effective in reducing sexual recidivism (Losel & Schmucker, 2005; Association for the Treatment of Sexual Offenders, 2011). Therefore, continuing to provide rehabilitative instead of punitive treatment will be key to maintaining or reducing the current rates of sexual offender recidivism. However, because of the negative stigma surrounding sexual offenders, it may be difficult for those who treat sexual offenders to avoid the systemic, negative attitudes toward their clients (Blanchard, 1995; Salter, 1988; O'Connell et al., 1990). Recognizing whether those who treat sexual offenders have more

positive attitudes toward sexual offender treatment than other mental health professionals, and whether working with these clients can impact the therapists themselves (e.g., burnout, level of empathy) is vital in providing the best treatment and understanding if these mental health professionals are at higher risk for negative consequences. This research will potentially assist mental health professionals in maintaining positive attitudes toward sexual offenders and could help aid in effective clinical treatment.

Hypotheses

1) Mental health professionals who work with sex offenders as their primary clientele will have more positive attitudes toward sex offender treatment than mental health professionals who work in community settings and those who work in correctional settings, but are not specifically providing sex offender treatment.
2) Mental health professionals who work with sex offenders as their primary clientele will have higher rates of burnout as compared to those in correctional and community settings.
3) Among those who work with sex offenders as their primary clientele, more negative attitudes toward sexual offender treatment will be related to higher rates of burnout.
4) Those who work with sex offenders as their primary clientele will have lower self-reported empathy than those who work in correctional and community settings.
5) Among those who work with sex offenders as their primary clientele, more negative attitudes toward sexual offender treatment will be related to lower levels of empathy.
6) Among those who work with sex offenders as their primary clientele, those with higher rates of burnout will have lower levels of empathy.

CHAPTER THREE

METHODOLOGY

Overview and Design

The current study used a correlational design. Participants were asked a number of questions regarding their demographics, level of burnout, attitudes toward sex offender treatment, and self-reported level of empathy. The primary predictor variable in this study was the work setting in which the professional primarily works (i.e., sex offender treatment, correctional setting, community-based practice). Criterion variables were attitudes toward sexual offender treatment, burnout, and empathy.

Power Analysis

The necessary sample size for statistical significance was determined by conducting a power analysis. A medium effect size was assumed, although this is not based on previous studies due to the dearth of research comparing groups on these measures. There has been little research done using the ATTSO and the Barrett-Lennard - Relationship Inventory since their creation. Additionally, although the MBI-HSS is a widely used measure, the effect size varies across studies. A power analysis using a power of .80 and alpha of .05 was used to minimize Type I and Type II errors. The power analysis suggested that 60 participants would be needed in each group when three groups are being compared on three measures using ANOVA. Additionally, Cohen (1992) recommends a sample size of at least 60 participants when using a bivariate correlation between sex offender treatment providers' scores on different measures.

Participants

Licensed mental health professionals were randomly selected from the American Psychological Association, American Psychology and Law Society, and Association for Treatment of Sexual Abusers, and were sent an email inviting them to participate. There was a two-pronged exclusion criterion. Prior to completing the questionnaires for the study, participants were asked whether clinical practice, academia, or research was their primary job duty. They were then asked if they had a history of practicing while licensed for at least one year. If they did not have a history of clinical practice, they were excluded from the study. In addition to sending individual emails, the study was posted on ListServs for the Association for Treatment of Sexual Abusers and the American Psychological Association Division 18 Criminal Justice Section. Based on studies using online survey methods (e.g., Crosby & Sprock, 2004), a response rate of 10-20% was expected, thus approximately 600 mental health professionals from each group (community treatment providers, correctional setting treatment providers, and those providing sex offender treatment) were randomly selected from email directories. Due to a low response rate and emails being returned as invalid, more email addresses were collected with a total of 2,347 emails sent. A total of 275 mental health professionals completed the study; however 17 did not meet the qualification requirements, 17 had large amounts of missing data, and 22 did not fit into any of the participant groups (e.g., they never provided treatment to sex offenders, not working in a community setting or in a correctional setting). The total number of participants whose data was analyzed was 219.

Demographic and professional characteristics of the participants are displayed in Table 1. Regarding the gender make-up of the sample, 44.7% ($N = 98$) of the participants were male, 54.8% ($N = 120$) were women, and 0.5% ($N = 1$) did not indicate their gender. The racial make-

up was 90.9% (*N* = 199) Caucasian, 3.7% (*N* = 8), African American, 2.3% (*N* = 5) Hispanic, 2.3% (*N* = 5) other, 0.5% (*N* = 1) Asian/Pacific Islander, and 0.5% (*N* = 1) Native American. The age of participants ranged from 25 to 79 with a mean of 51.31 years (*SD* = 12.90). The number of years of licensed experience ranged from 1 to 51, with a mean of 17.15 years (*SD* = 11.40). Eight participants did not report the number of years of licensed experience and three did not provide a number response, but their responses were changed into a number response (e.g. 30+ years changed to 30 years). In terms of work setting experience among the sample, 45.2% (*N* = 99) had experience in community-based settings (e.g., community mental health or independent practice), 42.9% (*N* = 94) worked as a sex offender treatment provider in various settings (e.g., correctional settings, outpatient settings, inpatient settings), and 11.9% (*N* = 26) worked in correctional settings. A majority of the participants' degrees were doctoral level with 55.7% (Ph.D., *N* = 94; Psy.D., *N* = 24; Ed.D., *N* = 6) of the participants holding a doctoral degree. Additional degree levels held were 23.7% (*N* = 52) M.A. or M.S, 13.2% (*N* = 29), M.S.W., and 5.5% (*N* = 12) other. Two participants did not indicate what degree they held. Most of the participants indicated that they have worked with incarcerated individuals or offenders (68.1%; *N* = 149) and sex offenders (63.5%; *N* = 139) at some point during their practice.

Table 1

Sample Demographics

Variable	*% (N)*	*M (SD)*
Gender		
Male	98 (44.7)	
Female	120 (54.8)	
Age		51.31 (12.90)
Years of Licensed Practice		17.15 (11.40)
Race		
Caucasian	199 (90.9)	
African American	8 (3.7)	
Hispanic	5 (2.3)	
Other	5 (2.3)	
Asian American/Pacific Islander	1 (0.5)	
Native American	1 (0.5)	
Job Setting		
Community-Based Mental Health	99 (45.2)	
Sex Offender Treatment Provider	94 (42.9)	
Correctional Setting	26 (11.9)	
Degree Held		
Ph.D.	94 (42.9)	
M.A. or M.S.	52 (23.7)	
Psy.D.	29 (13.2)	
M.S.W.	24 (11.0)	
Other	12 (5.5)	
Ed.D.	6 (2.7)	

