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Vicarious Traumatization and Burnout Among Therapists Working with Sex Offenders

Michaela A. Kadambi, Ph.D. and Derek Truscott, Ph.D.¹

Ninety-one Canadian therapists (49 women and 42 men, mean age 41 years) working primarily with sex offenders were surveyed to determine the presence of vicarious trauma, identify mitigating variables if present and assess its relationship to burnout. Participants completed a 24-item demographic questionnaire, the Traumatic Stress Institute Belief Scale – Revision L, the Impact of Event Scale, and the Maslach Burnout Inventory. Contrary to expectations, participants did not exhibit significantly higher degrees of vicarious traumatization than a criterion reference group of mental health professionals. Participants who reported having a venue to address the personal impact of their work were found to be more likely to score lower on the measure of vicarious trauma than those who did not. Other variables theorized to be related to vicarious trauma were not found to be related to scores on the measure assessing vicarious trauma. Twenty four percent of the sample was found to have a moderate to severe stress response to their work with offenders. Twenty three percent of the sample scored in the high range on the Emotional Exhaustion and Depersonalization subscales, hallmarks of professional burnout. High correlations among measures of vicarious trauma and burnout were also found, calling attention to the need to further differentiate the two constructs. Implications regarding the measurement of vicarious trauma and the appropriateness of generalizing the phenomenon to sex offender treatment providers are discussed.

Key Words: vicarious trauma, burnout, sex offenders, impact

Few client populations present as many personal and professional challenges to therapists as sexual offenders. It is well documented that therapists working with sex offenders can be significantly impacted by their work in ways that can produce disruptions in affect regulation and expression, interpersonal relationships, and sexuality, in addition to symptoms of psychological trauma, such as nightmares and intrusive imagery (Ellerby, 1997; Farrenkopf, 1992; Jackson, Holtzman, Barnard, & Paradis, 1997; Kearns, 1995; Layton, 1988; Mitchell & Melikian, 1995; Polson & McCullom, 1995). A growing body of research is beginning to document how providing treatment to this client population can affect treatment providers. Recently, vicarious traumatization (McCann & Pearlman, 1990) has begun to be investigated and considered as a useful conceptualisation of how these professionals may collectively respond to working with sexual offenders (Rich, 1997).

McCann and Pearlman (1990) developed the concept of vicarious traumatization to describe and explain the unique effect of working with sexual violence survivors on psychotherapists. They postulated that being exposed to graphic details of human cruelty and participating in “traumatic re-enactments” in therapy with these clients produced a

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qualitatively different experience and set of sequelae than work with other client populations. Vicarious traumatization is described as a process by which the therapists’ experience of themselves, others and the world around them is negatively affected as a direct result of an empathic connection with clients’ traumatic material (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a). This process can result in changes in the therapist's worldview, self-identity and cognitive schemata associated with safety and trust (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a). In addition, these changes often give rise to symptoms of intrusive imagery and painful affect. Although the construct was initially intended to describe the effects of working with survivors of sexual violence, the conditions thought necessary to produce vicarious trauma also exist in therapy with the perpetrators of sexual violence. Researchers are beginning to explore this connection; however, much of the research to date lacks the use of objective measures to assess and measure the existence of vicarious trauma among this professional group to determine if they are indeed vulnerable to the same phenomenon as professionals working with survivors of sexual trauma. Additionally, no studies have used samples consisting of professionals who work predominantly with perpetrators as opposed to survivors of sexual violence.

Rich (1997) conducted an investigation of vicarious traumatization among therapists working with survivors and perpetrators of sexually violent crime. Sixty-two percent of participants identified themselves as suffering from vicarious trauma. These participants were more likely to report experiencing difficulties in coping with stress associated with their work, doubts about their ability to manage the stress of their jobs, distressing images of traumatic material, discouragement, anxiety, and feeling “at odds” with the world. Although this study represents an important first step in investigating the prevalence of vicarious traumatization among therapists working with sex offenders, asking participants to identify themselves as vicariously traumatized limits conclusions about the prevalence and validity of the phenomenon among this population.

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 phenomenon and to explore the relationship between the construct and burnout. It was hypothesised that if therapists working with sex offenders were experiencing vicarious traumatization, they would exhibit evidence of cognitive disruptions, as measured by the Traumatic Stress Institute Belief Scale (TSI; Pearlman, 1996), at levels higher than a criterion reference group of general mental health professionals (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.

