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Vicarious Trauma Among Therapists Working with Sex Offenders

by

Michaela A. Kadambi 

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment for the degree of Master of Education

in

Counselling Psychology

Department of Educational Psychology

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Vicarious Trauma Among Therapists Working with Sex Offenders, by Michaela A. Kadambi in partial fulfillment of the requirements for the degree of Master of Education in Counselling Psychology.

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Date approved by thesis committee: Sept 30/98

Abstract

The purpose of this study was to investigate the phenomena of vicarious traumatization among therapists working with sex offenders. A review of the literature on the reported effects of this work suggested that these therapists worked within conditions thought to produce this type of response and may exhibit signs of vicarious trauma. To determine if vicarious trauma was present among this population, a total of 91 therapists currently providing sex offender treatment in Canada were surveyed using the Traumatic Stress Institute Belief Scale – Revision L (TSI), the Maslach Burnout Inventory Human Services Survey (MBI), and the Impact of Event Scale (IES). Participants did display symptoms of vicarious trauma as measured by the TSI, and were found to have moderate levels of Emotional Exhaustion, high levels of Depersonalization and high levels of Personal Accomplishment as measured by the MBI in comparison to other mental health professionals. Participants exhibited minimal intrusive and avoidant signs of Post Traumatic Stress as measured by the IES. Difficulties involving the concept of vicarious trauma as measured by the TSI, particularly the overlap between vicarious trauma and burnout, prevented conclusive statements regarding the presence of vicarious trauma among participants. This strong overlap between the constructs suggests problems with the construct validity of the TSI. Specialized training was found to offset the effects of burnout.

Dedication

I would like to dedicate this work to my parents who nurtured my desire to learn and who have always encouraged my pursuit of higher education

Acknowledgements

Anyone who has ever been through the process of conducting research and writing a thesis knows what a difficult process it can be. There are nights when you can't sleep because of the racing thoughts about various concepts, times when you don't leave the confines of your apartment for days because you are busy trying to write something brilliant and days where you just are unable to see the end of completing this last task for your degree. The material within this document represents the end of that process and while it was an arduous journey at times, it was one which I did not complete alone. I would like to express my sincerest thanks to the following individuals who gave their support, insight, enthusiasm and encouragement throughout the past year and a half.

To my parents Desikan and Kathleen Kadambi, without their support this degree would not have been possible.

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Last but certainly not least, I wish to express my admiration for all of the talented and courageous helping professionals who have chosen to devote their professional lives to the treatment of sexual offenders, especially those who chose to share their experiences for this research project. Thank you for making our community a safer place.

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CHAPTER 1

INTRODUCTION

Background to the Research

Providing treatment services to sex offenders is stressful (Bird Edmunds, 1997; Ellerby, 1997; Farrenkopf, 1992). Therapists working with this population must listen, empathize, and offer both challenge and support in the hope that their interventions will effect change in clients whose actions against others can only be considered as heinous. Adding to the difficulties inherent in the process of providing psychotherapy to difficult clients, therapists working with this population risk psychological harm as a direct consequence of their work (Bengis, 1997; Jackson, Holzman, Barnard, & Paradis, 1997; Rich, 1997). Literature suggests that therapeutic contact with sex offenders can produce reactions associated with trauma and significant emotional, interpersonal and behavioral changes in those offering treatment services (Ellerby, Gutkin, Smith & Atkinson, 1993; Farrenkopf, 1992; Layton, 1988; Ryan & Lane, 1991).

Previous conceptualizations of these therapists' collective experience have fallen under the labels of stress and burnout (Bird Edmunds, 1997; Ellerby, 1997). Although these conceptualizations have offered valuable frameworks from which to understand the potential consequences of providing psychotherapy, the experience of therapists working with sex offenders appears to be qualitatively different than for therapists providing psychological services to other populations (Ellerby, 1997). The application of the concept of vicarious traumatization (McCann & Pearlman, 1990) recognizes this qualitative difference

and may offer a more comprehensive framework from which to understand the effects of working with sex offenders on therapists.

Although vicarious trauma among therapists working with sex offenders is still in the early stages of investigation by the research community, individuals involved in this work have seized the idea as a means of explaining their collective response to their work (Jackson et al., 1997; Pullen & Pullen, 1996; Rich, 1997). Referring to the process by which the therapist becomes traumatized vicariously in response to the traumatic material presented by clients in therapy (McCann & Pearlman, 1993; Pearlman & McCann, 1990), vicarious traumatization produces changes in therapists' world view, sense of trust and safety, and their experience of self and others (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Considered a normal and inevitable response to exposure to traumatic material, vicarious trauma has been investigated almost exclusively among therapists providing therapy to survivors of trauma (Neumann & Gamble, 1995; Pearlman & Maclan, 1995; Shauben & Frazier, 1995). The concept has only recently been applied to the cumulative effects of working with perpetrators of trauma such as sex offenders (Rich, 1997).

Viewing the potential effects of working with sex offenders as traumatizing has important clinical implications. Providing effective treatment services to sex offenders requires the resolution of strong emotional and trauma reactions to these clients which can interfere with the treatment process (Hill, 1995; Peaslee, 1995). Vicarious traumatization offers a framework from which to explore and understand the process by which therapists working with sex offenders can

become negatively affected by traumatic material. Re – conceptualizing the experiences of these therapists as vicarious trauma may also allow these professionals to put their experiences in context and take appropriate measures at both the individual and organizational levels to mitigate the effects (Neumann & Gamble, 1995; Pearlman, 1995).

Overview of Study

Purpose of the Study

The purpose of this study is to determine the potential applicability of the concept of vicarious traumatization to account for the reported effects on therapists of working with sex offenders. Research investigating the emotional, psychological, interpersonal and behavioural consequences of working with sex offenders has been limited. Literature generated by professionals working within the field of sex offender treatment documenting work-related negative sequelea, however, has been more abundant (Alford, Grey & Atkisson, 1988; Bengis, 1997; Kearns, 1995; Lane, 1986, 1988; Poling, 1989; Pullen & Pullen, 1996; Scott, 1994). Empirical evidence to support the existence of vicarious trauma among therapists working with sex offenders confirms clinical observation and offers a new framework from which to understand and mitigate the impact of this work on therapists.

Format of Thesis

This thesis consists of four chapters: Introduction, Paper I, Paper II and Summary. A paper format was chosen to facilitate an efficient dissemination of the information contained within each chapter. In addition, the paper format

allows for each paper to be written for specific audiences, with differing areas of focus according to the needs of the target readers.

In Chapter 1, the researcher provides the rational for this research project, including background information on the research area and the purpose of the study. Within Chapter 2, the researcher offers a comprehensive review of the stressors associated with sex offender treatment and the effects therapists working with this population report experiencing. Written primarily for clinicians working in the area of sex offender treatment, this chapter was intended by the researcher to provide suggestions for individual and organizational strategies to deal with the impact of providing sex offender treatment on professionals. Presented within Chapter 3 are the findings of an empirical investigation examining the phenomena of vicarious traumatization among therapists working with sex offenders. A summary of the findings from chapters 2 and 3, and the global implications of this study are the focus of the material included in Chapter 4.

Personal Note

On a personal level, this research project represents much more to me than an academic exercise. The choice to investigate vicarious trauma among therapists working with sex offenders reflects my attempt to understand my own experience, as well as that of others who work with this difficult population. This study represents my efforts to honor the profound personal changes within myself and others who chose to do this work, and perhaps encourage a new way of conceptualizing and addressing the impact of working with sex offenders.

Prior to entering the Master of Education program at the University of Alberta, I was a volunteer with the Fresh Start Sex Offender Treatment Program in Brandon, Manitoba. Within the course of two years as a volunteer group co – facilitator for a Relapse Prevention group, I became very aware of significant personal changes that I was experiencing as a result of therapeutic contact with sex offenders. I began to notice that I was becoming increasingly paranoid about my own safety and that of those close to me. I frequently experienced intrusive imagery and thoughts relating to the material clients were presenting in group, and I began to notice that I could not tolerate scenes of sexual violence on television or in movies. I felt that I was profoundly changed in ways that people not involved in sex offender treatment did not understand.

Through conversations with colleagues involved in providing sex offender treatment, I realized that my reactions to the work were in fact commonplace, and that they, too, were deeply concerned about how this work was affecting them. While our experiences working with this population were well discussed within "debriefing sessions" following group, our collective difficulties were rarely addressed in the many workshops and conferences intending to prepare us to provide treatment services to sex offenders.

It has been well over two years since I last was involved with the Fresh Start Sex Offender Treatment Program and while it was an incredibly valuable learning opportunity, I still live with the legacy of the experience. Pepper spray on my key chain, a personal alarm under my pillow, talismans to protect me from the dangers of the world that I know all too well. As time has passed, however,

my awareness of harm has become lessened by the joy and goodness that I have begun to recognize all around me.

I hope that those of you reading the pages of this study find the information helpful and perhaps are encouraged to think in new ways in terms of understanding your own reactions to your work. I invite you to recognize the aspects of yourself which may have been profoundly affected by your work, as well as acknowledge the many rewards it provides. I wish to impart also the knowledge that the contributions you make to our community's safety do not go unrecognized, but are greatly appreciated by many.

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CHAPTER 2

PAPER I

Harming the Helper? A Review of the Reported Effects of Working with Sex Offenders on Therapists

Background

The personal and professional hazards of working with sex offenders are well recognized among therapists within this field (Alford, Grey & Atkisson, 1988; Giovannoni, 1997; Lane, 1986; Poling, 1989; Pullen & Pullen, 1996). Empirical research into the effects of working with sex offenders on therapists, however, is limited (Bird Edmunds, 1997; Farrenkopf, 1992; Jackson, Holzman, Barnard & Paradis, 1997; Rich 1997). The majority of information in this area comes from the self reported experiences of therapists, supplemented by a few qualitative investigations exploring therapists' reactions to their work. This literature has, however, found that therapists who work with sex offenders can be significantly affected by their work in ways which may serve to disrupt the treatment process and produce emotional reactions that extend beyond the therapist's professional life (Farrenkopf, 1992; Kearns, 1995; Layton, 1988; Polson & McCullom, 1995). In this paper, I intend to examine the difficulties associated with the treatment of sex offenders and explore the personal effects therapists experience as a result of working with this population.

In general, the provision of psychotherapy can be stressful for the therapist (Grosch & Olsen, 1994; Farber, 1983; Maslach, 1982). A review of this

research reveals several key areas corresponding to therapist stress which include: stressors embedded within the process of psychotherapy and the therapeutic relationship (Farber & Heifetz, 1981); difficulties related to the therapist's working conditions (Farber & Heifetz, 1981, 1982; Raquepaw & Miller, 1989; Savicki & Cooley, 1987); and stress associated with specific client populations and behaviors (Chessick, 1978; Deutsch, 1984; Farber & Heifetz, 1982).

These stressors are encountered by individuals providing psychotherapy across a wide range of settings and clients. Therapists who work with sex offenders, however, face added challenges and unique emotional stressors specific to their work. According to previous literature on the effect of providing psychotherapy on therapists (Farber & Heifetz, 1981, 1982; Deutsch, 1984), these compounded hazards may render individuals providing sex offender treatment particularly vulnerable to experiencing significant professional and personal sequelea as a result of their work (Ellerby, 1997).

Stressors Associated with Sex Offender Treatment

Difficulties Associated with Mandated Clients

In the vast majority of cases sex offenders are involuntary clients. Often these individuals enter treatment under court mandates, or have agreed to treatment to lessen the legal consequences of their offending behavior. For many of these individuals, participation in treatment programs may be viewed as a necessary evil for personal gain, as opposed to a sincere desire to change their behavior (Ellerby, 1997; Salter, 1988).