Note: The sample contained 219 participants

Measures

Maslach's Burnout Inventory. The third edition of Maslach's Burnout Inventory – Health Services Survey (MBI-HSS) was used for this study. Maslach's Burnout Inventory has been in use for over 20 years, and has proven to have adequate reliability and validity. The MBI-HSS asks participants to rate the items on 7-point Likert scale that ranges from "never" to "daily" (See Appendix C for the Maslach Burnout Inventory – Health Services Survey). Higher scores on the Depersonalization and Emotional Exhaustion scales and lower scores on the Personal Accomplishment scale indicate higher levels of burnout. When practitioners use the MBI-HSS, burnout is a categorical variable that categorizes people at low, moderate, and high levels of burnout (Maslach & Jackson, 1981). For this study the MBI-HSS was used as a continuous measure. The MBI-HSS consists of 22 items comprising three subscales: Personal Accomplishment has eight items, Depersonalization has five items, and Emotional Exhaustion has nine items (Maslach & Jackson, 1981). The Personal Accomplishment scale is meant to measure whether the individual feels competent and successful in their work. Personal Accomplishment scores range from 0 to 48. Personal Accomplishment scores from 0 – 31 indicate low levels, 32 to 38 indicate moderate levels, and over 39 indicate high levels. The Emotional Exhaustion subscale is meant to measure feeling emotionally overextended by one's work. Emotional Exhaustion scores range from 0 to 56. Emotional Exhaustion scores from 0-16 indicate low levels, 17-26 indicates moderate levels, and over 27 indicate high levels. Lastly, the Depersonalization subscale assesses for a negative, interpersonal response toward one's clients or people one works with. Depersonalization scores range from 0 to 30. Depersonalization scores from 0 to 6 indicate low levels, scores from 7 to 12 indicate moderate levels, and scores over 13 indicate high levels.

The MBI was originally constructed through exploratory analyses, and the three factors of burnout were identified and developed through principal components analysis (Maslach & Jackson, 1981). Subsequent research has shown that the MBI-HSS has strong construct validity (Lee & Ashforth, 1993; Pisanti, Lombarso, Lucidi, Violani, & Lazzari, 2013). Previous research suggests that there may be a high correlation between Depersonalization and Emotional Exhaustion; however, they still prove to be distinct factors (Lee & Ashford, 1993; Pisanti et al., 2013).

Internal consistency of the subscales of the MBI, as measured with Cronbach's alpha, was .90 for Emotional Exhaustion, .79 for Depersonalization, and .71 for Personal Accomplishment (Maslach et al., 1996). Additionally, the test-retest correlations that were measured across five experiments and examined in one analysis were .82 for emotional exhaustion, .60 for depersonalization, and .80 for personal accomplishment, all of which were significant beyond .001 (Maslach et al., 1996).

In the current study, Cronbach's alpha coefficients were .93 for Emotional Exhaustion, .73 for Depersonalization, and .77 for Personal Accomplishment. Additionally, the scales were all significantly correlated with each other (see Table 2). Emotional Exhaustion and Depersonalization were significantly correlated ($r = .57$, $p < .001$), Emotional Exhaustion and Personality Accomplishment were negatively correlated ($r = -.32$, $p < .001$), and Personal Accomplishment and Depersonalization were negatively correlated ($r = -.41$, $p < .001$). See Table 2 for means and standard deviations for each participant group's scores on the MBI-HSS scales.

Attitudes Toward Treatment of Sex Offenders. Wnuk et al. (2006) created a scale to measure attitudes toward the treatment of sex offenders. The initial scale had a pool of 35 items

rated on a 5-point Likert scale, with responses ranging from "Disagree Strongly" to "Agree Strongly," that were developed using modification of other attitudinal scales toward offenders (Hogue, 1993; Melvin et al., 1985). Using an exploratory factor analysis, Wnuk et al. (2006) removed items that did not load sufficiently on any one factor, which resulted in a total of 15 items in a three-factor solution. The factors include Incapacitation, Treatment Ineffectiveness, and Mandated Treatment. The 15-item version was used for this study. Total scores ranged from 15 to 75 with higher scores reflecting more negative attitudes toward sex offender treatment. Internal consistency for each of the subscales, as measured with Cronbach's alpha, was .86 for Incapacitation, .81 for Treatment Ineffectiveness, and .78 for Mandated Treatment with an overall alpha of .78 for the total score. In the current study, the Cronbach's alpha coefficient for the total score was .55. According to the authors of the scale, the psychometrics of the scale have not been further explored. Although the measure includes subscales, the total score was used as the measure of attitudes toward sex offender treatment in the present study (see Appendix D for the Attitude Toward the Treatment of Sex Offenders Scale). See Table 2 for means and standard deviations for each participant group's scores on the ATTSO scale.

Barrett–Lennard Relationship Inventory. Barrett-Lennard (1962) created a 61-item scale that is meant to examine Carl Roger's conditions of therapy (Rogers, 1957). The scale includes subscales that measure level of regard, empathic understanding, willingness to be known, and unconditionality of regard. This scale was created for both clients and therapists to rate their overall view of the therapeutic relationship on these constructs using a 6-point Likert Scale ranging from -3 ("I strongly feel that it is not true") to 3 ("I strongly feel that it is true"). Higher scores on this scale indicate higher levels of self-reported empathy. For the current study, only the 16 items assessing empathic understanding were used. Scores range from -48 to

48. The Empathic Understanding subscale has shown strong internal consistency with a Cronbach's alpha of .94 (Barrett-Lennard, 1962).

In the current study, Cronbach's alpha was .80 for the Empathic Understanding subscale. In light of the fact that the Empathic Understanding could be answered with a specific client in mind, the participants were asked to consider their interactions with clients in general, and not think of a specific client (see Appendix E for the Empathic Understanding Subscale of the Barrett-Lennard Relationship Inventory). See Table 7 for means and standard deviations for each participant group's scores on Empathic Understanding scale.

Demographic Questionnaire. Participants were asked to provide demographic information (e.g., age, ethnicity, sex) as well as information regarding their professional training and clinical experience (see Appendix F for the Demographic Questionnaire).

Procedure

Approval from Indiana State University's Institutional Review Board was obtained in order to conduct this study (see Appendix G for IRB approval letter**).** An online survey was developed using Qualtrics. A project proposal was sent to The Association for Treatment of Sexual Abusers Executive Directors in order to gain access to their email directory and ListServ. Division 42 has a directory that can be accessed by APA members and APA has directories that can be accessed by members. Emails were originally sent to 600 individuals from each group who were randomly selected from each professional organization inviting licensed mental health professionals to participate in the study. Due to insufficient responses additional emails were sent. A link was included in each email that directed participants to the online study (see Appendix A for Recruitment Letter). When participants clicked the link to access the online

survey they were presented with an informed consent that explained the purpose and procedures of the study (see Appendix B). Additionally, they were informed that there was an opportunity to win one of two $25 Amazon gift cards after completion of the survey. If mental health professionals indicated they were willing to participate they were taken to a page asking if they primarily worked in clinical practice, in academia, or conducting research. They were also asked if they have had at least one year of practice experience while they were licensed. If participants indicated that they had no history of clinical experience while licensed they were thanked for their time and exited from the study. All other participants were taken to a webpage with instructions and the questionnaires.