Additionally, 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).
Burnout is the diminishment of therapists' enthusiasm, emotional energy and interest in their work as a consequence of work demands and the emotional drain of working with people over a period of time (Farber, 1983; Pines & Maslach, 1978). The two constructs are thought to be interrelated: however, unlike vicarious trauma, burnout is commonly considered to be a temporary and preventable consequence of the demands of one's work setting, which manifests itself in the form of emotional exhaustion, disconnection and decreased sense of meaning directly related to one’s work (Farber & Heifetz, 1982; Maslach, Jackson & Leiter, 1996; Pines & Maslach, 1978). Moreover, the negative effects of burnout are primarily confined to the affected professional’s work-related activities. Conversely, vicarious trauma has been described as a permanent and inevitable consequence of an empathic connection with clients’ traumatic material. While the experience of vicarious trauma may encompass some of the effects characteristic of burnout, vicarious trauma extends beyond the workplace and into the personal life of the professional. Additionally, vicarious trauma includes emotional and behavioural manifestations of traumatic stress that are absent from the experience of burnout (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a). It was therefore hypothesised that while the TSI would have significant correlations with measures of burnout, these correlations would not be as strong as those found between the TSI and measures of traumatic stress.

Method

Participants

The sample of 91 therapists consisted of 49 women and 42 men. Ages ranged from 21 to 78 years of age, with a mean age of 41 years. Of the participants, 18.9% reported they had been providing therapy to sexual offenders 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% for over 15 years.

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 (Hilton, Jennings, Drugge, & Stephens, 1995) that found much higher proportions of therapists who had a personal history of being sexually abused or assaulted (33% vs. 9% for the current sample). This discrepancy may be explained by the fact that Hilton et al. (1995) utilized an extensive checklist of abusive experiences to determine prevalence rates, whereas participants in the present study were only asked to indicate whether they were, or were not, survivors of sexual abuse.

Measures

Treatment Provider Survey. The Treatment Provider Survey is a 24 item questionnaire developed for this study to gather information on therapist demographics, their work with sex offenders, and factors hypothesised to be predictive of vicarious traumatization (Pearlman & Maclan, 1995) and burnout (Adams & Betz, 1993; Bird
Edmunds, 1997; Ellerby, 1997; Farrenkopf, 1992). Participants were asked to provide information regarding; length of time working in the field, perceived exposure to traumatic material, work setting, supervision arrangements, education, presence of a personal trauma history, whether they addressed the effects of their work in personal therapy, venues to address the personal impact of their work, offender risk type, program intensity, specialized training, previous trauma work, and the amount of clinical time spent working with sex offenders.

Traumatic Stress Institute Belief Scale - Revision L (TSI). The TSI (Pearlman, 1996) is an 80 item questionnaire which measures disruptions in the five psychological need areas hypothesised to be sensitive to trauma - safety, trust, intimacy, control and power - relative to self and others yielding 10 subscale scores. The overall reported reliability (Cronbach's alpha) of the TSI is .98 (Pearlman, 1996). Subscale reliability ranges 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, with higher scores representing greater levels of disturbance.

Impact of Event Scale (IES). The IES (Horowitz, Wilner & Alvarez, 1980) is a 15 item self-report measure, which assesses reactions to stressful events among a variety of populations. Containing two subscales -- Intrusion and Avoidance -- the IES assesses the central features of Post Traumatic Stress Disorder. Reliability coefficients are .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 scale) each of the 15 statements were true for them with regard to their work with sex offenders.

Maslach Burnout Inventory - Human Services Survey (MBI). The 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. The MBI has reliability coefficients (Cronbach's alpha) of .90 for the Emotional Exhaustion subscale, .79 for Depersonalization and .71 for Personal Accomplishment (Maslach, Jackson & Leiter, 1996), and has been used widely with mental health professionals. The measure produces three scores for each of the three aspects of burnout that can each be categorized into high, moderate or low levels, relative to normative sample data.

Procedure

Participants for this research project were therapists providing sex offender treatment in Canada. A total of 220 individual surveys were mailed 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 falls within the range of previous survey research conducted with mental health professionals that have obtained response rates between 32% (Pearlman & Maclan,1995) and 50% (Brady, Guy, Poelstra & Brokaw, 1999).
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. Of the sample, 19% identified themselves as working with non-offending survivors of trauma in addition to sex offenders. Participants were asked to rate (more, equally, less, great deal less) how much time they spend with non-offending survivors of trauma in comparison to sex offenders. Only those who indicated that they worked “less” or a “great deal less” with non-offending survivors of trauma compared to sex offenders were included in the sample. Two participant surveys did not meet this criterion, and were subsequently excluded from the final sample. The majority of participants who indicated they also worked with survivors of trauma reported that they worked with them a great deal less than offender clients.