Representing authority, directing and expecting change, therapists who deal with these mandated clients are often the target of offenders' projections of anger, hostility, and blame (West, 1996; Ellerby, 1997; Salter, 1988). For therapists treating mandated clients, there are greater negative projections experienced within the therapeutic relationship (Steenson, 1987). Increased efforts which tax the emotional and therapeutic resources of the therapist are therefore required in order to recruit the cooperation of the client to participate in mandated therapy (Blanchard, 1995: Steenson, 1987).

Stressful Offender Characteristics and Behaviors

The difficulties associated with mandated clients can also be magnified by resistant and psychopathological behaviors consistently identified as sources of stress for mental health professionals (Deutsch, 1984; Farber & Heifetz, 1982; Hellman, Morrison, & Abramowitz, 1987). Specific traits and behaviors particularly difficult to deal with as identified by individuals providing treatment services to sex offenders include self centeredness, lack of empathy, denial, manipulation, minimization and rationalization, manipulation, externalization of personal responsibility, and lack of internal change motivation (Layton, 1988; Farrenkopf, 1992; Polson & McCullom, 1995; Strasburger, 1986). These personal qualities of the offender again place strain on therapist and the therapeutic process.

Throughout the treatment process the therapist may also participate in what Pearlman and Saakvitne (1995a) term "traumatic enactments". These traumatic enactments are the result of client casting the therapist in the various

roles of victim, perpetrator or bystander as the client re-enacts personal trauma. For example, throughout treatment offenders may present themselves as victims and/or try and deflect their responsibility for offending by rationalizing their own experience of traumatization (Barbaree, 1989; Salter, 1988; Williams & Khanna, 1987). Efforts to facilitate change, empathy and awareness within the offender are often then compounded by these dynamics of resistance encountered during the therapy process.

Offender clients can also re-enact with the therapist many of the same behaviors that preceded their offense, subjecting the therapist to acts of manipulation and exploitation. Some therapists report that their personal boundaries are invaded by offender clients (Ellerby, Gutkin, Smith, & Atkinson, 1993) and, on a more distressing level, therapists report experiencing verbal and physical attacks by clients (Jackson et al., 1997). Compounding the obvious stress associated with these interactions, therapists bear the added burden of feeling victimized, violated and fearful of the individuals to which they are attempting to provide treatment (Ellerby et al., 1993; Jackson et al., 1997).

Stress Related to Countertransference Dynamics and Reactions

Few client populations tax the emotional resources and produce greater affective countertransference responses within the therapist than sex offenders (Blanchard, 1995). Several aspects of offender treatment, including the content of the therapy and client characteristics, create a climate in which strong countertransference reactions are likely to occur. Countertransference reactions are often considered useful tools for therapists within the therapeutic process

(Elkind, 1992; Gill, 1983). In using the reactions to their clients as a means for gaining more self awareness and insight into individual client dynamics, therapists and clients can move to a more intense level of processing therapeutic issues (Mitchell & Melikian, 1995). Conversely, however, the reactions experienced by treatment providers can also serve to disrupt the therapeutic process and prove difficult for the therapist to both acknowledge and appropriately integrate into the treatment experience.

Hill (1995) proposes that therapists working with sex offenders experience a separation of their reactions to their clients or "dual countertransference". Institutional mandates and societal demands for punishment are often in opposition to the therapist's mandate to provide effective treatment services to this population. Hill (1995) argues that, as a result, the therapist is often challenged with understanding the client as an offender (whose offending behavior must be evaluated, addressed and monitored to protect society) and seeing the client as an individual needing help. Often these two ways of experiencing and responding to the client can create differential countertransference reactions which are difficult for the therapist to integrate, placing added strain on the therapeutic relationship and stress on the therapist's personal resources.

In addition to the special countertransference dynamics facing therapists working with sex offenders, the countertransference reactions themselves may also act as a source of personal and professional stress for the therapist (Farrenkopf, 1992; Mitchell & Melikian, 1995). Bearing witness to the details and

events leading up to offender's criminal behavior is a necessary and integral aspect of therapy with sexual offenders. Details of offenders' criminal acts are often requested to address the offenders' level of denial and minimization, and to evaluate the level of risk and responsibility they take for their actions (Barbaree, 1989; Marshall, Hudson, Jones, & Fernandez, 1995; Salter, 1988). These often horrific descriptions can produce a variety of emotional and physical responses within the treatment provider. Intense personal reactions such as disgust, rage, nausea, shock, profound detachment, and fear are cited in the literature as typical responses to offenders' stories (Kearns, 1995; Layton, 1988; Polson & McCullom, 1995; Pullen & Pullen, 1996; Scott, 1994).

Several studies reviewing the experiences of therapists working with offenders find that many treatment providers experience sadistic fantasies involving revenge or retribution toward their client (Bengis, 1997; Mitchell & Melikian, 1995; Poling, 1989). While these reactions may in part be triggered by a number of offender characteristics, (e.g. the lack of victim empathy, reliving the excitement while disclosing the offense) they can be highly distressing for therapists to acknowledge and address. Recognizing one's own potential for sadistic action may be thought of as frightening, unacceptable and highly incongruent with a therapist's perception of themselves as caring and nurturing individuals (Mitchell & Melikian, 1995; Poling, 1989; Polson & McCullom, 1995).

Compounding the intense feelings therapists can experience as a result of their exposure to the raw cruelty and violence of their client's behavior, therapists working with this population may also experience countertransference

in response to the sexual content of their clients' material. Distressing reactions to the sexual content of therapy reported by therapists include sexual attraction to clients, sexual arousal from client material, and sexually violent thoughts and impulses (Bengis, 1997; Ellerby et al., 1993; Layton, 1988; Mitchell & Melikian, 1995; Poling, 1989). Acknowledging and addressing these reactions can be especially difficult for therapists whose professional identity is one of beneficence. Experiencing sexual arousal related to violent, non-consensual sexual acts, which may involve children, can be extremely disconcerting for treatment providers. These responses may also serve to undermine and attack the therapists' sense of self as they are likely to be highly dissonant with the therapist's beliefs about both their personal and professional identity.

Difficulties Associated with Stigmatized Populations

Egan (1993) found that working with clients who were socially stigmatized was a factor which generated significant stress for therapists. For therapists working with sex offenders, often considered the most reviled of all social pariahs, the ignominy of their clients may also contribute to a sense of isolation and alienation for the treatment provider (Ryan & Lane, 1991). The nature of the work conducted by these therapists and the intentions of treatment itself are frequently misunderstood by the general public (Cooke, Baldwin & Howison, 1990). Therapists working with sex offenders are often confronted by the general perception that something has to be seriously wrong with them in order for them to work with such a deviant and morally reprehensible population (Alford, Grey & Atkisson, 1988). Isolated not only by the reactions of others,

therapists may also experience feelings of alienation as a result of their own personal reactions to their work, which can at times be exceedingly difficult to discuss with others (Lane, 1986). Working with clients who evoke such intense feelings within the therapist and the general public can leave the therapist feeling overwhelmed and alone (Alford, Grey & Atkisson, 1988).

Extended Clinical Responsibility and Potential to Re-offend

Working with forensic clients poses additional stressors in balancing the needs of the individual client with the protection of society. In assessing and managing their client's level of risk, therapists are often required to place the safety of society over the best interests of their individual clients (O'Connell, Leberg & Donaldson, 1990). Contributing to the stress of managing individual treatment needs with those of society, research has suggested that treatment may only be marginally effective in reducing recidivism (Barbaree, 1997; Hanson, Steffy, & Gauthier, 1993; Rice, Quinsey, & Harris, 1991). Therapists must deal with the constant awareness of their clients' dangerousness and the potential reality of a re-offense. Ellerby (1997) suggests that in comparison to treatment failures in other types of clinical practice, the emotional, societal, political and professional repercussions following the re-offense of a sex offender are more extensive and can serve to traumatize therapists working with this population. Feelings of guilt, depression, disillusionment, anger, personal incompetence and a sense of responsibility for the offense have all been reported by therapists following a client's re-offense (Ellerby et al., 1993; Layton, 1988).

The ultimate goal of offender treatment is to prevent re-offending behavior. Treatment, however, does not definitively cure the offending behavior, and the risk of re-offending continues throughout the offender's lifetime (Nagayama Hall, 1995; Hanson, Steffy, & Gauthier, 1993; Pithers, Marques, Gibat, & Marlatt, 1983). Successful treatment may only provide the skills by which offenders can monitor and manage their own behavior (Knopp, 1984). Even then, there is no guarantee that the offending behavior will stop or be discovered, as many re-offenses may not be reported. This ambiguity surrounding treatment outcomes and efficacy can be stressful for the therapist to manage. Therapists working with this population have reported developing pessimistic attitudes towards the potential for client change and diminished hopes and expectations in working with sex offenders (Farrenkopf, 1992; Layton, 1988). Pessimism for client change and diminished beliefs in one's ability to effect change are both factors that can contribute to therapist feelings of emotional exhaustion and disconnection from clients (Farber & Heifetz, 1981, 1982; Maslach, 1982; Penn, Romano & Foat, 1988).

Stress Related to Treatment Settings

Outside of the one-to-one relationship within psychotherapy, the therapist must also navigate, interact and function within the context of a larger agency, institution or organization. Aspects of the working environment have been shown to produce stress which can tax the emotional and coping resources of therapists. Therapists working with sex offenders usually work in institutional settings (Wormith & Borzecki, 1985) where they may experience excessive work

loads and have little impact on work policy; two factors which have been shown to be sources of stress and factors in professional burnout among mental health professionals (Farber & Heifetz, 1981; 1982; Savicki & Cooley, 1987). In addition, therapists working within these settings may encounter additional intra-organizational challenges working within environments where administrative or support staff may misunderstand and/or not support treatment efforts (West, 1996).

Successful management of sex offenders involves more than just psychotherapeutic interventions. Often therapists providing services are part of a vast array of professionals from agencies including: parole, probation, correctional facilities, judicial staff, and law enforcement. Coordinating efforts to provide comprehensive treatment and management of these individuals among agencies with different mandates, replete with systemic inconsistencies of their own, can serve as a source of frustration for therapists. Awareness of the justice system's inconsistencies and shortcomings can create additional stress in terms of therapists' concern about the system's ability to protect potential victims (Ryan & Lane, 1991). Therapists commonly experience frustration with the inconsistencies of the criminal justice system and the reactive rather than proactive approach to dealing with the issue of sexual offending behavior (Farrenkopf, 1992; Layton, 1988).

Effects of Working With Sex Offenders

While the numerous stressors encountered by individuals working with sex offenders can serve to strain the therapist's ability to provide effective

treatment services and tax professional resources, the effects of working with this population appear to extend beyond the workplace and into these therapists' personal life. Studies investigating the effects of providing services to sex offenders have indicated disturbing emotional, interpersonal and behavioral sequelae experienced by treatment providers as a result of their work. Indeed, Scott (1989) has argued that providing psychotherapeutic services to criminals is the most demanding work in the mental health field.

Emotional and Psychological Effects

Broad beliefs that one holds about the world, including values, moral principles, life philosophy, and locus of control are part of an individual's world view (Pearlman & Saakvitne, 1995a). A world view filters one's experience and interpretation of events and can encompass general attitudes towards others and their intentions, and global beliefs about the benevolence or malevolence of the world. Personal reports as well as empirical research suggest that therapists working with sex offenders can experience profound changes in their world view as a result of their work.

Therapists working with this population generally report increased difficulty trusting others (Bengis, 1997; Blanchard, 1995; Farrenkopf, 1992) and increased suspiciousness surrounding the intentions of others (Alford, Grey & Atkisson, 1988; Bengis, 1997; Bird Edmunds, 1997; Jackson et al., 1997). Following pilot interviews, Farrenkopf (1992) surveyed 24 experienced therapists working with sex offenders regarding the personal impact of their work. He found that therapists working with sex offenders can develop a cynical

attitude, having "...fewer illusions as a result of seeing the human dark side..." (p. 219).