All participants were asked to complete the demographic questionnaire first. In light of a lack of research of the importance of order of these three measures and what impact it may have on responses, participants were given the MBI-HSS, the ATTSO, and the Empathic Understanding questions of the Barrett-Lennard Relationship Inventory in a randomized order to attempt to partially control for order effects. Lastly, the participants were thanked for their participation and directed to a new page where they had the option of entering their email address in order to win one of two Amazon gift cards. The email addresses were not linked to the participants' questionnaires. The gift card winners were chosen randomly after data collection was finished.

CHAPTER FOUR

RESULTS

The data was collected by the Qualtrics online survey software and analyzed using the IBM SPSS statistical software version 19 (IBM corp., 2010). The first step in the data analyses involved examining the data for outliers or excessive missing data. Participants with excessive missing data were eliminated. Mean replacement was used for participants that were missing one or two items on the measures. The total number of participants whose data was used for the study was 219. Correlations among the dependent variables (i.e., Depersonalization, Empathic Understanding, Emotional Exhaustion, Attitudes Toward Sex Offender Treatment, and Personal Accomplishment) were examined. See Table 2 for bivariate correlations between dependent variables.

Table 2

Correlation Coefficient Values Between Dependent Variables for Total Sample

Dependent Variable	2	3	4	5
1. Emotional Exhaustion	**.566***	**-.315***	.063	**-.223***
2. Depersonalization		**-.407***	.081	**-.296***
3. Personal Accomplishment			**-.232***	**.350***
4. Attitudes Toward Sex Offender Treatment				**-.224***
5. Empathic Understanding				

Note. $N = 219$. Correlation coefficients that reached significance are displayed in bold. *$p < .05$ level, 2-tailed. Numbers labeling columns indicate the dependent variable with the same number in column one.

Additionally, correlation coefficients were calculated for all of the dependent variables for each of the three groups (see Tables 3, 4, and 5).

Table 3

Correlation Coefficient Values Between Dependent Variables for Community Based Providers

	1	2	3	4	5
1. Emotional Exhaustion		**.546****	-.118	.081	**-.266****
2. Depersonalization			**-.259***	.057	**-.229***
3. Personal Accomplishment				**-.208***	**.305****
4. Attitudes Toward Sex Offender Treatment					-.135
5. Empathic Understanding					

Note. $N = 99$. Correlation coefficients that reached significance are displayed in bold. *$p < .05$ level, 2-tailed. **$p < .01$ level, 2-tailed.

Table 4

Correlation Coefficient Values Between Dependent Variables for Correctional Based Providers

	1	2	3	4	5
1. Emotional Exhaustion		**.749****	**-.663****	.348	-.325
2. Depersonalization			**-.640****	.232	-.349
3. Personal Accomplishment				-.373	**.439***
4. Attitudes Toward Sex Offender Treatment					-.144
5. Empathic Understanding					

Note. $N = 26$. Correlation coefficients that reached significance are displayed in bold. *$p < .05$ level, 2-tailed. **$p < .01$ level, 2-tailed.

Table 5

Correlation Coefficient Values Between Dependent Variables for Sex Offender Providers

	1	2	3	4	5
1. Emotional Exhaustion		**.463****	**-.338****	.131	-.159
2. Depersonalization			**-.381****	**.225***	**-.336****
3. Personal Accomplishment				**-.377****	**-.339****
4. Attitudes Toward Sex Offender Treatment					**-.342****
5. Empathic Understanding					

Note. $N = 94$. Correlation coefficients that reached significance are displayed in bold. *$p < .05$ level, 2-tailed. **$p < .01$ level, 2-tailed.

Relationships between demographic variables and the dependent variables in the study were also examined (see Table 6). Older age was associated with lower scores on emotional exhaustion, depersonalization, and more positive attitudes toward sex offender treatment. More years of experience was associated with lower levels of emotional exhaustion and depersonalization, higher levels of personal accomplishment, and more positive attitudes toward sex offender treatment. There were no significant correlations between gender and the dependent variables. See Table 7 for means and standard deviations of each group on the dependent variables.

Table 6

Correlations between demographic and dependent variables

	Age	Years of Licensed Experience	Gender
Emotional Exhaustion	**-.207****	**-.272****	.036
Depersonalization	**-.309****	**-.241****	-.074
Personal Accomplishment	.103	**.157***	.022
Empathy	.016	.063	.053
Attitudes Toward Sex Offender Treatment	**.211****	**.175***	-.079

Note. Correlation coefficients that reached significance are displayed in bold. * $p < .05$ level, 2-tailed. ** $p < .01$ level, 2-tailed.

Table 7

Means and Standard Deviations of Participant Groups on Dependent Variables

	Sex Offender Tx M (SD)	Community M (SD)	Corrections M (SD)
Emotional Exhaustion	19.04 (10.96)	14.78 (9.87)	20.13 (12.55)
Depersonalization	6.31 (4.83)	4.12 (3.90)	8.54 (6.02)
Personal Accomplishment	39.89 (4.67)	37.91 (6.53)	41.31 (5.81)
Empathy	21.36 (9.75)	20.05 (9.89)	16.05 (11.61)
Attitudes Toward Sex Offender Treatment	22.71 (5.15)	27.62 (5.42)	27.50 (5.12)

Note. $N = 219$. Sex offender tx refers to sex offender treatment providers.

Sex Offender Treatment Providers Compared to Other Professionals

The first set of hypotheses predicted that those that provide sex offender treatment would be different than the other professional groups (e.g., correctional mental health providers, those providing community-based treatment) in terms of their attitudes toward sex offender treatment, levels of burnout, and self-reported empathy. The first hypothesis predicted that mental health professionals that work providing sex offender treatment would have more positive attitudes toward sex offender treatment than mental health professionals who work in community settings and those who work in correctional settings, but are not providing sex offender treatment. Higher scores on the ATTSO represent more negative attitudes toward sex offender treatment. Table 8 displays the results of the ANOVA. There was a statistically significant difference between the groups, as determined by a one-way ANOVA, $\eta^2 = .18$. Those who worked providing sex offender treatment had more positive attitudes ($M = 22.71$, $SD = 5.15$) than those working in the community ($M = 27.62$, $SD = 5.42$) and those working in correctional settings, but not providing sex offender treatment ($M = 27.5$, $SD = 5.12$). Post hoc comparisons using the Tukey test indicated that the mean scores for the sex offender treatment providers were significantly different than both the correctional ($p < .001$) and community based ($p < .001$) treatment providers, and there was no significant difference between community based and correctional based providers ($p = .995$).

Table 8

Summary of ANOVA Results

Source of Variation	*df*	*SS*	*MS*	*F*	*p*
Between groups	2	1277.59	638.80	22.97	.00
Within groups	216	6007.01	27.81		
Total	218	7284.60			

Note. df is referring to degrees of freedom, *SS* is referring to sum of squares, *MS* is referring to mean squares, *F* is referring to *F* value, and *p* is referring to probability statistic.