Results

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 that varied in their levels of education and number of years in practice. Contrary to expectations, test analysis for independent groups failed to indicate a significant difference between the participants’ mean score on the TSI and that of the criterion reference group mean [t (91) = .07, p > .05]. The mean scores for participants on each of the measures are presented in Table I.

Table I

Means and Standard Deviations for Dependent Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSI Belief Scale</td>
<td>167.36</td>
<td>35.56</td>
</tr>
<tr>
<td>IES Total Score</td>
<td>16.6</td>
<td>13.30</td>
</tr>
<tr>
<td>IES Intrusion Subscale</td>
<td>8.1</td>
<td>7.65</td>
</tr>
<tr>
<td>IES Avoidance Subscale</td>
<td>8.9</td>
<td>7.59</td>
</tr>
<tr>
<td>MBI Emotional Exhaustion</td>
<td>19.42</td>
<td>10.73</td>
</tr>
<tr>
<td>MBI Depersonalization</td>
<td>8.34</td>
<td>5.63</td>
</tr>
<tr>
<td>MBI Personal Accomplishment</td>
<td>37.78</td>
<td>6.28</td>
</tr>
</tbody>
</table>
The IES was administered to participants to assess intrusive and avoidant symptoms associated with traumatic stress, consistent with the experience of vicarious trauma. Participant means and standard deviations for the IES intrusion, avoidance subscales and total score are presented in Table I. Total scores above 26 on this measure are considered to reflect moderate to severe reactions to stress inducing events. Twenty-four percent of the sample obtained an IES score above 26.

Factors Associated with Vicarious Trauma

Variables thought to be predictive or mitigating factors of cognitive disruption as measured by the TSI (Pearlman & Maclan, 1995; Schauben & Frazier, 1995) were entered as independent variables into a step-wise multiple regression. They were: 1) amount of professional time spent working with offenders, 2) perceived exposure to traumatic material, 3) whether participants felt they had a venue to address the personal impact of their work, and 4) whether participants were supervised. The only variable found to have significant predictive power for scores on the TSI was the perceived existence of a venue in which participants could address the personal impact of their work \( R^2 = .30, F (1, 89) = 8.53, p = .004 \). When given the opportunity to elaborate via an open-ended survey question, participants consistently identified clinical team meetings, meetings with colleagues, debriefing periods with team members following treatment, and supervision related activities such as forums in which they felt they had opportunities to address the negative impact of their work.

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 therapists with a trauma history scored comparably higher on the TSI (M = 182.63, SD = 23.54, range = 141 - 209) than therapists without a trauma history (M = 165.87, SD = 36.28, range = 92 - 275).

Presence of Burnout

To understand more fully the experience of providing therapy to sexual offenders, MBI levels were examined. The sample means for each of the three burnout subscales were as follows: Emotional Exhaustion, 19.42 (SD = 10.73); Depersonalization, 8.34 (SD = 5.63); and Personal Accomplishment, 37.78 (SD = 6.28). Participants' mean scores were compared with established criteria for the presence of burnout (Maslach, Jackson, & Leiter, 1996). 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 mean scores for the sample all fell within the moderate range for Emotional Exhaustion, Depersonalization, and Personal Accomplishment subscales.
Vicarious Traumatization (Maslach, Jackson & Leiter, 1996). High scores on both the Depersonalization and Emotional Exhaustion subscales, were present in 12% of participants. Only 2% of the sample showed the combination of high scores on the Emotional Exhaustion and Depersonalization scores in combination with a low score on Personal Accomplishment. This pattern of response is proposed to represent a high level of experienced burnout (Maslach, Jackson & Leiter, 1996).

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 II 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. Strong positive correlations were also obtained between TSI and the Depersonalization subscale. The TSI was found to be moderately negatively correlated with the Personal Accomplishment subscale.