Intensive contact with the "dark side" of human nature also appears to produce changes in the sense of safety treatment providers feel for both themselves and others. Although safety issues may clearly be linked to the keenly developed awareness of the potential for violence in the world as a result of their contact with sex offenders, events within the treatment process itself may contribute directly to these changes. The majority of therapists surveyed by Ellerby et al. (1993) reported having felt threatened or endangered by their sex offender clients. Similarly, Jackson et al. (1997), sampled therapists working with sex offenders using a survey designed to allow respondents to describe their experiences and reactions to working with sex offenders through forced choice and open ended questions. Over half of the 98 respondents in this study reported being assaulted by their clients verbally and/or physically. Over 40% of these respondents also reported fearing retribution by clients (Jackson, Holzman, Barnard & Paradis, 1997). Not surprisingly, therapists working with this population frequently report an increased sense of vulnerability to violence, a heightened fear of being victimized in some way, and hypervigilance with respect to their own and other's personal safety (Alford, Grey & Atkisson, 1988; Bengis, 1997; Ellerby et al. 1993; Farrenkopf, 1992; Jackson et al., 1997; Lane, 1986; Layton, 1988; Pullen & Pullen, 1996).

These increased concerns about personal and other's safety appear to be particularly pronounced for female therapists (Bird Edmunds, 1997; Ellerby et al.

1993; Farrenkopf, 1992). Farrenkopf (1992) suggests that through their work female therapists may be re-sensitized to previous incidences of victimization by men, which may lead to a generalized negative attitude towards all men. It was found that male therapists, however, appear to become more aware of a "collective guilt" or may experience gender shame surrounding male abusive behavior (Farrenkopf, 1992).

Providing sex offender treatment can also effect treatment providers' sense of identity as they attempt to integrate reactions to the work, including thoughts, feelings and impulses incongruent with personal and professional perceptions of themselves. As a result of working with sex offenders, therapists confront parts of themselves and their own life, previously beyond their awareness. Hill (1970) explains:

> The therapist's understanding and capacity to know another's experience is based on his knowledge of his own. We can only know those on the inside by an act of identification. We can only know those on the outside by an act of perception. It is in this way that the therapist faces himself as he faces his patient (p.232; as cited in Cordess & Cox, 1996).

Therapeutic contact with offender clients, therefore, often involves becoming aware of one's own potential for violence and/or facing the ugliness and "dark side" of oneself (Bengis, 1997).

Therapists have reported that since working with sex offenders, they have worried about their own deviance and potential for violence

(Bengis, 1997; Mitchell & Melikian, 1995), have questioned their own use of power and aggression in both their personal and professional lives (Poling, 1989; Pullen & Pullen, 1996), and have expressed concern over their past and current behaviors wondering if they may be considered abusive in some way (Ellerby et al. 1993; Pullen & Pullen, 1996). These concerns, if not successfully addressed and integrated, may also serve to threaten the therapists' self concept and self esteem.

Affect tolerance, regulation and expression also appear to be affected by therapeutic contact with sex offenders. Therapists frequently report difficulty in tolerating the strong emotional responses evoked within the context of their work (Mitchell & Melikian, 1995; Polson & McCullom, 1995; Scott, 1994). As a result, therapists may minimize or rationalize these intense feelings in an attempt to cope with the unrelenting onslaught of powerful reactions they experience within their work, a coping mechanism that appears to continue to function outside of the work setting (Layton, 1988). Almost 50% of the respondents in Farrenkopf's (1992) study reported that they experienced a numbing or hardening of their emotions with respect to both their clients and their own interpersonal relationships.

Continual exposure to violent and disturbing content during the course of therapy also takes a toll on the therapist. This exposure appears to produce painful and distressing effects, which again extend beyond the treatment setting. Emotional responses commonly associated with psychological trauma, such as nightmares and intrusive imagery, are consistently reported among therapists

working with sex offenders (Bengis, 1997; Farrenkopf, 1992; Jackson et al., 1997; Layton, 1988).

Interpersonal Effects

The experience of working with sex offenders means having to confront the reality and horror of how other human beings are capable of behaving. This process of realization can leave treatment providers with a profound sense of personal change and sorrow. Highly sensitized to the prevalence and devastation of sexual abuse, therapists may feel disconnected from others and distance themselves from individuals who may minimize sexual abuse or do not understand the difficulty of their work (Alford, Grey, & Atkisson, 1988; Cooke, Baldwin, & Howison, 1990; Pullen & Pullen, 1996). Ironically, this emotional distancing can occur with family members and friends, the very sources of support who can mitigate the adverse effects of the work. Interpersonal relationships may also be affected by the decreased levels of tolerance for other individuals behavior, loss of a sense of humor, and general increases in frustration levels and anger which are commonly reported by therapists doing this work (Bird Edmunds, 1997; Farrenkopf, 1992).

Behavioral Effects

It could be argued that given the nature and content of therapy with sex offender clients, the therapists' own sexuality and sexual behavior are inevitably bound to be affected. Jackson et al. (1997) found that almost 50% of therapists within their sample reported changes in their sexual behavior since beginning their work with sex offenders. Most commonly, therapists reported diminished

interest and activity in sex (Bird Edmunds, 1997; Ellerby et al. 1993; Farrenkopf, 1992). Closely connected with these changes in desire may be the feelings of guilt surrounding normal sexual thoughts and behavior which therapists have reported experiencing following therapeutic work with offender clients (Layton, 1988). Ellerby et al. (1993) found that therapists indicated they had avoided sexual activity, had been distracted during sexual activities, and had prematurely ended sexual activity as a direct consequence of their work with sex offenders. Increases or occurrences of sexually deviant impulses and fantasies have also been reported among therapists following their participation in sex offender treatment (Ellerby, 1997; Bengis 1997; Poling, 1989). On a more positive note, however, Farrenkopf (1992) found that some therapists reported that their work had resulted in greater sexual consideration for their partner.

The extreme sensitivity surrounding the potential for violence that many therapists working in this field experience has the potential to significantly impact parenting behaviors. Since beginning their work with sex offenders, therapists commonly report significantly increased concerns and anxiety about their children's safety (Ellerby et al. 1993; Farrenkopf, 1992; Lane, 1986). For some therapists, these concerns manifest themselves in over-protective parenting, limiting their children's' activities with others, and supervising their children more closely (Ellerby, et al. 1993; Lane, 1986; Ryan & Lane, 1991). Ellerby et al. (1993), however, found that as a result of their work some therapists reported being more open in discussing personal safety, sexuality and sexual abuse with

their children, in addition to developing a greater awareness of their own parenting behavior.

Therapist reports of behavioral changes in their personal life appear to be primarily related to both sexuality and parenting. Outside of these changes, some studies have also reported that a number of therapists have experienced changes in sleep patterns and appetite (Bird Edmunds, 1997; Jackson et al., 1997). While these changes are reported by fewer therapists, they are important in that they represent symptomatology commonly linked with depression and anxiety.

Reported Rewards

Despite the stressors inherent within the psychotherapeutic process, the challenges specific to sex offender clients and the subsequent potentially negative effects of providing treatment services, therapists report that their work with this population does provide rewards. Many therapists develop a sense of mission about their work which enables them to continue to provide treatment services to this population (Farrenkopf, 1992; Jackson et al., 1997). A sense of purpose and a belief that their work with offenders ultimately helps victims have also been expressed by therapists as to why they choose to continue their work in this challenging field (Jackson et al. 1997; Polson & McCullom, 1995). For some, the exposure to the very worst of human behavior appears to bring them closer to understanding it, producing an increased sensitivity toward others and more empathy for human suffering (Farrenkopf, 1992).

Discovering ways to cope with the stressors inherent in the provision of psychotherapy and those specific to sex offender treatment are key factors for therapists in maintaining their ability to work with this population. Research in this area suggests that therapists providing services to sex offenders employ a wide range of coping strategies within and outside their work setting to deal with the effects of their work. Therapists have identified supervision, seeking personal therapy, separating their work from their personal life and receiving support from other therapists involved with sex offender treatment as important components of coping strategies that enable them to continue their work (Jackson et al. 1997).

Understanding the Overall Effects on Therapists

As described above, the cumulative impact of providing treatment services to sex offenders is beginning to be viewed as qualitatively different than with other "difficult clients". This reaction is related to the unique stressors associated with sex offender treatment as well as the exposure to violent and distressing material. These aspects of sex offender treatment appear to produce a collection of reactions which extend well beyond what might be expected as a result of simple work related stress (Ellerby, 1997; Rich, 1997).

A potentially useful way of understanding these reactions is that providing sex offender treatment may in fact be traumatizing to the therapist. The process by which therapists become traumatized through their therapeutic contact with clients has been termed vicarious traumatization (McCann & Pearlman, 1990). Although the construct was initially developed to describe and understand the

unique effects of working with trauma victims, the underlying assumptions regarding the necessary conditions within the therapeutic relationship that produce trauma reactions also appear to apply to therapists working with sex offenders.

Vicarious Traumatization

Vicarious traumatization is a new concept developed to understand and describe the unique effect of trauma work on trauma therapists. Research in this area has almost exclusively been conducted with therapists who work with trauma victims (Genest, Levine, Ramsden, & Swanson, 1990; Munroe, 1991; Pearlman & Maclan, 1995; Raphael & Wilson, 1994; Schauben & Frazier, 1995). The concept of vicarious traumatization has only recently been applied to the cumulative effects of working with perpetrators of trauma, such as sex offenders (Rich, 1997).

Developed by McCann and Pearlman (1990), vicarious traumatization refers to the process by which the inner experience of the therapist who works with trauma is negatively affected through empathic bonding with the client's traumatic material. The therapist's empathic engagement with this material is thought to be facilitated by the graphic nature of the material, exposure to the reality and cruelty of the way people treat one another, and observation and participation in traumatic re–enactments within the therapeutic relationship (Pearlman & Saakvitne, 1995a).

The experience of vicarious traumatization is considered a normal response unique to therapists providing therapy to traumatized clients (Pearlman

& Saakvitne, 1995a). Producing changes in the therapists world view, self identity, and disruptions in cognitive schemas associated with safety and trust, vicarious traumatization also provokes symptoms of post traumatic stress disorder such as intrusive imagery and nightmares. While distressing to experience, vicarious trauma also influences the therapists' provision of psychotherapeutic services (McCann & Pearlman, 1990; Neumann & Gamble, 1995). Therapists experiencing vicarious trauma may become sad, cynical, less able to manage their countertransference reactions and less confident in their ability to help clients (Pearlman & Saakvitne, 1995b)

Vicarious traumatization, although conceived to understand and describe the impact of trauma work on trauma therapists, clearly has the potential to be applied to those working with perpetrators of trauma. Therapists who work with sex offenders encounter similar therapeutic dynamics thought to produce vicarious traumatization, and report effects similar to those of trauma therapists that are the hallmarks of vicarious traumatization. These similarities include participation in traumatic re-enactments and the commonly reported changes in world view, personal safety, sexual and parenting behaviours in addition to intrusive symptoms of trauma (Ellerby, 1997; Farrenkopf, 1992; Layton, 1988; Mitchell & Melikian, 1995; Polson & McCullom, 1995).

Despite the fact that little empirical evidence exists, therapists working in the field have been quick to label their collective experience as vicarious trauma (Jackson, et al., 1997; Rich, 1997; Pullen & Pullen, 1996). The commonsensical appeal the construct appears to have for those working with sex offenders may

be related to the fact that vicarious traumatization accounts for the range of reactions experienced by these therapists. In addition to offering a comprehensive framework from which to describe and understand the therapist's experience, vicarious trauma is also viewed an inevitable response to bearing witness to human cruelty and traumatic material. The fact that therapists' experiences are validated and not pathologized may also contribute to its appeal.

