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Predicting Psychological Distress in Sex Offender Therapists

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The provision of psychological services to sexual offenders presents therapists with many challenges, including exposure to vivid descriptions of sexual violence and trauma. Although there is an increasingly robust body of literature investigating the effects of such traumatic exposure on therapists who work with the victims of sexual abuse, there have been few studies of its impact on those who treat the perpetrators. This study provides an exploratory investigation of the experience of psychological distress among therapists who work with sex offenders, as well as the social support mechanisms that may serve to mitigate therapist risk. Fifty-nine sex offender therapists completed a self-report measure of posttraumatic stress symptomatology, and rated their perceptions of family and peer support. Therapists also reported the number of hours that they devote to sex offender treatment and the amount of clinical supervision they participate in on a weekly basis. As a group, participants reported experiencing low levels of general and trauma-related distress. Although statistical analyses failed to indicate the existence of a significant positive correlation between number of hours devoted to sex offender treatment and the experience of therapist distress, greater perceptions of peer support were significantly predictive of lower levels of psychological distress and PTSD symptoms. These results are discussed relative to their implications for sex offender therapist self-care and future research.

KEY WORDS: psychological distress; social support; therapist; sex offenders.

Historically, the experience of traumatic stress has been specifically associated with those individuals who have been the primary victims of traumatic events.

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However, in recent years there has been growing recognition that individuals who have been indirectly exposed to traumatic events can also suffer from posttraumatic stress reactions. Therapists, whose only exposure to traumatic stimuli has been through their interactions with clients who have experienced it directly, are themselves at risk of experiencing a range of PTSD symptomatology (Battley, 1994; Kassam-Adams, 1994; Munroe, 1991; Pearlman & MacIan, 1995; Schauben & Frazier, 1995). This phenomenon has been conceptualized from a variety of theoretical standpoints, and has been referred to using various terminology, including vicarious traumatization (McCann & Pearlman, 1990) and secondary traumatization (Figley, 1995). McCann and Pearlman (1990) have suggested that vicarious traumatization exhibits three primary characteristics: (1) it is pervasive, affecting many aspects of the therapist's life; (2) it is cumulative, in that each exposure to victim reported trauma increases the risk and impact of the secondary traumatization; and (3) the effects are potentially permanent.

Although work-related traumatic stress among trauma therapists has become a point of focus for both clinicians and researchers, little attention has been paid to the investigation of psychological distress among clinicians who work with the perpetrators, rather than the victims of violence. In treating the perpetrators of sexual crimes, mental health professionals are also exposed to intense, traumatic material. Abel (1983, p. 283) stated that "one cannot ignore the very personal impact of working day in and day out with rapists, and potential rapists. The recounting and exploring of the details of such violent fantasies and atrocious acts in effect serve to surround the therapist in an emotional world of violence on top of violence." When working with sex offenders, therapists' exposure to traumatic material frequently comes from individuals who may deny, or conversely, revel in their role as a victimizer. Moreover, the sex offender client typically presents for treatment under the influence of court order rather than of his or her own volition, and research has indicated that therapists tend to report experiencing greater stress when working with mandated rather than voluntary clients (Stenson, 1987 cited in Farrenkopf, 1992).

In one of the few studies to explore the impact that working with sex offenders has on the therapist, Farrenkopf (1992) found that nearly one third of the sex offender therapists surveyed stated that they had experienced hypervigilance, suspiciousness, and an increased concern for the safety of loved ones as a consequence of their work. Twenty-five percent of this sample also endorsed high levels of generalized stress, exhaustion, depression, or burnout. Kearns (1995) has suggested that clinicians who work with sex offenders can become increasingly isolated from those that do not work with offenders. Kearns further stated that the work climate often discourages clinicians from discussing the negative aspects of their work, and that lack of support from friends and colleagues may further discourage sex offender clinicians from processing their negative reactions.

Ellerby's study (Ellerby 1998) of 683 sex offender treatment providers lends support to Kearns' assertions. Ellerby found that therapists who reported having

limited opportunity to participate in clinical supervision and consultation were more likely to report higher levels of distress and burnout. Conversely, therapists who reported greater opportunity to consult tended to report a greater sense of personal accomplishment in their work. These results are consistent with previous literature that has identified clinical supervision and ongoing consultation as sources of professional coping that moderate the experience of stress (Figley, 1995; Pearlman & Saakvitne, 1995). Feedback from focus groups conducted by Ellerby (1998) addressing the importance of supervision and consultation, indicated that therapists viewed these supports as beneficial because they gave therapists opportunities to vent, provided an arena in which to receive clinical guidance and direction, and provided a means of confirmation and validation.

The purpose of the present study was to provide an exploratory investigation of the effects of exposure to traumatic material on therapists who work with sex offenders. This exploration was guided by two primary research questions: (1) do self-reported symptoms of posttraumatic stress increase with the amount of time clinicians devote to practice with sex offenders; and (2) does perceived support from family and peers, and participation in professional supervision diminish the risk of psychological distress?