Table II

Pearson Product – Moment Intercorrelations Among Dependent Variables

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

* p < .05  ** p < .01
Discussion

Vicarious Trauma

Contrary to expectations, there was no significant difference between participants’ scores on the TSI and those of a criterion reference group of mental health professionals, as one might expect if in fact vicarious trauma was present. It may be quite premature to conclude that the impact of providing treatment to sex offenders may produce a different set of effects from those associated with working with survivors of trauma. While results suggest that professionals providing treatment services to sex offenders do not show greater cognitive disruptions indicative of vicarious trauma than do general mental health professionals, difficulties may exist with using this criterion reference group for comparison. The mental health professional group was obtained by sampling individuals at a trauma training workshop (Pearlman, 1996). It is unclear if direct (personal history) and indirect (psychotherapy with survivors of trauma) exposure to trauma among the professionals composing this reference group was adequately controlled for. Consequently, until more empirically sound normative data is collected for the TSI on professionals providing general psychotherapy, it is difficult to make definitive statements about the potential presence or absence of vicarious trauma when using a criterion reference group that may in fact have inflated TSI scores.

Participants’ scores on the measure of vicarious trauma, however, were shown to be significantly influenced by whether they had a venue in which to address the personal impact of their work. Researchers investigating mitigating influences of psychological distress and burnout have found that for those working with offenders, strong collegial relationships and perceived social support appear to be instrumental in assisting these professionals to cope with the demands of their work (Ellerby, 1998; Ennis & Horne, 2003). Support systems have been found to be essential for many mental health professionals in combating burnout and psychological distress associated with the provision of psychotherapy (Farber & Heifetz, 1982; Saavicki & Cooley 1987). This has particular relevance for professionals working with sex offenders in that the social stigma of their client population may in itself produce a sense of alienation and influence the therapists’ ability to access additional support (Alford, Grey & Atkisson, 1988; Egan, 1993; Ryan & Lane, 1991). Consultation with colleagues is likely to provide an opportunity for therapists to express, process, and normalize their responses to providing treatment. Strong connections with colleagues and professional associations may also serve to offset the stress and isolation resulting from the stigma of working with sex offenders. At an individual level, seeking out these connections may be essential in coping with the stressors associated with offender work, especially for those providing treatment in isolation (e.g. rural communities). Organizational strategies promoting collegial connections such as regular staff meetings, offender-specific supervision, educational opportunities and consultation among professionals may also assist these professionals cope with the demands of sex offender treatment.
Several other variables previously shown to be related to vicarious trauma (e.g., length of time working in the field, perceived exposure to graphic details of trauma etc.) were not found to be related to the measure of vicarious trauma within this sample. Given the proposed importance of these factors in the development and severity of vicarious trauma (McCann & Pearlman, 1990), this result is surprising. Our results are, however, consistent with those found in a recent study of female psychotherapists (Brady, Guy, Poelstra, & Brokaw, 1999), which also failed to find support for similar variables as predictors of TSI scores.

Adding to concerns surrounding the construct validity of the TSI were the correlations found among the TSI, MBI and IES. Although a high degree of overlap was anticipated, the TSI was more highly correlated with a measure of burnout than with symptoms of post traumatic stress. This result was interesting in that burnout and vicarious trauma have been proposed to be related but distinct constructs (Schauben & Frazier, 1995; Pearlman & Saakvitne, 1995a). These results may be suggestive of psychometric limitations of the TSI. In light of the strong correlations between the TSI and the MBI subscales, further research may be warranted in clearly differentiating these two constructs.

In sum, the potential sampling bias of the criterion reference group, the lack of support for variables theorized to be predictive of vicarious trauma and correlational patterns found between measures raise serious questions surrounding the construct validity of the TSI. At minimum, further research establishing appropriate comparison groups for the TSI is needed prior to generalizing the construct to professionals working with sex offenders.

Burnout

Perhaps the most interesting findings of this study involved the experience of burnout among professionals treating sex offenders. Approximately one fifth of the sample fell within the high range for the Emotional Exhaustion and Depersonalization subscales. High scores on these subscales are considered key features of professional burnout (Maslach, Jackson, & Leiter, 1996). Previous research investigating aspects of burnout among therapists working with sex offenders have found similar prevalence rates of one quarter (Bird Edmunds, 1997; Farrenkopf, 1992). Only 2% of the sample, however, showed high scores on both subscales in combination with low scores on the Personal Accomplishment scale. This combination of scores on all three subscales is considered reflective of a high level of an experienced feeling of burnout (Maslach Jackson & Leiter, 1996).