Implications for Therapists Working with Sex Offenders

The clinical appeal of vicarious traumatization may also lie in the fact that it offers a multi-layer solution focused approach to addressing the detrimental effects of working with trauma. By effectively addressing vicarious trauma, it is suggested that it can be transformed by accepting the reality of it and by realizing the inevitability of internal change and the resultant emotional pain (Saakvitne & Pearlman, 1996). By working through the grief associated with internal change, vicarious traumatization is transformed as the therapist reaches a place of "inner equilibrium necessary for us to address out truth and remain grounded in the face of the torrent of feelings and assaults to our cherished beliefs that characterize vicarious traumatization" (Saakvitne & Pearlman, 1996, p. 78). Saakvitne and Pearlman (1996) propose that the central aspects of all interventions to "transform" vicarious traumatization involve Awareness, Balance and Connection (ABC's) in professional, personal and organizational environments of the individual. In *Transforming the Pain: A Workbook on Vicarious Traumatization for Helping Professionals who Work with Traumatized*

Clients, Saakvitne and Pearlman (1996) provide therapists with exercises to assist in identifying and addressing vicarious trauma. To do so, therapists must deal with both the internal and external stressors associated with vicarious trauma, and directly confront the demoralization and loss of hope which often accompanies it. While a focus on addressing both endogenous and exogenous aspects of vicarious trauma are essential in mitigating its' effects, it is also imperative that this process is facilitated at both individual and organizational levels (Neumann & Gamble, 1995; Pearlman, 1995).

To address the stress which contributes to vicarious trauma, emphasis is placed on the individual to develop ways of taking care of one's physical, psychological, spiritual and emotional being. Practicing good self care, engaging in nurturing activities and escaping the demands and stress associated with one's work have been suggested as potential tools for therapists to improve their quality of life and reduce stress (Neumann & Gamble, 1995; Pearlman, 1995; Shauben & Frazier, 1995). Improved self care and stress reduction alone, however, are not thought to be sufficient to fully address the complexity of vicarious trauma. Negative beliefs, despair loss of meaning and cynicism must also be addressed if a transformation of this phenomena is desired. Strategies which serve to generate meaning have been suggested to oppose the despair that can result from vicarious trauma. Saakvitne and Pearlman (1996) encourage therapists to 1) create meaning in life, 2) infuse current activities with meaning 3) challenge negative belief and assumptions and 4) participate in community building activities.

Implications for Agencies and Organizations Addressing Vicarious Trauma

Considering therapists working with sex offenders as vulnerable to vicarious trauma has significant implications for agencies/institutions within which sex offender treatment occurs. Research investigating vicarious traumatization among therapists working with traumatized clients indicates that agencies, institutions and organizations may contribute significantly to addressing and transforming trauma among their staff by offering adequate training, supervision, and support to employees (Neumann & Gamble, 1995; Pearlman & Maclan, 1995).

Recognizing that addressing vicarious traumatization is part of ensuring effective and ethical practice is a first step in working with agency staff to address the signs of vicarious trauma (Saakvitne & Pearlman, 1996). Organizations can validate and support staff in efforts to address vicarious traumatization in various ways which serve to offer recognition of the difficult nature of the work, encourage healthy self care within the work place and facilitate connection among staff members. Staff meetings, retreats and social and recreational activities are just some of the strategies which can be initiated at the organizational level to combat vicarious trauma.

The provision of comprehensive training and/or opportunities for continuing education may have particular relevance in mitigating vicarious traumatization among therapists working with sex offenders. Ellerby et al. (1993) reported that most of the participants in his sample lacked offender specific training before they began delivering treatment and felt poorly prepared

to deal with sex offenders. In addition, O'Connell, Leberg and Donaldson (1990) found that therapists working with sex offenders often initially underestimate the severity of their clients' problems and possess unrealistic expectations about their clients' ability to control their offending behavior. Comprehensive training may prepare these therapists to feel more competent in their ability to deal with their clients presenting issues. Realistic expectations surrounding client issues and subsequent treatment may serve to mitigate feelings of professional frustration and disillusionment which can set the stage for vicarious trauma to occur.

Adequate supervision is also essential in addressing vicarious traumatization (Neumann & Gamble, 1995; Pearlman & Maclan, 1995). Supervision offers therapists the opportunity to explore and process the strong countertransference reactions that can both contribute to vicarious traumatization and interfere with the therapeutic relationship (Pearlman & Saakvitne, 1995b). Supervision which is founded in a theoretical orientation which provides an understanding of the impact of trauma on psychological functioning and which provides a safe environment to discuss countertransference reactions is considered optimal. In addition, the supervision experience should include education and discussion about post traumatic stress, and vicarious traumatization, with a focus on symptom management (Saakvitne & Pearlman, 1996).

Conclusion

Although the potential hazards of working with sex offenders are well recognized and discussed among therapists within the field (Ellerby et al., 1993; Kearns, 1995; Mitchell & Melikian, 1995; Polson & McCullom, 1995; Pullen & Pullen, 1996; Scott, 1994), comparatively little research has been conducted to investigate and confirm the nature, extent and severity of what therapists working with this population report experiencing (Bird Edmunds, 1997; Ellerby, 1997; Farrenkopf, 1992). Professional validation of these effects could encourage personal reflection and provide a sense of much needed support to therapists who are often ostracized or criticized by both their personal and professional communities for the work they do (Barbaree, 1989; Ryan & Lane, 1991; Salter, 1988).

For treatment providers, effective work with sex offenders requires the resolution of personal issues producing both strong emotional and trauma reactions which can interfere with the treatment process (Hill, 1995; Peaslee, 1995). Vicarious traumatization offers a framework for exploration into and understanding of the process by which these countertransference and trauma reactions develop. Re-conceptualizing their experiences as vicarious traumatization may also allow therapists working with sex offenders to put their experience in context, explore aspects of their experience, and take appropriate measures to mitigate the effects (Edwards, 1995). These measures may provide added protection against the negative sequelae experienced among a

professional group that works so diligently to contribute to our community's safety.

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CHAPTER 3

PAPER II

An Investigation of the Phenomenon of Vicarious Traumatization Among Therapists Working with Sex Offenders

Background

It could be argued that what makes sex offender treatment different from other forms of therapy is that the risk of psychological harm may be greater for the therapist than it is for the client. Research investigating this potential for psychological harm among these professionals, however, has been limited. The majority of published studies investigating the effect of working with sex offenders have been exploratory in nature, using qualitative approaches to describe therapist reactions to their work. Collectively, this research suggests that therapists working with sex offenders can be significantly and negatively influenced by their work in ways which may produce profound, distressing changes in therapists' perceptions of themselves, others and the world around them (Farrenkopf, 1992; Kearns, 1995; Layton, 1988; Polson & McCullom, 1995).

The global effect of working with sex offenders on therapists has been conceptualized in a number of ways. Labels such as "burnout" and "occupational stress" have been used to describe helping professionals' negative responses to providing psychotherapeutic services (Farber, 1983; Grosch & Olsen, 1994; Maslach, 1982). These concepts may not fully account for the range of responses they experience, however (Bird Edmunds, 1997;

Farrenkopf, 1992). A review of the literature addressing the effects of working with sex offenders suggests that therapeutic contact with this population has the potential to influence therapists' world view, affect regulation and expression, interpersonal relationships, sexuality, parenting behaviors as well as arouse symptoms of psychological trauma, such as nightmares and intrusive imagery (Ellerby, 1997).

Viewing such experiences within the conceptual framework of vicarious traumatization (McCann & Pearlman, 1990) may offer a more useful conceptualization of how these professionals respond to their work. Developed by McCann and Pearlman (1990) to describe and understand the unique effect of trauma work on trauma therapists, vicarious traumatization refers to the process by which the therapist's experience of self and others is negatively affected through empathic bonding with the client's traumatic material. The complex interaction between traumatic material, the process of trauma therapy and core aspects of the therapist's self, results in vicarious trauma. Producing changes in the therapists' world view, self identity, and disrupting cognitive schemas associated with safety and trust, vicarious traumatization can also give rise to symptoms of Post Traumatic Stress Disorder, such as intrusive imagery and nightmares (Pearlman & Saakvitne, 1995a).

Research investigating this phenomenon has almost exclusively been conducted with therapists who work with trauma survivors, (Genest, Levine, Ramsden, & Swanson, 1990; Munroe, 1991; Pearlman & Saakvitne, 1995a; Raphael & Wilson, 1994; Schauben & Frazier, 1995). Although conceived to

understand and describe the impact of trauma work on trauma therapists, vicarious traumatization clearly has the potential to be applied to those working with perpetrators of trauma. Professionals who work with sex offenders encounter similar therapeutic dynamics thought to produce vicarious traumatization, and report effects similar to those of trauma therapists (Farrenkopf, 1992; Jackson, Holtzman, Barnard, & Paradis, 1997; Mitchell & Melikian, 1995; Polson & McCullom, 1995). Preliminary studies linking vicarious traumatization with the provision of sex offender treatment, however, have been limited (Rich, 1997).

Rich (1997) conducted an investigation of vicarious traumatization among professionals working with survivors and/or perpetrators of sexually violent crime. Participants in the sample were divided into two groups based on whether they identified themselves as suffering from vicarious trauma. Demographic information, cognitive schemata and coping behaviors were then compared between those participants who identified themselves as vicariously traumatized (62%) and those who did not. Results indicated that larger proportions of the vicariously traumatized participants experienced difficulties in coping with stress associated with their work. Participants in this sample also reported experiencing distressing images of traumatic material, were easily discouraged, anxious and expressed feeling more at odds with the world than participants who did not identify themselves as vicariously traumatized (Rich, 1997). In addition, a higher percentage of participants who considered themselves vicariously traumatized reported doubts about their ability to manage

the stress of their jobs as opposed to participants not identifying themselves as traumatized. Although this study represents and important first step in investigating the prevalence of vicarious traumatization among clinicians working with sex offenders, there was no attempt to empirically measure the phenomena among participants within the sample. In addition, the study relied on participants to identify themselves as vicariously traumatized, thus limiting conclusions about the prevalence and validity of the phenomena among this population.

Representing the first attempt to operationalize and measure vicarious traumatization, Pearlman and Maclan (1995) explored the relationship between aspects of trauma therapy, the therapist, and the therapist's psychological functioning. They surveyed a sample of 188 self-identified "trauma therapists" using four measures; (a) the Traumatic Stress Institute Belief Scale (TSI), a measure developed to assess cognitive disruptions in psychological need areas sensitive to trauma; (b) the Impact of Event Scale (IES) to confirm trauma related distress; and (c) the Symptom Checklist – 90 - Revised (SCL – 90), to differentiate general distress from trauma related distress. The TSI was found to have significant correlations with the intrusion and avoidance subscales of the IES, consistent with the hypothesized relationship between disrupted cognitive schemas and symptoms of trauma related distress. Therapists newest to trauma work and those who reported a personal history of trauma experienced the most psychological disruption as measured by the TSI, IES and SCL – 90.

The current study is intended to determine whether or not therapists working with sex offenders exhibit signs of vicarious traumatization, to identify predictive or mitigating factors associated with the phenomena and to differentiate vicarious traumatization from burnout. It was hypothesized that if therapists working with sex offenders were experiencing vicarious traumatization, they would exhibit evidence of cognitive disruptions, as measured by the TSI, at levels similar to or higher than a criterion reference group of general Mental Health Professionals who had attended trauma training workshops (Pearlman, 1996). Given the aforementioned parallels between the dynamics of trauma therapy and offender therapy, variables identified by Pearlman and Maclan (1995) such as length of time working with offenders and personal trauma history, were expected to be significant predictors of vicarious trauma as measured by the TSI.

While vicarious traumatization and burnout are conceptually similar (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a; Schauben & Frazier, 1995), the two constructs are thought to be distinct by those conducting research in the area of vicarious traumatization (Pearlman & Saakvitne, 1995b; Schauben & Frazier, 1995). It was therefore hypothesized that while the TSI would have significant correlations with the Maslach Burnout Inventory – Human Services Survey, these correlations would not be as strong as those found between the TSI and IES.