METHOD

Participants

A mail survey was forwarded to 314 mental health professionals in the United States and Canada. Two hundred surveys were sent to members of an international nonprofit organization dedicated to the advancement of the field of sex offender evaluation and treatment. These 200 prospective participants were randomly selected from the organization's membership list. The other 114 surveys were sent to hospitals, mental health agencies, and private practices without consideration of the prospective participants' clinical focus. Respondents of all levels of professional training were invited to participate in the study.

Of the 314 surveys that were distributed, 112 (36%) were completed and returned. Consistent with Ellerby's study, (Ellerby, 1998) only data from mental health professionals who devoted at least 3 hr per week to working with sex offenders were included in these analyses. Of the 112 surveys that were returned to the researchers, 59 (53%) met the criterion for inclusion. Responses were solicited by mail from diverse regions of the United States and Canada. Twenty-eight of the respondents were male and 31 were female. The vast majority (53) of participants identified themselves as Caucasian, whereas the remaining 6 participants identified themselves as Native American (2), Latino/Hispanic (2), Asian American (1), or Other (1). Ages of participants ranged from 27 to 81, with a median age of 46 years. The majority of clinicians (28) had a Master's degree in arts or sciences, and an

additional 14 clinicians had Master's of social work degrees. Thirteen clinicians had Doctoral degrees, 3 had Bachelor's degrees, and 1 was a medical doctor.

Instruments

The Los Angeles Symptom Checklist (LASC)

The LASC was developed by King, King, Leskin, and Foy (1995) to assess three areas related to PTSD. The 43-item instrument is Likert scaled from 1 (*no problem*) to 4 (*extreme problem*). The first scale is a measure of overall psychological distress and adjustment problems and consists of all 43 items. The second scale is an overall measure of PTSD-specific symptoms and includes 17 items. The third scale is diagnostic of PTSD based on DSM-IV criteria, and was not used for this study due to speculation that few participants would meet the criteria for diagnosis .

Clinician Survey

A clinician survey was developed for the purpose of this study. In addition to general demographic information, clinicians rated perceived support from family and peers. Peers and family were rated as being "not at all supportive," "somewhat supportive," "fairly supportive," or "very supportive." Clinicians were also asked to indicate the amount of clinical supervision they typically received on a weekly basis. Categorical response options for this variable included "less than 1 hour per week," "1 to 2 hours per week," or "more than 2 hours per week." Finally, participants were asked to indicate whether or not they themselves were survivors of trauma/abuse.

RESULTS

The researchers had intended to investigate the possibility that the participants' own histories of trauma in their personal lives might influence their current self-report of psychological distress. However, meaningful analyses of this variable were precluded by the fact that only 15 of the 59 respondents in this sample identified themselves as survivors of trauma/abuse. In an effort to identify potential differences between participants with and without histories of personal victimization, 15 subjects who reported no history of personal trauma were randomly selected and compared to subjects reporting personal trauma histories on measures of psychological distress. Independent t-tests failed to indicate significant differences between these two groups on either the general psychological distress, $t(28) = 0.11$, $p = .912$, or the PTSD symptom-specific, $t(28) = -0.28$,

$p = .784$, scales of the LASC. Subsequently, all subjects were included in the analyses regardless of personal trauma history. Additionally, no differences were found between male and female respondents on either the general psychological distress, $t(57) = 0.06$, $p = .950$, or PTSD symptom-specific, $t(57) = 0.28$, $p = .783$, scales.

Bonferroni alpha adjustment was performed, and an alpha level of .016 was utilized for all analyses. With regard to the question of whether self-reported symptoms of psychological distress increase with the amount of time clinicians devote to practice with sex offenders, Pearson product–moment procedures failed to identify significant relationships between the number of hours spent working with sex offenders, and measures of psychological distress.

Overall, participants reported low levels of general psychological distress ($M = 17.24$, $SD = 13.90$) and PTSD symptomatology ($M = 9.07$, $SD = 7.56$). Closer investigation of participants' responses to individual items of the LASC indicated that the following symptoms were rated as being moderately, seriously, or extremely problematic by at least 20% of the respondents: restlessness (22%), irritability (34%), easily fatigued (24%), tension and anxiety (32%), waking during the night (25%), difficulty with memory (20%), and problems with authority (22%). Five of these seven symptoms are among the 17 LASC items most closely associated with PTSD symptomatology.

Linear regression analyses were conducted to investigate the hypothesis that the number of sex offender contact hours, peer support, family support, and supervision hours would significantly predict measures of psychological distress. Variables were entered into the regression equation simultaneously. Although four is a relatively large number of independent variables to include for analysis with a sample of this size, the emergence of significant findings under such conditions of limited statistical power improve the confidence with which these findings may be accepted as valid.

With regard to general psychological distress as assessed by the LASC, the model was shown to significantly explain 26.70% of the variance, $F(4, 53) = 4.8268$, $p = .0021$. Perceived peer support was negatively associated with psychological distress ($\beta = -6.67$, $p = .0047$), suggesting that therapists who feel supported by their colleagues are less likely to report generalized psychological disturbances than those who do not feel supported by their peers. Beta weights and multiple R^2 for this analysis are included in Table I.