While mean scores on the Emotional Exhaustion and Depersonalization scales for a normative sample of mental health professionals fall within the low range, participants in this study fell within the moderate range for both subscales. Higher mean scores on the depersonalization subscale are particularly notable. Depersonalization is in direct
opposition to the core aspects of empathy and empathic engagement, which is considered an essential ingredient in effective therapy (Rogers, 1992). The Depersonalization subscale measures indifferent, cynical and impersonal attitudes towards clients (Maslach, Jackson & Leiter, 1996). High scores on the Depersonalization subscale are often conceptualised negatively. In the case of sex offender treatment providers, these results may actually be a by-product of countertransference dynamics specific to sex offender clientele and could suggest an adaptive coping response to their work. Although such reactions may be an adaptive response for treatment providers, it may come at the expense of therapeutic success with sex offender clients.

Several researchers have commented on the unique countertransference dynamics that result when working with offenders. Hill (1995) has suggested that professionals working with sex offenders typically deal with the responsibilities to, and demands of, not only their clients, but also institutional mandates and societal expectations for treatment. The interaction of client, institutional and societal factors creates what Hill (1995) terms “triadic countertransference”. The interactions among the therapist, offender client, society and institutional mandates produce a unique pattern of empathic engagement and disengagement with the client throughout the therapy process. Consequently, this pattern of engagement and disengagement may produce a therapeutic alliance that is somewhat more distant than with a non-offender clientele.

Farrenkopf (1992) has also commented on the emotional distance of professionals providing treatment services to sex offenders. In his descriptive study of professionals working with this population, Farenkopf (1992) identified four phases of adjustment through which these professionals progressed; shock, mission, anger, and alternatively, erosion or adaptation. Farrenkopf’s proposed phase of erosion, appears to closely resemble the experience of burnout. Professionals in this phase of adjustment experience resentment towards clients, depression, feelings of exhaustion and reduced expectations surrounding treatment efficacy. Farrenkopf suggests that rather than enter into the erosion phase some professionals alternatively enter a phase he refers to as adaptation. Professionals in this phase appear to find renewed sense of meaning and motivation for their work by adopting realistic treatment expectations and an attitude of detachment towards their sex offender clientele.

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 an important aspect of successful treatment (Polson & McCullom, 1995), as it is for clients who seek counselling in general (Horvath & Greenberg, 1994; Orlinsky, Grawe, & Parks, 1994). Understanding the therapist's experience of connection and disconnection with clients who sexually offend may offer important insights into the development and prevention of negative impacts for the therapist, and the attainment of positive treatment outcomes for their sex offender clients.
Conclusion

It is important to recognize that this study represents a preliminary and exploratory investigation of vicarious trauma among professionals working with sex offenders. These results are based on a relatively small sample size and it is clear that before the construct of vicarious trauma can be confidently generalized to this professional group, the psychometric limitations of the TSI need to be addressed. Further research may also need to use designs that control for therapist variables such as age and experience as they may affect the degree and extent to which therapists may be impacted by their clinical work.

Another limitation of this and many other studies on the impact of work with sex offenders, is that samples consist only of individuals who are presently involved in providing treatment to offenders. There are likely to be unidentified key differences between professionals who continue to work with sex offenders and those who have chosen to cease working with this population. Investigations involving professionals who have chosen not to continue treating offenders may offer untapped information on the potential impact of working with offenders. In future research, the use of mental health professionals providing therapy to general populations as comparison groups would also prove valuable to understand more fully the effect of working with sex offenders and to determine the necessity of unique preventative or remedial strategies for such professionals.

An often neglected finding in the literature surrounding the impact of clinical work with sex offenders is that the majority of participants in studies using established measures have not shown drastic impairments in emotional and psychological functioning, or highly elevated levels of burnout or traumatic stress (Ellerby, 1998; Ennis & Horne, 2003). In fact, the majority of sex offender treatment providers described in the literature appear to be coping quite well with the demands of their work. The provision of psychotherapy in general has shown to be stressful for the practitioner for a variety of factors both intrinsic and extrinsic to the therapy process (Deutsch, 1984; Farber & Heifetz, 1981; 1982; Raquepaw & Miller, 1989; Savicki & Cooley, 1987). Professionals who work with offenders most certainly experience unique stressors associated both with their clientele and with the dynamics of therapy (Blanchard, 1995; Ellerby, 1997; Farrenkopf, 1992; Hill, 1995; Mitchell & Melikian, 1995), but their collective response may in fact be more similar than dissimilar to professionals providing psychotherapy to more general populations. There is presently a paucity of research that focuses exclusively on what these dedicated professionals find rewarding and meaningful about providing treatment services to sex offenders. A more balanced approach to investigating the detrimental and beneficial aspects of providing treatment to sex offenders may be a crucial missing link in fully understanding the apparent resiliency of this professional group.
References