Method

Participants

Target participants for this research project were therapists currently providing sex offender treatment in Canada. A total of 220 individual surveys were distributed to therapists working with sex offenders in British Columbia, Alberta, Saskatchewan, Manitoba and Ontario. A response rate of 43% was attained with 93 surveys completed and returned. This response rate is consistent with previous research which has found response rates from therapists between 37% (Kassam–Adams, 1994) to 58% (Pope & Feldman-Summers, 1992).

In order to limit the sample to therapists working predominantly with sex offenders, the participants' current work with non-offending survivors of trauma was assessed in the independent measure. For those who identified themselves as working with non-offending survivors of trauma (19.0 %), only those who indicated that they worked less (6.7 %) or a great deal less (11.2 %) with trauma survivors compared to sex offenders were included in the sample. Two participant surveys did not meet this criteria, and were subsequently excluded from the final sample, for a total of 91 participants.

Procedure

Contact persons currently working with sex offenders in Canada who identified themselves to the researcher (via individuals within Correctional Services of Canada and Community and Youth Corrections) were pre-contacted by telephone and the purpose of this study was explained. These individuals

were then asked if they would be willing to receive and/or distribute individual survey packages to therapists within their program, institution or agency. The majority of survey packages (165) were grouped and sent to contact individuals for distribution to individual treatment providers. The remaining survey packages (55) were sent directly to individual therapists.

Each survey package contained the independent and dependent measures, with a letter explaining in detail the purpose of the intended research and instructions as to how to complete the enclosed materials (see Appendix A). Potential participants were informed that their participation in this study was on a voluntary and confidential basis. No information which would identify them or their program or was collected.

Survey recipients were instructed that should they consent to participate in this study they were to complete the survey materials and return them to the researcher in the self addressed stamped envelope that was provided. Due to the sensitive nature of the questions on both independent and dependent measures, and in efforts to ensure confidentiality, participants completed and returned the measures anonymously.

Measures

The Treatment Provider Survey, is a 24 item questionnaire developed and utilized as an independent measure (see Appendix B) to examine therapist demographics, their work with sex offenders, and also to determine predictive factors of Vicarious Traumatization and Burnout. The Treatment Provider Survey included questions used by Pearlman & Maclan (1995) relating to the

therapists' length of time in the field, exposure to traumatic material, work setting, supervision arrangements, education, presence of a personal trauma history, and whether they addressed the effects of their work in personal therapy. Additional information regarding venues to address personal impact of work, offender risk type, program intensity, specialized training, previous trauma work, and the amount of clinical time spent working with sex offenders was included on the basis of previous research (Adams & Betz, 1993; Bird Edmunds, 1997; Ellerby, 1997; Farrenkopf, 1992).

The Traumatic Stress Institute Belief Scale - Revision L (TSI; Pearlman, 1996) is an 80 item questionnaire which measures disruptions in the five psychological need areas hypothesized to be sensitive to trauma - safety, trust, intimacy, control and power - relative to self and others yielding 10 subscale scores (see Appendix C). The overall reported reliability (Cronbach's alpha) of the TSI is .98 (Pearlman, 1996). Subscale reliabilities range from .77 for Other Control to .91 for Self Esteem (Pearlman, 1996).

The TSI yields a total score which represents the overall extent of cognitive disruption. Higher scores represent greater levels of disturbance. The TSI was utilized in the current study to determine the overall level of cognitive disruption indicative of vicarious traumatization, for therapists working with sex offenders.

Impact of Event Scale (IES; Horowitz, Wilner & Alvarez, 1980) is a 15 item self report measure which has been used to assess reactions to stressful events with diverse populations. Containing two subscales - Intrusion and

Avoidance - the IES assess the central features of Post Traumatic Stress Disorder. Reliability data indicates good internal consistency, with coefficients of .86 for the Intrusion subscale and .90 for the Avoidance subscale (Fischer & Corcoran, 1994).

Participants in this study were directed to indicate how frequently (on a four point Likert – like scale) each of the 15 statements made by individuals following stressful life events were true for them with regards to their work with sex offenders (see Appendix D). The Impact of Event Scale was used in this study to identify trauma related distress among therapists associated with offender work, consistent with vicarious traumatization (Pearlman & Maclan, 1995).

The Maslach Burnout Inventory - Human Services Survey (MBI; Maslach, Jackson, & Leiter, 1996) is a 22 item questionnaire designed to assess the three central aspects of burnout: emotional exhaustion, depersonalization and decreased sense of personal accomplishment (see Appendix E). The MBI has been used extensively with mental health professionals with reported reliability coefficients (Cronbach's alpha) of .90 for the Emotional Exhaustion subscale, .79 for Depersonalization and .71 for Personal Accomplishment (Maslach, Jackson & Leiter, 1996). The measure produces three scores for each of the three aspects of burnout which although cannot be combined, can each be categorized into high moderate or low levels, relative to normative sample data.

Results

Demographic Information

The sample consisted of 91 participants; 49 women and 42 men. Ages ranged from 21 to 78 years of age, with a mean age of 41 years. Participants varied in terms of the length of time they had been working with sex offenders. A total of 18.9% reported they had been working between 0 and 2 years, 25.6% between 2 and 5 years, 25.6% between 5 and 10 years, 20.0% between 10 and 15 years and 10.0% reported they had been working with this population for over 15 years. Of the sample 48.4% indicated that they were exposed to enormous amounts of traumatic material, 29.7% reported a great deal of exposure and 22.0% experienced moderate amounts. The majority of participants, 64.8% reported that they were supervised by a professional, however, 35.2% indicated that they were not currently receiving supervision. Of those receiving supervision, 47.5% indicated that their supervision experience addressed treatment issues only, for 42.4% supervision addressed both treatment issues and the personal impact of the work, and 5.1% reported that supervision addressed only the personal impact of the work.

Participants were also asked to indicate if they felt that they had a venue either within or outside their work setting within which they felt that they could address the personal effect of their work. Of the sample, 58.9% indicated that they did have a venue to address the impact of their work, 42.1% reported that they did not. Of particular interest also is that 70.3% indicated that they had received specialized training either through their employing agency, professional

workshops, conferences or formal academic institutions to prepare them to work with sex offenders. The remaining 29.7% reported that they had received no training specific to sex offender treatment. Additional demographic information is presented in Table 2 - 1.

Overall, the demographic characteristics of the sample are representative of therapists working with sex offenders in Canada (Wormith & Borzecki, 1985). The sample did differ from previous research which found much higher proportions of therapists working with this population who had a personal history of being sexually abused or sexually assaulted (Hilton, Jennings, Drugge, & Stephens, 1995). This discrepancy may be due to Hilton et al. (1995) using a comprehensive checklist of experiences constituting abuse to determine prevalence rates, as opposed to asking participants in the present study to identify themselves as survivors of sexual abuse/assault.

Table 2 – 1

Percentages of Participants Within Sample Corresponding to Specific Demographic Information.

Highest Degree Obtained		***Professional Designation***	
Diploma/Certificate	29.7%	Therapist/Counsellor	22.0%
Bachelors Degree	33.0%	Social Worker	11.0%
Masters Degree	27.5%	Nurse	23.1%
Doctorate	8.8%	Psychologist	15.4%
Medical Degree	1.1%	Psychiatrist	1.1%
		Correctional Officer	2.2%
Length of Time Working with Offenders		Probation/Parole Officer	17.6%
0 – 2 years	18.9%	Other	7.7%
2 – 5 years	25.6%		
5 – 10 years	25.6%	***Received Specialized Training***	
10 – 15 years	20.0%	Yes	70.3%
over 15 years	10.0%	No	29.7%

How Training Was Acquired	
Employing Agency	20.9%
Workshops/Conferences	7.5%
Academic Institution	1.5%
Combination of Above	67.2%
Other	3.0%

Training Adequate to Work with Offenders	
Not at All	0.0%
Minimally	15.2%
Moderately	50.0%
A Great Deal	34.8%

Training Adequate to Prepare for Personal Impact of the Work	
Not at All	7.6%
Minimally	33.3%
Moderately	43.9%
A Great Deal	15.2%

Exposure to Traumatic Material	
Moderate Amount	22.0%
A Great Deal	29.7%
Enormous Amount	48.4%

Clinical Time Spent with Sex Offenders	
Minimal Clinical Time	14.3%
Half of Clinical Time	19.8%
Majority of Clinical Time	29.7%
Nearly all Clinical time	36.3%

Work Setting	
Hospital	20.9%
Correctional Institute	30.8%
Community Program	38.5%
Multiple Settings	6.6%
Other	3.3%

Addressed Work Impact in Personal Therapy	
Yes	17.8%
No	82.2%

Treatment Program Intensity	
Intensive	46.2%
Intermediate	14.3%
Low	25.3%
Combination	9.9%
Other	4.4%

Individual vs. Group Work with offenders	
Mostly Individual Contact	17.6%
Mostly group Work	45.1%
Both Individual & Group Work	34.7%

Venue to Address Personal Impact of work	
Yes	58.9%
No	42. 1%

Type of Offenders Worked With	
High Risk	38.9%
Moderate Risk	20.0%
Low Risk	1.1%
Special Needs	1.1%
Combination	38.9%

Currently Supervised	
Yes	64.8%
No	35.2%

Personal History of Sexual Abuse/Assault	
Yes	8.8%
No	91.2%

Supervision Experience	
Addresses Treatment Issues	47.5%
Addresses Personal Impact	5.1%
Addresses Treatment Issues and Personal Effects of the Work	42.4%

Presence of Vicarious Trauma

In order to test the hypothesis that therapists working with sex offenders exhibit signs of vicarious trauma, participant scores for the TSI were compared with the criterion reference group of mental health professionals. A t test for a

single mean was used to determine if the sample TSI mean (167.36, SD = 35.56) and the criterion reference group mean (166.38, SD = 36.23) differed significantly. They did not, ($t = .07$, $df = 91$, $p > .001$), supporting the hypothesis.

To identify predictive or mitigating factors of cognitive disruption as measured by the TSI, the Eta statistic was first calculated to determine the proportion of variance within the TSI total score that could be accounted for by each of the independent variables. Variables accounting for significant proportions of variance were then to be selected to enter into a step-wise multiple regression. Only three independent variables were found to account for more than 10% of the variance for the TSI total score: 1) the participant's professional designation (Eta = .315), 2) whether the participant worked primarily in individual, group or both types of settings (Eta = .364) and 3) whether or not participants felt they had a venue in or outside their work setting to address the personal impact of their work (Eta = .321). None of these three variables were found to have significant predictive power for scores on the TSI, however.

While differences among TSI mean scores for therapists with a personal history of sexual abuse/assault were to be explored, only 8 therapists in the sample identified themselves as having a personal trauma history. This was not a sufficient sample size to allow meaningful statistical investigation. It is interesting to note, however, that as a group, survivor therapists' scores on the TSI (mean = 182.63, SD = 23.54, range = 141 - 209) were comparably higher

than for therapists without a trauma history (mean = 165.87, SD = 36.28, range = 92 - 275).

Overall scores on the IES indicated a mean score of 8.1 (SD = 7.65) for the Intrusion subscale, 8.9 (SD = 7.59) for the Avoidance subscale and a mean of 16.6 (SD = 13.30) for the overall IES measure. Overall scores on this measure above 26 are considered to reflect moderate to severe reactions to the stress inducing event.

Vicarious Trauma and Burnout

To test the hypothesis that the TSI would show stronger correlations with the IES than the MBI, the Pearson Product Moment Correlation was employed to investigate the relationships among the dependent measures. Table 2 - 2 presents the intercorrelations among the TSI, IES, and MBI. The TSI total score showed moderate positive correlations with the IES total score and the Intrusion and Avoidance subscales. Contrary to the hypothesis, however, stronger correlational relationships were found between the TSI and the three subscales of the MBI, showing the strongest relationship with the Emotional Exhaustion subscale. High positive correlations were obtained between TSI and the Emotional Exhaustion and Depersonalization subscales. The TSI was found to be moderately negatively correlated with the Personal Accomplishment subscale.