Another hypothesis predicted that mental health professionals that provide sex offender treatment would have higher rates of burnout compared to those working in community or correctional settings. This hypothesis had mixed findings and was partially supported. On the MBI-HSS, higher scores on emotional exhaustion and depersonalization and lower scores on personal accomplishment indicate higher rates of burnout. The groups differed on two scales of the MBI-HSS as determined by an ANOVA. First, there was a significant difference between the groups on the Depersonalization scale $F(2, 214) = 11.50$, $p < .01$, $\eta^2 = .10$. Post hoc comparisons using the Tukey test indicated the mean score on Depersonalization for sex offender treatment providers ($M = 6.31$, $SD = 4.83$) was significantly higher at $p < .01$ than the community-based sample ($M = 4.12$, $SD = 3.90$). However, although it approached significance ($p = .077$), correctional mental health professionals ($M = 8.54$, $SD = 6.02$) mean scores on the Depersonalization scale were not significantly different than the scores for sex offender treatment providers. There was also a significant difference between correctional and community based providers' scores on the Depersonalization scale ($p < .01$).

There was also a significant difference between groups on the Emotional Exhaustion scale $F(2, 214) = 4.87$, $p < .01$, $\eta^2 = .04$. Post hoc comparisons using the Tukey test indicated that the mean score for Emotional Exhaustion for sex offender treatment providers ($M = 19.04$, $SD = 10.96$) was significantly higher ($p < .05$) than the community based providers ($M = 14.78$, $SD = 9.87$). However, the correctional mental health professionals' ($M = 20.13$, $SD = 12.55$) mean score on Emotional Exhaustion did not significantly differ ($p = .891$) from the sex offender treatment providers' mean score. There was also not a significant difference between correctional based and community based providers ($p = .063$). The overall ANOVA found that the groups differed on the Personal Accomplishment scale $F(2, 214) = 4.48$, $p < .05$, $\eta^2 = .04$. However, post hoc comparison using the Tukey test did not show individual-level comparisons across groups as being significant when comparing sex offender treatment providers ($M = 39.89$, $SD = 4.67$) to the other two groups. However, there was a significant difference between correctional ($M = 37.91$, $SD = 6.53$) and community based providers ($M = 41.31$, $SD = 5.81$), $p < .05$).

An additional hypothesis predicted that mental health professionals that work providing sex offender treatment would have lower rates of empathy compared to community and correctional mental health professionals. Higher scores on the self-reported empathy scale indicate higher levels of empathy. There were no significant differences between sex offender treatment providers ($M = 21.36$, $SD = 9.75$), community treatment providers ($M = 20.05$, $SD = 9.89$), and correctional based treatment providers ($M = 16.05$, $SD = 11.61$) on the Empathic Understanding scale $F(2, 214) = 2.77$, $p = .065$, $\eta^2 = .03$.

Comparison of Variables Among Sex Offender Treatment Providers

It was predicted that among those who work providing sex offender treatment, more negative attitudes toward sex offender treatment would be related to higher rates of burnout. Pearson correlation coefficients were computed among the three scales of the MBI-HSS and the ATTSO for the sex offender treatment providers group, and this hypothesis was partially supported. The bivariate correlation between ATTSO scores and Emotional Exhaustion was not significant ($r = .131$, $p = .212$). However, the bivariate correlations between ATTSO scores and Depersonalization ($r = .225$, $p < .05$) and between ATTSO scores and Personal Accomplishment ($r = -.377$, $p < .001$) were significant.

Additionally, it was hypothesized that among those that provide sex offender treatment, lower scores on the Empathic Understanding scale would be associated with higher rates of burnout. Pearson correlation coefficients were computed among the Empathic Understanding Scale and the MBI-HSS, and this hypothesis was also partially supported. The bivariate correlation between Empathic Understanding and Emotional Exhaustion was not significant, ($r = -.159$, $p = .128$). However, the bivariate correlations between Empathic Understanding and Depersonalization ($r = -.336$, $p < .01$) and between Empathic Understanding and Personal Accomplishment ($r = .339$, $p < .01$) were significant.

Finally, it was predicted that among those that provide sex offender treatment lower scores on the Empathic Understanding scale would be associated with higher scores on the ATTSO. This hypothesis was supported. The bivariate correlation between Empathic Understanding and ATTSO was significant ($r = -.342$, $p < .01$). Simultaneous multiple regressions were also run to further examine the relationships between these variables and predict scores on empathic understanding and scores on attitude towards sex offender treatment

from the three burnout variables among those that work providing sex offender treatment. Both variables The MBI-HSS variables significantly predicted scores on Empathic Understanding, $F(3, 89) = 5.94$, $p < .01$, $R^2 = .167$; however only Personal Accomplishment $\beta = .257$, $p < .05$ and Depersonalization $\beta = -.261$ significantly added to the model. The MBI-HSS variables statistically predicted scores on ATTSO $F(3, 89) = 5.285$, $p < .01$, $R^2 = .151$; however only Personal Accomplishment significantly added to the model, $\beta = .348$, $p < .01$.

CHAPTER FIVE

DISCUSSION

Overview

The purpose of this study was to explore differences in attitudes toward sex offender treatment, levels of burnout, and levels of empathy among mental health professionals that work in a correctional setting, in a community-based setting, or work providing sex offender treatment. Providing treatment to sex offenders is a unique task that is fraught with ethical dilemmas and difficult clients, and there has been an increase is court mandated treatment, which has resulted in a need for more professionals providing this treatment (Prescott & Levenson, 2010). There is currently a dearth of research on people that provide sex offender treatment and this study was conducted to explore this new area of research. Sex offender treatment is a unique field of psychological treatment, and there is little known about those that provide this treatment. A review of the extant literature reveals that most of studies done on sex offender treatment focuses on the treatment modality itself and not those that are providing this treatment. Although there is limited research, it is apparent that the perception and opinions of both mental health professionals and members of the public, can impact the success of treatment of sex offenders and their reintegration into society (Tewksbury, 2004). Additionally, it is important to explore how those providing sex offender treatment differ from other professionals in levels of empathy and burnout. Previous research has found that burnout may be caused by an unhappy or unfulfilling relationship between the person and their working environment (Norcross & Guy,

2007). Therefore, this research can explore whether burnout is an issue for sex offender treatment providers. Furthermore, entering a job with high levels of commitment and then facing adversity, discontentment, or lack of positive outcomes can lead to burnout among healthcare professionals (Pines, 2003). Understanding more about this group of treatment providers can help us understand if they require more support due to their job stress compared to other groups of mental health professionals. Additionally, there is limited research about self-reported empathy among mental health professionals generally, and none exploring quantitatively measured self-reported empathy among sex offender treatment providers. This research will fill the gap in the current research.

Sex Offender Treatment Providers Compared to Other Providers

It was hypothesized that those providing sex offender treatment would have more positive attitudes toward sex offender treatment, higher levels of burnout, and lower levels of self-reported empathy. It was also predicted that among those that work providing sex offender treatment, more negative attitudes would be related to higher rates of burnout and lower levels of self-reported empathy, and higher rates of burnout would be related to lower levels of self-reported empathy. Many of these findings were supported, but it was also found that sex offender treatment providers often do not differ from professionals who provide services within correctional settings.

The first hypothesis postulated that mental health professionals who work with sex offenders as their primary clientele would have more positive attitudes toward sex offender treatment than mental health professionals who work in community settings and those who work in correctional settings, but are not specifically providing sex offender treatment. This hypothesis was confirmed by the data, with those providing sex offender treatment having more

positive attitudes toward sex offender treatment than correctional or community-based professionals. It is likely that those providing this treatment not only have more contact with sex offenders, which may impact their attitudes but are also engaged in treatment, so may have more confidence in its efficacy. It is unlikely that these individuals would choose this work if they felt that treatment was going to be ineffective. This hypothesis was based on past research that has shown mental health professionals to have more positive attitudes toward sex offenders compared to public samples (Hogue, 1993; Nelson et al., 2002). Moreover, the research has shown that those that work with sex offenders, regardless of their job (e.g., probation officer, mental health professional), have more positive attitudes than those who do not (Craig, 2005; Hogue, 1993; Nelson et al., 2002). A positive attitude toward clients is an important aspect of successful treatment. A study by Bauman and Kopp (2006) indicated that therapists that have a non-judgmental attitude toward their client in sex offender treatment have lower rates of treatment attrition and more positive outcomes. Other research also suggested that sex offenders have reported that a non-judgmental attitude from their therapist influenced their attitudes and behaviors to be more positive, and that a positive attitude increased their ability and willingness to change as part of treatment (Drapeau, 2005; McCallum, 1997; Polson & McCullom, 1995). Although there is little research on how sex offender treatment providers' attitudes toward treatment impact sex offender treatment, there is more extensive research about mental health professionals generally. The existing research suggests that positive attitudes toward the client and the treatment modality and positive therapist engagement are associated with positive psychotherapeutic outcomes (Bachelor, 2013; Beck, Friedlander, & Escudero, 2006; Holdsworth, Bowen, Brown, & Howat, 2014; Norcross, 2011).

It was hypothesized that mental health professionals who work with sex offenders as their primary clientele would have higher rates of burnout as compared to those in correctional and community settings. In the present study this hypothesis was partially supported. Correctional mental health professionals and sex offender treatment providers had similar levels of Emotional Exhaustion and Depersonalization, but both groups had significantly higher scores than the community-based treatment providers; however it should be noted that the means were relatively low for all groups. There was no difference in levels of Personal Accomplishment when comparing sex offender treatment providers to either of the other groups. Previous research supports this hypothesis. For example, past research found that mental health professionals working with sex offenders have higher levels of burnout, as measured by post-traumatic stress responses from vicarious trauma, when compared to mental health professionals working in other settings (Kadambi & Truscott, 2003; McCann & Pearlman, 1990). Additional research has found that sex offender treatment providers had elevated scores on measures of burnout, stress response, and perceived cynicism, and it was hypothesized that this was related to the nature of their work (Farrenkopf, 1992; Figley, 1999). There are also several studies that have found that those who work in correctional settings have elevated levels of burnout due to organizational factors, case load size, additional duties outside clinical work, and safety risk (Boothby & Clements, 2000; Otero et al., 1981; Senter et al., 2010).

It may be that many of the organizational factors and stressors that correctional mental health professionals have to navigate within their job are similar for those that provide sex offender treatment. Additionally, the difficult nature of working with criminal offenders may be an additional reason for similarities in scores on the Depersonalization and Emotional Exhaustion scales for both the sex offender treatment providers and correctional professionals.

Emotional Exhaustion, particularly among health service workers, is characterized by having their ability to be involved and respond to their clients decreased due to being exhausted by the emotional demands of their work (Maslach et al., 2001). Both sex offender treatment providers and correctional mental health providers are working with individuals that may be considered manipulative or difficult to work with and have additional layers of complexity that may not be present in other settings (Sandhu & Rose, 2012). Perhaps the setting and types of clients these professionals work with increase their level of Emotional Exhaustion. Additionally, Depersonalization is characterized by distancing oneself from their client by making the client an impersonal object of one's work (Maslach et al., 2001). Both sex offender treatment providers and correctional mental health professionals work with individuals that have committed some type of crime. Perhaps this elevated level of Depersonalization serves as a protective factor when working with these clients. When providing sex offender treatment in particular, part of treatment usually includes discussing the clients' crime, which could be hard for the treatment provider to hear. Additionally, focusing on the crime could also be a part of correctional treatment. In order to avoid burnout or vicarious trauma the treatment providers depersonalize from their clients. In addition, previous research has suggested that Depersonalization can be conceptualized as a defensive coping mechanism meant to reduce Emotional Exhaustion, therefore it is expected that if one of these variables is elevated, the other is likely to also be elevated (Schaufeli & Peeters, 2000). In fact, Depersonalization and Emotional Exhaustion were significantly correlated (r = .56) in the present study.

Lastly, there was not a significant difference between Personal Accomplishment scores when comparing sex offender treatment providers' scores to the other groups, which could have occurred for a number of reasons. Although the correctional and sex offender treatment

providers had elevated scores on the other scales indicating that they are experiencing some level of burnout, it does not mean that they are unable to find accomplishment in their work (Maslach & Jackson, 1981). Additionally, there is research that has found that those with postgraduate degrees have the highest level of Personal Accomplishment (Maslach & Jackson, 1981). Almost all of the participants hold a postgraduate degree, which may impact their level of Personal Accomplishment. Moreover, research has also found that those working in the mental health profession, regardless of job setting, list their primary reason for being in the field as self-fulfillment and accomplishment, and having the ability to find meaning in their work (Moore & Cooper, 1996). Perhaps the similarity in scores indicates that regardless of job setting, the participants were able to find meaning and a sense of accomplishment in their area of work.

It was also hypothesized that those who provide sex offender treatment would have lower levels of self-reported empathy compared to community based or correctional mental health professionals. This hypothesis was not supported. Levels of empathy across the three groups did not differ significantly. Due to the dearth of research on self-reported empathy among mental health professionals, particularly comparing different groups, there is no previous research to explain why this might have occurred. Tyagi (2006) suggested that empathy could be compromised by attitudes and reactions to sex offenders, and Sandhu and Rose (2012) found that empathy may be a dynamic factor within therapists and could be challenged or changed by working with sex offenders. However, neither study actually measured therapist empathy and instead interviewed professionals about how they were impacted by the nature of their work more generally. Farrenkopf (1992) reported that sex offender treatment providers experienced a decrease in empathy over time, particularly after five years of working in the field; however

Farrenkopf did not explain how empathy was measured or how the data was analyzed, making it difficult to explore the reliability and utility of these findings.