Table 2 - 2

Pearson Product – Moment Intercorrelations Among Dependent Variables

Variable	1	2	3	4	5	6	7
1. TSI Belief Scale	—	.407**	.322**	.342**	.621**	.595**	-.562**
2. IES Total Score		—	.833**	.937**	.494**	.535**	-.240*
3. Intrusion			—	.662**	.433**	.444**	-.186
4. Avoidance				—	.417**	.501**	-.225*
5. Emotional Exhaustion					—	.748**	-.332*
6. Depersonalization						—	-.449*
7. Personal Accomplishment							—

* $p < .05$ ** $p < .01$

Examination of the relationship between the MBI and IES revealed moderate positive correlations between the IES total score, Intrusion and Avoidance subscales and with the Emotional Exhaustion and Depersonalization subscales of the MBI. Personal Accomplishment showed a similar low negative correlation with the IES total score and the Avoidance subscale. There was no significant relationship, however, between Personal Accomplishment and the Intrusion subscale.

In order to more fully understand the experience of burnout in the participant sample, MBI levels and their relationship to demographic characteristics were examined. The sample means for each of the three burnout

subscales were as follows; Emotional Exhaustion, mean = 19.42, SD = 10.73, Depersonalization, mean = 8.34, SD = 5.63, and Personal Accomplishment, mean = 37.78, SD = 6.28. Participants' mean scores were compared with occupation specific normative samples of mental health professionals. Of the sample, 39.6% scored within the low range on the Emotional Exhaustion subscale, compared to 37.4% in the moderate range and the remaining 23.1% were within the high range on this subscale. On the Depersonalization subscale, 45.1% of the sample scored within the low range, 31.9% in the moderate range and 23.1% in the high range. Overall, the obtained samples' scores were within the moderate range for Emotional Exhaustion, the high range for Depersonalization, and low range for Personal Accomplishment compared to other mental health professionals (Maslach, Jackson & Leiter, 1996).

Phi Coefficients were calculated to determine if there were significant associations between the categorical levels of the three burnout subscales and the independent variables. Independent variables showing a significant degree of association with one or more of the subscales are shown in Table 2 - 3. Analysis showed that six of the independent variables had significant associations with at least one of the MBI subscales: work setting, if supervision addressed personal effects of their work, if participants' had a venue within or outside their work setting to explore personal impact of work, length of time working in the field, perceived amount of exposure to traumatic material, and if participants' had received specialized training for their work.

Table 2 - 3

Phi Coefficient Values Indicating Associations Between Independent Variables and Maslach Burnout Inventory Subscales

Independent Variables	Emotional Exhaustion	Depersonalization	Personal Accomplishment
Work Setting	.352*	.316	.197
Venue	.208	.279*	.242
Training	.059	.105	.346**
Exposure	.189	.205	.360*
Supervision	.121	.216	.337*
Time	.221	.248	.309*

* $p < .05$ ** $p < .01$

Note. Independent Variables: Work Setting: What is your work setting? - (Hospital Correctional Institute or Community Agency). Venue: Do you have a personal venue within/outside work setting to explore the personal impact of your work? - (Yes/No). Training: Do you have specialized training? - (Yes/No). Exposure: How much exposure do you have to traumatic & graphic material? - (Moderate/Great Deal/Enormous Amounts). Time: Number of years working in the field? - (Under 5 years/Over 5 years). Supervision Experience: Does your supervision experience address the personal effects of this work? - (Yes/No).

Significant moderate associations were found between work setting and Emotional Exhaustion, and also between Depersonalization and participants' identification of a venue to address personal aspects of their work. The Personal Accomplishment subscale was significantly associated with the remaining four independent variables (specialized training, exposure to traumatic material, supervision experience and length of time working with sex offenders) showing the strongest degree of association with the amount of exposure to traumatic material.

Independent variables exhibiting a significant degree of association to one or more of the three burnout subscales were then entered into Chi Square Analysis to test for independence. A significance level of .10 was used in these analyses to identify possible differences between groups. Although this is a liberal level of significance, which increases the probability of Type I Error, it was deemed appropriate in this case due to the exploratory nature of the analysis, and in order to generate further research questions and areas of investigation.

A total of 18 Pearson Chi Square tests were conducted. To control for incremental Type I Error associated with this number of tests of independence, an experimentwise error rate of 10% was achieved by apportioning an alpha of .005 for each of the dependent variables. These results revealed that only one test of independence was significant; Specialized Training and Personal Accomplishment (X^2 =10.916, df = 2). Goodman's post hoc procedure was then used to identify statistically contrasts for Specialized Training across levels of Personal Accomplishment. Results from this comparison procedure showed a

significant difference among those who had received training and those who did not between the low and high levels of Personal Accomplishment ($Z = -2.888$, $df = 2$, $p<.05$). Significantly more participants who had received training (85%) fell into the low category (indicating a high levels of feelings of competency and accomplishment in one's work) of Personal Accomplishment than participants who did not receive training (41%). The proportion of participants within the high level (indicating lower levels of feelings of competency and accomplishment in one's work) of Personal Accomplishment was approximately equal between those with training (53%) and those without (47%).

Discussion

This study was conducted to determine whether or not therapists working with sex offenders exhibit signs of vicarious traumatization, identify predictive or mitigating factors and differentiate vicarious traumatization from burnout.

Are Therapists Working with Sex Offenders Vicariously Traumatized?. It was hypothesized that if vicarious traumatization was present among participants in the sample, mean scores on the TSI would be as high, if not higher, than mean TSI scores for a criterion reference group of Mental Health professionals sampled at a trauma training workshop. Although this hypothesis was supported, closer examination of the relationship between the TSI and MBI suggests that the concept of vicarious trauma has not yet been clearly established in relation to burnout.

It was hypothesized on the basis of previous research that variables such as the length of time working in the field and having a personal trauma history

would be significant predictors of vicarious trauma (Neumann & Gamble, 1996; Pearlman & Maclan, 1995; Schauben & Frazier, 1996). The obtained sample did not contain an appropriate number of participants with a personal trauma history to conduct statistical analyses, and none of the other independent variables were significant predictors of vicarious trauma. Given the apparent importance of many of these factors in the development and severity of vicarious trauma, this result is surprising, and again serves to question the construct validity of the TSI.

Generalizing the concept of vicarious trauma to therapists working with sex offenders is dependent on the assumption that the graphic and violent material content of the therapy is sufficient to produce the phenomena. While there are parallels between therapy with trauma survivors and sex offenders, such as traumatic enactments (Pearlman & Saakvitne, 1995a), clinician's experience of providing therapy to perpetrators of abuse is quite different than to victims. This discrepancy may account for the findings that similar contributing factors to vicarious trauma were not found for participants within this sample.

Relationship Between Vicarious Trauma and Burnout. The relationships found among the dependent measures are of particular interest. Correlational patterns were investigated in an attempt to distinguish between vicarious trauma and burnout among participants. It was hypothesized that while the TSI would have significant correlations with the MBI, these correlations would not be as strong as those found between the TSI and IES as these measures are both designed to assess aspects of trauma. The results, did not support this

hypothesis; vicarious trauma as measured by the TSI is more highly correlated with burnout than with symptoms of post traumatic stress. A potential explanation however, may lie in that the TSI primarily focused on the cognitive aspects of vicarious trauma as opposed to the emotional consequences of the phenomena. The MBI may tap the emotional aspect or reactions not assessed by the TSI which are related to vicarious trauma, thus accounting for high correlations among these two measures.

These findings give cause for caution in the interpretation of participant scores on the TSI, as the measure appears to be tapping into aspects of both vicarious trauma and burnout. In light of the fact the two constructs have been suggested to be distinct, however, the construct validity of the TSI requires closer examination. The correlational findings also suggest a complex interaction between the experience and signs of vicarious trauma and burnout as measured by the TSI and MBI respectively, which requires the attention of further research.

Aspects of Burnout Among Participants. Scores on the MBI subscales yielded valuable information regarding therapists' overall levels of emotional exhaustion, depersonalization and personal accomplishment. High scores on the Emotional Exhaustion and Depersonalization subscales are thought to be the hallmarks of professional burnout (Maslach, Jackson, & Leiter, 1996). Participant scores indicate that about one fifth of the sample fell within the high range on each of these two subscales. Previous research investigating burnout

among therapists working with sex offenders have found similar prevalence rates of approximately 25% (Bird Edmunds, 1997; Farrenkopf, 1992).

Of particular interest are the sample's high scores in comparison to other mental health professionals on the Depersonalization subscale of the MBI. Reflecting the antithesis of core aspects of empathy and empathic engagement, the Depersonalization subscale measures indifferent, cynical and impersonal attitudes towards clients. Explanations for these high levels of cynicism and negative feelings towards clients in comparison to other mental health professionals may lie in closer examinations of the therapeutic dynamics of sex offender treatment.

Hill (1995) has suggested that the required interactions between the offender client, society and institutional/agency mandates produces a unique pattern of engagement and disengagement with the client throughout therapy. Empathic engagement with both the client and subsequent trauma material may, therefore, be disrupted throughout the therapy process. These disruptions may possibly facilitate a sense of disconnection from these clients, which may foster the development of attitudes and beliefs which depersonalize the therapists' experience of the offender client. Potentially this could also prevent empathic bonding to the offender client's traumatic material, thus reducing the potential for vicarious trauma to occur.

Higher scores on this subscale compared to other mental health professionals, may also be related to the content of offender therapy. The development of attitudes and beliefs which depersonalize the client may serve to

neutralize the toxicity of the graphic and violent material presented in therapy. For therapists working with sex offenders, depersonalizing these clients could be conceptualized as an effective coping strategy to protect themselves from being contaminated by the disturbing nature of their clients' presenting issues. Emotional and empathic distancing may provide therapists with a buffer against the traumatic enactments, which often occur within offender treatment.

The clinical implications of these findings are significant. The establishment of a genuine and empathic therapeutic relationship has been reported by sex offender clients as a highly important aspect of successful treatment (Polson & McCullom, 1995). Therapists' depersonalization of clients interferes in this process. A better understanding of the role that depersonalization of offender clientele plays within the therapeutic relationship may be another necessary step in conceptualizing the effect of this work on clinicians.

Consistent with the findings of previous research (Bird Edmunds, 1997; Farrenkopf, 1992), the results of this study indicate that participants in this sample as a group had a high degree of job satisfaction. Specialized training in the area of sex offending behaviour and treatment was found to be associated with high levels of personal accomplishment, consistent with the findings with other populations (Penn, Romano & Foat, 1988; Shapiro, Burkey, Dorman, & Welker, 1996). Specialized training may be of particular relevance for therapists working with this population. Research suggests that therapists initially tend to underestimate the severity of sex offender clients' problems and possess

unrealistic expectations about their client's ability to control their offending behaviour (O'Connell, Leberg & Donaldson, 1990).

The majority of participants who indicated they had receiving special training felt that it had prepared them to work with sex offenders. Specialized training may have served to combat unrealistic expectations that could have lead to frustration and disillusionment that could produce reduced scores on the Personal Accomplishment subscale. In addition, the findings within this sample indicate that the benefit of specialized training is not limited to that received through formal academic institutions. The vast majority of participants in the sample received training from a variety of sources, most often through a combination of professional workshop, agency training and formal academic courses.

Limitations and Delimitations. It must first be noted, that this study represents an initial attempt to examine the possibility of Vicarious Trauma among therapists working with sex offenders using the TSI. The lack of control for variables such as prior exposure to trauma and personal trauma history within the criterion reference group of mental health professionals for the TSI, posed serious limitations in terms of this measure's potential to identify the presence of vicarious trauma within this sample. Given also the exploratory nature of this study and the lack of available research into the impact in working with sex offenders, results will need further exploration and replication. Although the sample, across several demographic variables, appeared representative of therapists working with sex offenders in Canada, systematic differences may

exist between those individuals who chose to participate in this study and those who did not. Liberal levels of significance were also employed throughout statistical analyses, thus increasing the probability of Type I error.