Much of the current research on empathy utilizes semi-structured interviews of the mental health professional or the viewing of therapy sessions with ratings of the professional's empathy (e.g., Peebles, 1980; Pugh & Vetere, 2009; Spivak, 1996). Therefore, it is difficult to find research on self-reported empathy, particularly among mental health professionals. It could be that mental health professionals are expected to have high levels of empathy, regardless of their job setting. Since Rogers (1957) indicated that empathy plays a key role in positive change in clients, there have been numerous studies that have found empathy is related to positive change across different therapeutic orientations and treatment modalities (Bohart, Elliott, Greenberg, &Watson, 2002; Norcross, 2002; Norcross & Wampold, 2011; Watson, 2011). Additionally, research has found that empathy can account for more variance in therapy outcomes than the intervention that is being utilized (Bohart et al., 2002). Beginning clinicians are taught that empathy is crucial for the therapeutic relationship. As a result, it could be that mental health professionals know they should have high levels of empathy toward their clients and that participants are unaware of empathy deficits or unwilling to acknowledge that they have lower levels of empathy. Furthermore, the scale used to measure empathy was face-valid, making it easy for participants to discern what was being measured and to potentially answer in a way that was consistent with their professional training. Lastly, the scale was created for the participant to answer with one client in mind, but in this study participants were asked to think of clients in general. It is likely that participants have high levels of empathy toward at least a proportion of their clients, so asking participants to think about clients in general might result in higher levels of empathy overall.

Relationships Between Variables Among Sex Offender Treatment Providers

It was hypothesized that among sex offender treatment providers more negative attitudes toward treatment would be related to lower levels of empathy. This hypothesis was supported. Previous research indicated that individuals providing sex offender treatment reported that their empathy tended to decrease over time, and that those that felt they had higher levels of empathy also had more positive attitudes toward sex offenders (Farrenkopf, 1992; Polson & McCullom, 1995). Previous research has suggested that having a negative attitude toward the client can have a negative impact on treatment (Bauman & Kopp, 2006). Research on other providers working with clients that are also perceived to be difficult (e.g., personality disorders) found that negative attitudes toward clients were related to feelings of losing capacity to have empathy for the client (Freestone et al., 2015). Additionally, empathy is defined as "a capacity of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts and experiences of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner" (Merriam-Webster Dictionary, n.d.) and is considered a key factor in any psychological treatment. Therefore it is likely that those with higher levels of empathy would have more positive attitudes toward the treatment that they are providing. The ability to have empathy toward sex offenders has been found to be related to positive therapy outcomes, therefore it may be that those that have more negative attitudes or lower levels of empathy are less effective in treatment and have more negative treatment outcomes, which in turn causes the negative attitude toward treatment or lower level of empathy to persist.

The relationship between self-reported empathy and levels of burnout among sex offender treatment providers was also examined. It was hypothesized that higher levels of

empathy would be related to lower levels of Emotional Exhaustion and Depersonalization and higher levels of Personal Accomplishment. There was not a significant relationship between the Emotional Exhaustion scale and self-reported level of empathy, but there were significant relationships between Depersonalization and Personal Accomplishment and self-reported empathy. The definition of Depersonalization can be seen as opposite of the definition of empathy. The ability to view clients as individuals and have the ability to empathize with them would indicate that the professional could not view them as an impersonal object of their work. There is one previous study that examined burnout as measured by the MBI-HSS and its relationship with empathy. Although empathy was measured differently in the study, Thomas et al. (2007) found an inverse relationship between empathy and Depersonalization and a positive relationship between empathy and Personal Accomplishment among medical students. They also found that higher levels of empathy were associated with higher levels of Emotional Exhaustion (Thomas et al., 2007). Some research has suggested that high levels of empathy may actually predispose someone to experience higher levels of Emotional Exhaustion due to the inability to cope with the reactions that they have or take on from their clients (Miller, Stiff, & Ellis, 1988). Given the limited amount of research on the relationship between empathy and burnout, and the known negative consequences that burnout can have on professionals, it is important to continue this area of research, especially among those that are providing sex offender treatment.

Additional hypotheses postulated that among sex offender treatment providers, higher levels of burnout would be related to more negative attitudes toward sex offender treatment. This hypothesis was partially supported. Higher levels of Personal Accomplishment and lower levels of Depersonalization were related to more positive attitudes toward sex offender treatment;

however there was not a significant relationship between ATTSO scores and levels of Emotional Exhaustion. Although there is not previous research examining this, a study by Gallavan and Newman (2013) found that mental health professionals working in a correctional setting had higher rates of burnout when they reported more negative attitudes toward offenders. It was expected that although there were some differences in the types of participants and the questionnaires used in Gallavan and Newman's study, the current study would have similar results. Personal Accomplishment is characterized by finding meaning and feeling competent and efficacious in one's work. Additional research on mental health professionals working with other types of difficult clients (e.g., personality disorders) found that negative attitudes toward the client or treatment were related to lack of confidence in the efficacy of the treatment and feelings of burnout (Freestone et al., 2015). It is likely that having more positive attitudes toward treatment would indicate that a professional is able to find meaning and feel competent in what they are doing; therefore, it is unsurprising that having more positive attitudes toward treatment is related to higher levels of Personal Accomplishment. Depersonalization is characterized by viewing clients as impersonal objects of one's work (Maslach, 1981). Having more positive attitudes toward treatment indicates that these providers view their clients as able to change and therefore would not view them as an impersonal object of their work. Lastly, attitudes toward sex offender treatment scores were not significantly related to levels of Emotional Exhaustion. However, research with correctional mental health professionals has suggested that there are many additional factors that lead to burnout in mental health professionals that are separate from the treatment they are providing (Boothby & Clements, 2000; Otero et al., 1981; Senter et al., 2010). It is likely that there would be some overlap in

organizational factors, such as caseload size and safety risk, that would also influence burnout among sex offender treatment providers.

Relationships Between Dependent and Demographic Variables

Although not hypothesized there were relationships between demographic variables and several of the dependent variables. In terms of demographic variables, age has the most consistent findings related to burnout among mental health professionals in previous research. In the current study, both Depersonalization and Emotional Exhaustion were inversely related to both age and years of experience, indicating that levels of burnout decrease with age and experience. Personal Accomplishment was not related to age, but levels of Personal Accomplishment increased as years of licensed experience increased. In previous research, early-career professionals and those who are younger have the highest rates of burnout (Ackerley et al., 1988; Bearse, et al., 2013; Kadambi & Truscott, 2003; Maslach, 2003; Rosenberg & Pace, 2006). Prior research has found that mental health professionals develop better resiliency and coping factors with experience, which helps counteract burnout as they age and obtain more experience in the field (Maslach, 2003).

Gender of the mental health professional was not related to any of the dependent variables in this study, and previous research has not found gender to be a consistent predictor of burnout (Maslach et al., 2001; Rupert & Kent, 2007; Rupert & Morgan, 2005). There is no previous research on the impact of gender or ethnicity on levels of empathy or attitudes toward sex offender treatment. There was not enough ethnic diversity within the current study's sample to compare levels of burnout across different ethnic groups. Over 90% of the study's participants were Caucasian, so this was not explored and is a limitation of the study. Additionally, ethnic minorities are underrepresented in the research on burnout overall. Many of

the studies focus on the Caucasian experience, and do not have enough minority participants for analysis. The limited studies that have enough participants to examine racial differences find that ethnic minority status is not a predictor of higher burnout among mental health professionals (Lent & Schwartz, 2012; Maslach, 2003).

Implications

This study has broad implications for both the correctional and psychological communities. As noted before, there is a dearth of research about mental health professionals' attitudes toward sex offender treatment. Although it is commonly acknowledged that holding a negative attitude toward clients can have unfavorable effects on the therapeutic relationship, there is little research examining what effects these negative attitudes have on mental health professionals and how these outcomes are different across different employment settings. A review of the existing research reveals there have been few studies that have examined mental health professionals' attitudes toward sex offender treatment, levels of burnout, and self-reported levels of empathy, and there are currently no studies that examine these three variables across different employment settings. The present study attempted to address these gaps in the research.

Additionally, these findings may have more substantial implications for mental health professionals interested in treating sex offenders. With an increase in reported sexual offenses and individuals seeking or mandated to attend sex offender treatment, it is critical that therapists interested in working in this field be aware of how negative attitudes toward their clients may impact themselves and treatment. Negative attitudes toward sex offender treatment are associated with higher rates of burnout and lower rates of empathy. There is research evidence (e.g., Sandhu & Rose, 2012) that suggests that therapist characteristics play an important role in

the treatment of sex offenders and have a large influence on the outcome of sex offender treatment; however this research is limited and much of the current research is qualitative in nature. Therapist empathy and warmth were found to be important characteristics and were related to attrition and positive change in treatment (Ware & Bright, 2008). Additionally, research found that both the therapists and sex offenders reported that therapist empathy and the therapist having a positive attitude toward the client as important aspects of treatment (Bauman & Kopp; Drapeau, 2005; Marshall, 2005; Polson & McCullom). Providing sex offender treatment is a complex challenge that is fraught with difficult clients, topics, and factors that most mental health professionals will not come into contact with. Previous research has found that there are numerous negative aspects related to working with sex offenders. Treatment providers report that they have difficulty touching or working with children (Bird-Edmunds, 1997), feel desensitized to the concept of abuse (Ellerby, 1997), and feel as though they have lost trust in others (Jackson et al., 1997) due to working with sex offenders. Additionally, providers discuss hearing about the crime the sex offender committed, the apparent lack of empathy by some of the offenders, the ability to navigate both the offender's abuse history and their history as an abuser as difficult parts of their job (Sandhu, Rose, Rostil-Brookes, & Thrift, 2012), One study quoted a participant as saying "I think that anyone who says that sex offender treatment programs does not affect them is being very naïve…it makes you cynical" (Collins & Nee, 2010, p. 324). Understanding how these mental health professionals differ and how this unique client group could impact them is important for helping these individuals navigate this difficult area of treatment. Previous research has suggested that in order to help these providers counteract the negative effects of working with difficult clients it is important to integrate wellness and self-care into their training and education (Newsome, Christopher, Dahlen, & Christopher, 2006).

Additionally, organizing supervision groups for those that provide sex offender treatment would be a forum for information and support. Research has also suggested that maintaining a strong, supportive network of peers and supervisors can help mental health professionals navigate the difficulties of their work (Lambie, 2006). Overall, it is important that sex offender treatment providers find a supportive peer network, gain education through both their schoolwork and continuing education, and monitor the impact that working with sex offenders may have.

Limitations

This study has several potential limitations. First, two of the measures utilized in this study have limited psychometric data available. The ATTSO and Barrett-Lennard Relationship Inventory have few published studies that examine their psychometrics. In fact, there has not been research on the psychometrics of the ATTSO scale since its creation (Wnuk et al., 2006). Additionally, the ATTSO has high face validity, and because mental health professionals are trained to have a neutral, if not positive, attitude toward clients they may be unwilling to acknowledge that they have negative attitudes toward sex offenders. The internal consistency of this measure was also lower than has been found in previous research indicating that it may not be a reliable measure of attitudes toward sex offender treatment. The Barrett-Lennard Relationship Inventory's Empathic Understanding subscale is typically used to examine feelings of empathy toward a specific client, but participants in this study were asked to consider clients more generally when completing the measure. Although this subtle change in directions was not expected to have a significant impact on scores, it is noteworthy that the internal consistency of this measure in the current study was lower than has been found in previous research, which indicates that it may not be a reliable measure of self-reported empathy.

Second, although the study achieved a response rate of approximately 12%, which is consistent with similar research (10-20%; Crosby & Sprock, 2004) there are questions as to what prevented other mental health providers from responding and what is different about those who did respond. Moreover, there was a relatively small sample size for correctional mental health providers, which limits the utility of the research for that group and lowered the statistical power when making comparisons to that group. Given these shortcomings, the results of the study may be of limited generalizability. Additionally, most respondents identified as Caucasian, which limited the diversity within the sample and also resulted in a sample that was not representative of mental health professionals as a whole. This is consistent with previous research that has failed to explore burnout among ethnic minorities.

Another potential limitation of the study was the portrayal of sex offenders as a homogeneous group. Sex offenders are a heterogeneous group; therefore, assigning attitudes toward the entire group may be unfair. Participants were asked to think of sex offenders homogenously and may hold varying attitudes toward specific members of that group. Therefore, the results from this study are in no way meant to represent a complete view of attitudes toward sex offenders.

Despite the limitations of the present study, the findings provide additional information regarding sex offender treatment providers and how they differ from other mental health professional groups. The extant literature in this area is limited, but suggests that sex offender treatment providers are faced with difficult ethical and clinical issues, that could impact them negatively. This study was able to find that sex offender treatment providers do differ on self-reported levels of empathy, burnout, and attitudes toward sex offender treatment when compared to correctional or community-based mental health professionals. This study provides several

ideas for further research. The concept of this study was formulated based on prior research on mental health professionals generally and attempted to fill the gap in the research on sex offender treatment providers. It would be interesting to recreate this study with a longitudinal design to see if scores on these variables change over time. For example, do those that choose to work providing sex offender treatment have higher levels of empathy when they start working, or is this developed over time? The approach would allow researchers to examine the longitudinal impact of working with this unique population. As there is more of a push for sex offender treatment, this area of research will continue to be important in the future.

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APPENDIX A: RECRUITMENT LETTER

Dear Mental Health Provider:

My name is Melanie Mivshek, and I am a graduate student in the Clinical Psychology Doctoral program at Indiana State University. As part of the requirement for my dissertation, I am conducting a research study with Dr. Jennifer Schriver. The overall purpose of the study is to explore how you view clients, questions about your experience at work, and your opinions about sex offender treatment. The study consists of completing a brief online survey. If you have at least one year of licensed experience in a mental health profession, I hope you will participate.

Participants will have the opportunity to enter a raffle to win one of two $25.00 gift cards. Contact information for those choosing to participate in the raffle will be stored separately from responses to the main survey and there will be no way to match a participant's identifying information with their responses to the main survey.

The survey should take approximately 10 minutes to complete. Additional information regarding informed consent is found at the beginning of the survey. Clicking on the link below will initiate your participation in the online survey. Thank you in advance for your support and participation.

http://(name of website for survey).com

Sincerely,

Melanie Mivshek, M.S.