Recommendations for Future Research. Emerging from this investigation are a number of recommendations for future research. While the TSI has been used with therapists working in the area of trauma and among individuals who have experienced trauma directly, it has yet to be administered to therapists not involved in trauma therapy. In theory, therapists working with trauma survivors would have significantly higher TSI scores than other therapists who do not work with trauma. In light of the fact that there is no data on how therapists not working with trauma score on the TSI, caution should be exercised in making the diagnosis of vicarious trauma based on this instrument.

It appears essential that the TSI be further validated on other populations that have not had exposure or experience with severe trauma. These investigations would serve to establish more appropriate comparison groups and possibly assist in the determination of a TSI minimum score above which vicarious trauma would be judged to be present. Investigations which use the TSI in a pre and post group within subjects design may also assist in determining the validity of the measure. For example, therapists in training or volunteers at a sexual assault center who have not witnessed or have personal trauma histories at the beginning of their program/training would be administered the TSI before and after they have been exposed to traumatic material.

The results of this study also suggest that a significant amount of overlap exists between the phenomena of vicarious trauma and burnout. Further investigations are needed to more clearly differentiate the two constructs or more clearly explain the interrelationship between them. These endeavors may encourage examination of the construct validity of the TSI, as it is unclear at this point if the measure is an acceptable measure of vicarious trauma, or if it is largely measuring burnout.

The findings of this study also suggest that further research into the therapeutic connection therapists form with sex offender clients is of great clinical relevance. Qualitative investigations which focus on the therapist's experience of connection to these clients may offer important clues about strategies used to foster and maintain a sense of connection or empathy. This type of research is also essential to identify aspects of the therapeutic relationship which may contribute to some therapists' depersonalization of sex offender clients.

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CHAPTER 4

SUMMARY

The purpose of this study was to explore the effects of working with sex offenders on therapists, to establish empirical support of the presence of vicarious trauma, and to identify mitigating factors of this process among participants in this sample.

Review of Research Findings

Therapists working with sex offenders face a multitude of stressors associated with the process of conducting therapy with offender clientele, as well as difficulties associated with these clients' individual characteristics (Ellerby, Gutkin, Smith, & Atkinson, 1993; Farrenkopf, 1992). Literature suggests that therapeutic contact with sex offenders can be psychologically harmful for those providing treatment services (Ellerby, 1997; Farrenkopf, 1992; Jackson, Holzman, Barnard, & Paradis, 1997). The effects reported by therapists suggest that with this population has the potential to be traumatizing and can produce significant emotional, interpersonal and behavioral changes as a direct consequence of their work (Bird Edmunds, 1997; Ellerby, 1997; Jackson et al., 1997), consistent with the phenomena of vicarious trauma (McCann & Pearlman, 1990).

Empirical evidence for the presence of vicarious trauma among this population, however, proved inconclusive. The Traumatic Stress Institute Belief Scale – Revision L (Pearlman, 1996), used to measure and diagnose vicarious trauma was found to require further validation before statements regarding the

presence of vicarious trauma can be confidently made. Results of this study also suggest that a significant amount of overlap exists between the phenomena of vicarious trauma and burnout. Further investigations are needed to more clearly differentiate the two constructs or more clearly explain the interrelationship between them.

In comparison to other mental health professionals, participants in this study exhibited moderate levels of Emotional Exhaustion, high levels of Depersonalization and high levels of Personal Accomplishment. The high levels of Personal Accomplishment among this population were somewhat surprising given the difficulties associated with providing sex offender treatment. These results, however, suggest that as a group participants within this sample are able to find meaning in the work and feel that their efforts are contributing to positive client growth and change. The acquisition of specialized training in the area of sex offending behavior and treatment was found to be particularly important in developing and maintaining a sense of personal accomplishment while working with this population.

Although the empirical results of this study were inconclusive as to the presence of vicarious trauma among therapists working with sex offenders, the concept has high clinical appeal for those working in the field (Jackson et al., 1997; Pullen & Pullen, 1996; Rich, 1997), and appears to have even greater practical applications. Strategic interventions at both the individual and organization level to acknowledge, address and treat the effects of working with difficult populations have been proposed and encouraged in the hopes of

transforming the experience of vicarious trauma (Saakvitne & Pearlman, 1996). These strategies, which serve to address both the symptoms of trauma and the internal changes in therapist's sense of self and others, appear highly relevant to therapists working with sex offenders regardless of whether their experience is labeled as "vicarious trauma".

Viewing the experiences of therapists working with sex offenders within the framework of vicarious trauma may be somewhat premature, given the limited research in this area and the differences between the process of conducting psychotherapy with clients who have survived trauma as opposed to clients who have perpetrated trauma. The clinical relevance and potential practical applications of the concept for therapists working with sex offenders, however, warrants further investigation. Although this research was limited in providing support for a comprehensive framework from which to understand the effects of working with sex offenders on therapists, the study was successful in terms of providing information on the pattern of burnout among this population and generating areas of future research.

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APPENDIX A

Participant Contact Letter

Michaela Kadambi

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T5K 0P1
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January 1, 1998

Dear Treatment Provider,

I am an Educational Psychology Graduate student at the University of Alberta, currently working on my Master of Education Degree in Counseling Psychology. For my Masters thesis project, I will be investigating the impact working with sex offenders has on therapists. I am writing to request your participation in a research study that will explore the extent to which therapists are personally affected by their work.

You as a treatment provider, along with your colleagues, are familiar with the professional and personal challenges associated with working with this particular population. Although these challenges are well recognized by those who work in the field, little empirical research has been undertaken. By participating in this research project you have the opportunity to contribute to, and focus attention on an exceptionally important area of investigation. By undertaking this research, I hope to better our understanding of how working with sex offenders impacts treatment providers, thereby possibly assisting individuals and agencies in their efforts to promote a healthy working environment.

Enclosed with this letter are four questionnaires; one asks for background information and the other three assess potential areas of personal impact. It should take you approximately thirty minutes to complete all four.

In efforts to assist in the development of the Traumatic Stress Institute Belief Scale, and establish normative data, anonymous participant scores on the measure and general demographic information (age, gender and education) will be forwarded to Dr. Laurie Anne Pearlman, developer of the scale.

Your participation in this study is on a ***voluntary*** and ***confidential*** basis. All information obtained as a result of your participation in this study, will remain confidential. In addition, only general overall group findings will be passed on to the agencies, institutions or individuals involved in sex offender treatment. No information that is specific to you as an individual or data that will identify a single institution/agency will be included in the discussion of the research findings. Each institution, agency or individual who participates

in this study will receive a detailed summary of the results, and final copy of the research upon completion.

Your participation in this study would be greatly appreciated. Should you decide to consent to participate in this study, please complete all four enclosed measures and return them in the envelope provided. This form may be kept for your own records.

If you have any questions or concerns, please do not hesitate to contact me (Michaela Kadambi [403 - 454 - 8338] or <<mkadambi@gpu.srv.ualberta.ca>>) or my university advisor, (Dr. Derek Truscott [403 - 492 - 1161] or <<dtruscott@ualberta.ca>>).

Sincerely,

Michaela A. Kadambi, B.Sc.
University of Alberta

It would be appreciated if completed measures are returned as soon as possible, preferably before February 10, 1998.

Thank - you for your participation

APPENDIX B

The Treatment Provider Survey

Treatment Providers Survey

This questionnaire is designed to collect information about you as a treatment provider, and details about the nature and setting of your work with sex offenders.

It is important that all questions are answered, please note that all measures are double sided.

All information obtained through this study will be kept confidential, and you will return the completed measures anonymously. Thank - you again for your assistance in this research project.

Demographic Information

Age: _____

Gender *(Please circle)*

1. Male
2. Female

Highest Education Obtained

1. Diploma/Certificate
2. Bachelors Degree
3. Masters Degree
4. Doctorate of Philosophy
5. Medical Degree
6. Other: Specify _____

Professional Designation:

1. Therapist/Counselor
2. Social Worker
3. Nurse
4. Psychologist
5. Psychiatrist
6. Correctional Officer
7. Probation/Parole Officer
8. Other (Specify):_____

Information Regarding Work & Work Setting

(Please Circle)

1. **Are you presently working with non-offending survivors of trauma (sexual abuse/assault survivors, spousal abuse survivors, war veterans etc.) in conjunction to your clinical work with sex offenders?**

    1. Yes
    2. No (Go to Question #3)

2. **If you are currently working with non-offending trauma survivors, how would you estimate the amount of your clinical time you spend working with trauma survivors as compared with your clinical work with sex offenders?**

    0. I work a great deal *more* with non-offending trauma survivors than I do with sex offenders
    1. I work *equally* with non-offending trauma survivors than sex offenders
    2. I work *less* with non-offending trauma survivors than sex offenders
    3. I work a *great deal less* with non-offending trauma survivors as compared with my work with sex offenders

3. **How long have you been working with sex offenders?**

    1. 0 - 2 years
    2. 2 - 5 years
    3. 5 - 10 years
    4. 10 - 15 years
    5. 15 - 20 years
    6. 20 + years

4. **Have you received specialized training in order to prepare you to work with sex Offenders?**

    1. Yes
    2. No (Go to question #8)

5. **How have you acquired this training?**

    1. Training offered through employing institution/agency
    2. Professional workshops or conferences
    3. Through an academic institution
    4. Other(Specify)_____

6. **Do you feel that the specialized training you have received has adequately prepared you to work with this population?**

    1. Not at all
    2. Minimally
    3. Moderately
    4. A great deal

7. **Do you feel that the specialized training that you have received has adequately prepared you to deal with the feelings and personal reactions you may have to this work?**

    1. Not at all
    2. Minimally
    3. Moderately
    4. A great deal

8. **How much exposure do you currently have to graphic/traumatic material regarding sex offenders' offenses or offending history?**

    1. None
    2. Moderate Amount
    3. Great Deal
    4. Enormous Amount

9. **In your estimation, how much of your clinical time is spent working directly with sex offenders?**

    0. Minimal amount of time
    1. About half the time
    2. Majority of time
    3. Nearly all clinical time

10. **What is your work setting?**

    1. Hospital
    2. Correctional Institute
    3. Community Based Program
    4. Multiple Work Settings
    5. Other (specify)_____

11. **Within your work setting do you work with sex offenders *mostly*:**

    1. On an individual basis
    2. In a group setting
    3. Work equally between individual and group settings

12. Regarding your work setting with sex offenders, do you provide therapeutic treatment within what may be considered:

1. An *intensive treatment* program (usually residential program of more than 8 months within a specialized treatment facility/organization)
2. An *intermediate intensity* treatment program (usually non-residential program offered within a general institution/agency)
3. A *low intensity* treatment program (typically relapse prevention type programs offered through minimum security institutions or community based agencies)
4. Combination (Specify)

_____

5. Other: (Specify)

_____

13. Regarding your work with sex offenders, do you work *mostly* with:

1. High Risk Offenders
2. Moderate Risk Offenders
3. Low Risk Offenders
4. Special Needs Offenders
5. Combination (Specify): _____

14. Regarding your provision of treatment services to sex offenders are you:

1. Currently supervised by a professional
2. Currently not supervised by a professional (go to question 16)

15. Does your supervision experience:

1. Address the personal and professional impact that working with this population has on you as a treatment provider?
2. Address clinical treatment issues in dealing with this population?
3. Addresses both the personal impact of this work and treatment issues?
4. Other (specify)

_____

_____

16. Is there a venue for you to address and explore the personal impact of working with this population?

1. Yes
2. No

If you answered "Yes" to the above question, please specify how and with whom this is accomplished (on a general level, no information identifying specific individuals is needed):

1. Within Work Setting (Please Specify)

_____

_____

2. Outside Work Setting (Please Specify)

_____

_____

17. Have you ever addressed the effects of your work in your own personal therapy?

1. Yes
2. No

18. Do you yourself have a personal trauma history of being sexually abused or assaulted?

1. Yes
0. No

19. Do you yourself have a personal history of perpetrating sexual abuse or assault?

1. Yes
2. No

20. What are the positive aspects, or rewards that motivate you to provide and continue to provide treatment services to sex offenders?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

APPENDIX C

The Traumatic Stress Institute Belief Scale – Revision L

AGE:_____ GENDER:_____ EDUCATION (highest grade level completed): _____

ETHNICITY (circle one): Asian African American Hispanic Native American White Other

TSI BELIEF SCALE Revision L (c)

This questionnaire is used to learn how individuals view themselves and others. As people differ from one another in many ways, there are no right or wrong answers. Please place next to each item the number from the scale below which you feel most closely matches your own beliefs about yourself and your world. Try to complete every item.