APPENDIX B: INFORMED CONSENT

You are being asked to participate in a research study regarding mental health professionals' experience with burnout. This research is being conducted under the supervision of Dr. Jennifer Schriver for the fulfillment of a doctoral degree in Clinical Psychology at Indiana State University. Your participation in this study is entirely voluntary. Please read the information below before deciding whether or not to participate.

If you volunteer to participate in this study, you will be asked to provide information regarding how you view clients, questions about your experience at work, and your opinions about sex offender treatment. The total time that is needed to complete the survey is approximately 10 minutes.

Your participation and responses will be held strictly anonymous and confidential. You can choose whether or not to be in this study, and if you participate, you may discontinue your participation at any time.

Risks of participation are minimal and not expected to be greater than you encounter in everyday activities. Your information is very valuable to me, and by participating in this study, you will help to advance our knowledge of burnout and attitudes among mental health professionals.

At the completion of the survey there will be a link available where you can enter your email address to be entered into a drawing for one of two $25 Amazon gift cards. This email address will not be linked in any way to your responses, and the drawing will be done upon completion of data collection.

If you have any questions or concerns about this research, please contact the principle researcher, Melanie Mivshek, M.S. by email at mmivshek@sycamores.indstate.edu. Questions or concerns can also be directed to Jennifer Schriver, Ph.D., in the Department of Psychology at 812-237-3950, or by e-mail at jennifer.schriver@indstate.edu.

I confirm that I am at least 18 years old. I understand the procedures described above, and I agree to participate in this study. By clicking on "Yes" below, you are giving your electronic consent, and agreeing to participate in the study.

APPENDIX C: MBI-HSS

MBI Human Services Survey

Christina Maslach & Susan E. Jackson

The purpose of this survey is to discover how various people working in human services or the helping professions view their job and the people with whom they work closely.

Because people in a wide variety of occupations will answer this survey, it uses the term *recipients* to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

Instructions: On the following page are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about *your* job. If you have *never* had this feeling, write the number "0" (zero) in the space before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example:

How often:	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

How often 0-6	**Statement:**
1. _____	I feel depressed at work.

If you never feel depressed at work, you would write the number "0" (zero) under the heading "How often." If you rarely feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week but not daily), you would write the number "5."

APPENDIX D: ATTITUDES TOWARD SEX OFFENDER TREATMENT SCALE

The statements listed below describe different attitudes toward the treatment of sex offenders. There are no right or wrong answers, only opinions. You are asked to express your feelings about each statement by indicating whether you (1) Disagree strongly, (2) Disagree, (3) Undecided, (4) Agree, or (5) Agree strongly. Indicate your opinion by selecting the number that best describes your personal attitude.

1	2	3	4	5
Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly

1) I believe that sex offenders can be treated
2) Treatment programs for sex offenders are effective.
3) People who want to work with sex offenders are crazy.
4) Psychotherapy will not work with sex offenders.
5) Regardless of treatment, all sex offenders will eventually reoffend.
6) Sex offenders can be helped using proper techniques.
7) Treatment doesn't work; sex offenders should be incarcerated for life.
8) It is important that all sex offenders being released receive treatment.
9) We need to urge our politicians to make sex offender treatment mandatory.
10) All sex offenders should go to treatment, even if they don't want to.
11) Sex offenders don't deserve another chance.
12) Sex offenders don't need treatment since they chose to commit the crime(s).
13) Sex offenders should be executed.
14) Sex offenders should never be released.
15) Sex offenders should not be released back into the community.

APPENDIX E: BARRETT-LENNARD RELATIONSHIP INVENTORY: FORM OS-64 COUNS – EMPATHIC UNDERSTANDING SCALE

DIRECTIONS: Below are listed a variety of ways that counselors may feel or behave in relation to clients. Please consider each statement with reference to your relationship with your clients in general. Please try to answer in regard to all of your clients, and do not have specific clients in mind when answering the questions.

Answer each statement according to how strongly you feel that it is true or not true in your relationships with your clients

-3	-2	-1	1	2	3
NO, I feel strongly that it is not true	No, I feel it is not true	(No) I feel that it is probably untrue, or more untrue than true	(Yes) I feel that it is probably true, or more true than untrue	Yes, I feel it is true	YES, I strongly feel that it is true

1) I want to understand how my clients see things.
2) I understand my clients' words, but do not really know how they feel.
3) I nearly always know what my clients mean.
4) I look at what my clients do from my own point of view.
5) I usually sense or realize how my clients are feeling.
6) My own feelings can stop me from understanding my clients.
7) Sometimes I think that my clients feel a certain way, because that's the way I feel myself.
8) I can tell what my clients mean, even when they have difficulty saying it.
9) I usually catch and understand the whole of my clients' meanings.
10) I ignore some of my clients' feelings.
11) I appreciate how clients' experiences feel to them.
12) At times, I *think* that my clients feel strongly about something and then it turns out they do not.
13) At the time, I don't realize how touch or sensitive my clients are about some of the things we discuss.
14) I understand my clients.
15) I often respond to my clients rather automatically, without taking in what they are experiencing.
16) When my clients are hurt or upset I can recognize just how they feel, *without* getting upset myself.

APPENDIX F: DEMOGRAPHIC QUESTIONNAIRE

1) What are your primary job duties?

   _____ Academia
   _____ Research
   _____ Practice/Therapy

2) Do you have at least one year of licensed practice experience?
   _____ Yes
   _____ No

3) Which of the following best describes your gender identity?
   _____ Male
   _____ Female
   _____ Other (please specify)

4) Please indicate your age: _____

5) Please indicate your ethnicity:
   _____ African American
   _____ Asian/Pacific Islander
   _____ Caucasian
   _____ Hispanic/Latino/Latina
   _____ Native American
   _____ Other (please specify)

6) Please indicate the degree you hold:
   _____ Ph.D.
   _____ Psy.D.
   _____ Ed.D.
   _____ M.A.
   _____ M.S.
   _____ M.S.W.
   _____ Other (please specify)

7) Please indicate how many years of licensed experience you have: _____

8) Please indicate what best describes your primary work setting/clients:
   _____ Community Mental Health
   _____ Independent Practice
   _____Correctional Facility
   _____ Sex Offender Specific Treatment (in a correctional setting)
   _____ Sex Offender Specific Treatment (in an inpatient setting)
   _____ Sex Offender Specific Treatment (in an outpatient setting)
   _____ Sex Offender Specific Treatment (in any other setting)

9) Do you work with sex offenders in your clinical practice?
   _____ Yes
   _____ No

10) How many years have you been working with sex offenders? ____

11) On the Likert Scale below, please indicate if you think people have reacted negatively to you because you work with an offender population or a sex offender population:

1	2	3	4	5
People have strong negative reactions	People have some negative reactions	People have reacted neutrally	People have some positive reactions	People have strong positive reactions

Reactions toward working with offenders in general ____
Reactions toward working with sex offenders ____