1	2	3	4	5	6
Disagree strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Agree Strongly

_____1. I generally feel safe from danger.
_____2. People are wonderful.
_____3. I can comfort myself when I'm in pain.
_____4. I find myself worrying a lot about my safety.
_____5. I don't feel like I deserve much.
_____6. I can usually trust my own judgment.
_____7. I feel empty when I am alone.
_____8. I have a lot of bad feelings about myself.
_____9. I'm reasonably comfortable about the safety of those I care about.
_____10. Most people destroy what they build.
_____11. I have a difficult time being myself around other people.
_____12. I enjoy my own company.
_____13. I don't trust my own instincts.
_____14. I often think the worst of others.
_____15. I believe I can protect myself if my thoughts become self-destructive.
_____16. You can't trust anyone.
_____17. I'm uncomfortable when someone else is leading the group.
_____18. I feel good about myself most days.
_____19. Sometimes I think I'm more concerned about the safety of others than they are.
_____20. Other people are no good.
_____21. Sometimes when I'm with people, I feel disconnected.
_____22. People shouldn't place too much trust in their friends.
_____23. Mostly, I don't feel like I'm worth much.

1	2	3	4	5	6
Disagree strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Agree Strongly

_____24. I don't have much control in my relationships.
_____25. My capacity to harm myself scares me sometimes.
_____26. For the most part, I like other people.
_____27. I deserve to have good things happen to me.
_____28. I usually feel safe when I'm alone.
_____29. If I really need them, people will come through for me.
_____30. I can't stand to be alone.
_____31. This world is filled with emotionally disturbed people.
_____32. I am basically a good person.
_____33. For the most part, I can protect myself from harm.
_____34. Bad things happen to me because I'm bad.
_____35. Some of my happiest experiences involve other people.
_____36. There are many people to whom I feel close and connected.
_____37. Sometimes I'm afraid of what I might do to myself.
_____38. I am often involved in conflicts with other people.
_____39. I often feel cut off and distant from other people.
_____40. I worry a lot about the safety of loved ones.
_____41. I don't experience much love from anyone.
_____42. Even when I'm with other people, I feel alone.
_____43. There is an evil force inside of me.
_____44. I feel uncertain about my ability to make decisions.
_____45. When I'm alone, I don't feel safe.
_____46. When I'm alone, it's like there's no one there.
_____47. I can depend on my friends to be there when I need them.
_____48. Sometimes I feel like I can't control myself.
_____49. I feel out of touch with people.
_____50. Most people are basically good at heart.
_____51. I sometimes wish I didn't have any feelings.
_____52. I'm often afraid I will harm myself.

1	2	3	4	5	6
Disagree strongly	Disagree	Disagree Somewhat	Agree Somewhat	Agree	Agree Strongly

_____53. I am my own best friend.
_____54. I feel able to control whether I harm others.
_____55. I often feel helpless in my relationships with others.
_____56. I don't have a lot of respect for the people closest to me.
_____57. I enjoy feeling like part of my community.
_____58. I look forward to time I spend alone.
_____59. I often feel others are trying to control me.
_____60. I envy people who are always in control.
_____61. The important people in my life are relatively safe from danger.
_____62. The most uncomfortable feeling for me is losing control over myself.
_____63. If people really knew me, they wouldn't like me.
_____64. Most people don't keep the promises they make.
_____65. Strong people don't need to ask for others' help.
_____66. Trusting other people is generally not very smart.
_____67. I fear my capacity to harm others.
_____68. I feel bad about myself when I need others' help.
_____69. To feel at ease, I need to be in charge.
_____70. I have sound judgment.
_____71. People who trust too much are foolish.
_____72. When my loved ones aren't with me, I fear they may be in danger.
_____73. At times my actions pose a danger to others.
_____74. I feel confident in my decision-making ability.
_____75. I can't work effectively unless I'm the leader.
_____76. I often doubt myself.
_____77. I can usually size up situations pretty well.
_____78. I generally don't believe the things people tell me.
_____79. Sometimes I really want to hurt someone.
_____80. When someone suggests I relax, I feel anxious.

APPENDIX D

The Impact of Event Scale

Impact of Event Scale

Dear Treatment Provider, below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true for you with ***regards to your work with sex offenders***, during the past 7 days. If they did not occur during that time, please mark the "not at all" column.

	FREQUENCY			
	Not At all	**Rarely**	**Sometimes**	**Often**
1. I have thought about it when I didn't mean to.				
2. I avoided letting myself get upset when I thought about it or was reminded of it.				
3. I tried to remove it from memory.				
4. I had trouble falling asleep or staying asleep, because of pictures or thoughts about it that came to mind.				
5. I had waves of strong feelings about it.				
6. I had dreams about it.				
7. I stayed away from reminders of it.				
8. I felt as if it hadn't happened or it was not real.				
9. I tried not to talk about it.				
10. Pictures about it popped into my mind.				
11. Other things kept making me think about it.				
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.				
13. I tried not to think about it.				
14. Any reminder brought back feelings about it.				
15. My feelings about it were kind of numb.				

APPENDIX E

The Maslach Burnout Inventory

MBI Human Services Survey

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

On the following page there 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 a "0" (zero) 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:
_____	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 a "5."

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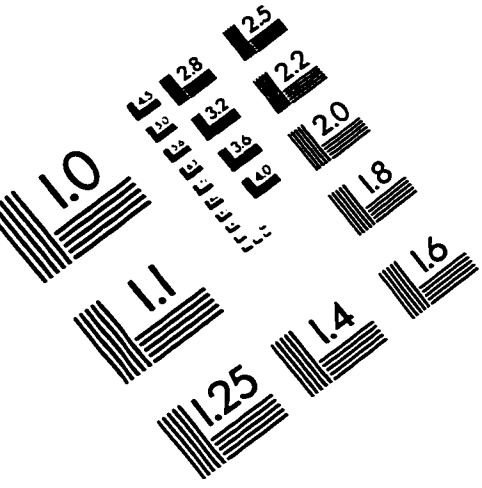
MBI Human Services Survey

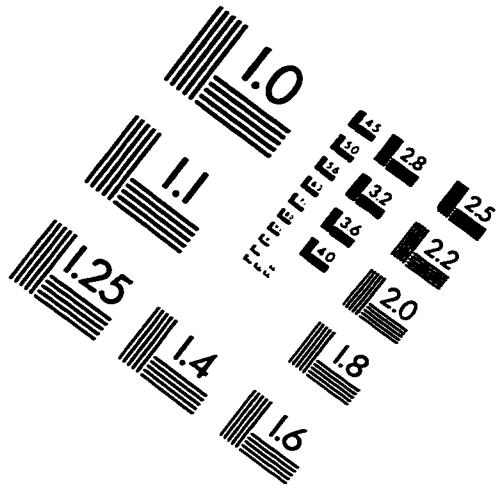
HOW OFTEN:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

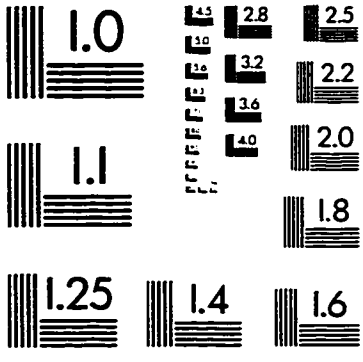
HOW OFTEN 0 - 6	Statements:
1. _____	I feel emotionally drained from my work.
2. _____	I feel used up at the end of the workday.
3. _____	I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____	I can easily understand how my recipients feel about things.
5. _____	I feel I treat some recipients as if they were impersonal objects.
6. _____	Working with people all day is really a strain for me.
7. _____	I deal very effectively with the problems of my recipients.
8. _____	I feel burned out from my work.
9. _____	I feel I'm positively influencing other people's lives through my work.
10. _____	I've become more callous toward people since I took this job.
11. _____	I worry that this job is hardening me emotionally.
12. _____	I feel very energetic.
13. _____	I feel frustrated by my job.
14. _____	I feel I'm working too hard on my job.
15. _____	I don't really care what happens to some recipients.
16. _____	Working with people directly puts too much stress on me.
17. _____	I can easily create a relaxed atmosphere with my recipients.
18. _____	I feel exhilarated after working closely with my recipients.
19. _____	I have accomplished many worthwhile things in this job.
20. _____	I feel like I'm at the end of my rope.
21. _____	In my work, I deal with emotional problems very calmly.
22. _____	I feel recipients blame me for some of their problems.

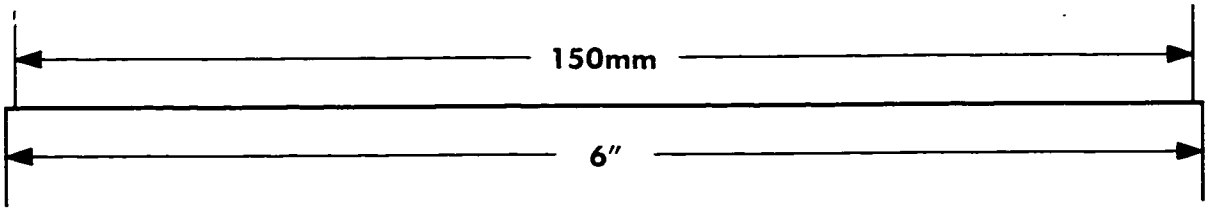
(Administrative use only)		cat.		cat.		cat.
EE:	_____	_____	DP: _____	_____	PA: _____	_____

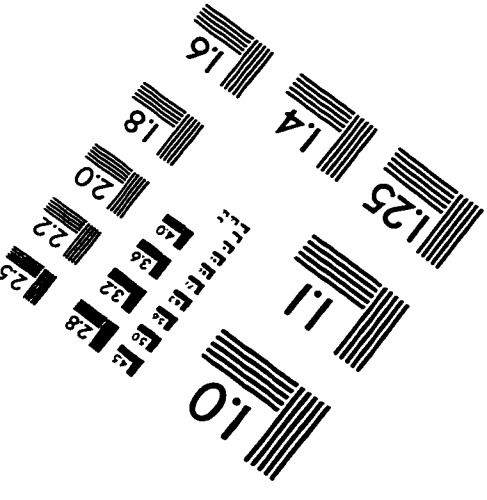
IMAGE EVALUATION
TEST TARGET (QA-3)

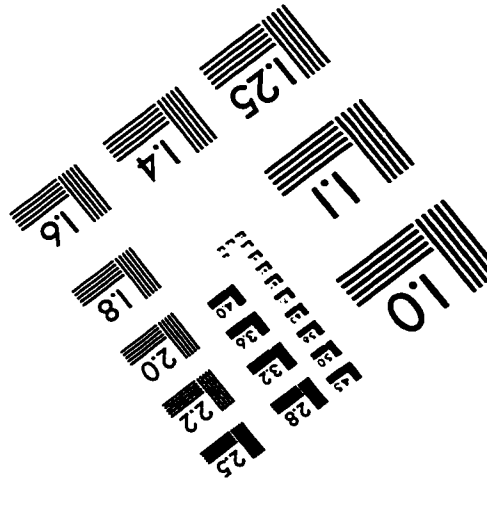












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