The model was also shown to explain a significant proportion of the variance (26.70%) for the PTSD symptom-specific scale of the LASC, $F(4, 53) = 3.95$, $p = .0070$. Once again, perceptions of higher levels of peer support was a significant predictor of lower reporting of PTSD-related symptoms ($\beta = -3.33$, $p = .0107$. Although the PTSD Diagnostic Scores of the LASC were not included in these analyses, it is notable that 3 (5%) of the clinicians in this sample met DSM-IV criteria for PTSD diagnosis. Beta weights and multiple R^2 for this analysis are included in Table II.

Table I. Beta Weights for Linear Regression Analysis: Prediction of Psychological Distress

Predictors	β	R^2	F^a
Model		.27	4.83
Contact hours	.10		
Supervision	.06		
Family support	−.25		
Peer support	−.36*		

[a] $df = 4, 53$.
* $p < .016$.

DISCUSSION

Contrary to expectations, the results of this study do not support the presence of a significant positive relationship between the number of hours spent working with sex offenders and therapist distress. Although a sizeable segment of the therapists in this study indicated that their experience of a handful of posttraumatic symptoms is moderately to extremely problematic, the majority of participants appeared to be coping quite well with negative aspects of their work.

One possible explanation for this finding is that over time, therapists who choose to work with sex offenders may develop coping strategies to manage the psychological impact that their work may have on them. Farrenkopf (1992) has suggested that sex offender therapists may progress through distinct "phases of impact." These phases, which are affected in part by amount of work experience, influence therapists' beliefs about themselves and their clients, and their capacity to cope with the negative personal impact of their work. Correspondingly, therapists who attain Farrenkopf's "Adaptation" phase, which is characterized by a more detached attitude and ability to "philosophically tolerate the human dark side" (p. 221), may be less affected by large doses of trauma exposure than therapists with relatively little trauma exposure who are newly initiated to the field. Future research

Table II. Beta Weights for Linear Regression Analysis: Prediction of PTSD Symptomatology

Predictors	β	R^2	F^a
Model		.230	3.95
Contact hours	.21		
Supervision	.05		
Family support	−.21		
Peer support	−.33*		

[a] $df = 4, 53$.
* $p < .016$.

should empirically investigate the experience of vicarious trauma relative to years of relevant experience, and the validation of therapists' progression through these proposed developmental phases.

The data suggest that factors related to social support play a role in reducing the experience of trauma-related symptomatology. Specifically, the perception of peer support was a significant predictor of lower levels of reported psychological distress, and PTSD related symptoms. This suggests that having supportive colleagues in one's work environment may buffer against the negative, potentially traumatizing effects of conducting sex offender treatment. This finding is consistent with research on therapists who work with trauma survivors, which has suggested that variables related to social support may serve to moderate the risk of therapist distress (Arvay & Uhlemann, 1996; Ellerby, 1998; Pearlman & MacIan, 1995).

Although the constructs of perceived peer support and opportunity for consultation may be defined somewhat differently, the findings of this study are generally supportive of Ellerby's study (Ellerby, 1998). Unlike Ellerby's findings, however, less time spent in supervision was not found to be predictive of increased psychological distress in this study. However, of the 59 therapists who participated in this study, 29 (49%) reported receiving less than 1 hr of general supervision per week, and 36 (61%) reported receiving less than 1 hr of sex-offender-specific supervision per week. Professional peers and coworkers represent a highly valued resource among sex offender therapists (Kadambi & Truscott, 2001). In lieu of opportunities for formal supervision, the presence of supportive peers with whom the therapist can process his or her work-related stressors appears to be a particularly valuable asset.

Data from a recent study by Kadambi and Truscott (2002) lend support to the current findings regarding peer support, supervision, and therapist distress. This study investigated the role of a variety of factors as predictive variables in the experience of vicarious trauma among 91 Canadian sex offender therapists. Results indicated that the only variable that significantly predicted lower levels of cognitive disruption was the presence of a venue in which therapists felt they were able to address the personal impact of their work. Neither the amount of time spent working with offenders, nor participation in formal supervision were shown to significantly influence the experience of vicarious trauma.

Due to the paucity of research that has been conducted on the negative impact that therapeutic work may have on treatment providers who work with sexual abusers, this study is primarily exploratory in nature. Results are based on a relatively small sample of therapists, and measures of distress are based on clinician self-report. Additionally, interpretation of the data was conducted in the absence of specific information detailing the nature of clinical contact between individual therapists and their clients. These results should be considered with due caution in light of these limitations.

The provision of treatment to sex offenders is an endeavor that has the potential to be both intensely rewarding, and overwhelmingly taxing for the treatment provider. The findings of this study suggest that the support of one's professional peers may provide a form of coping that increases therapists' resilience to the risk of psychological distress. For therapists who work in private practice, in rural communities, or who are the sole sex offender treatment provider within their work environments, opportunities to seek support from peers who are both interested in, and familiar with, their clinical endeavours may be greatly limited. For these individuals, active membership in local or national organizations for sex offender treatment providers may provide alternative sources of peer support. Internet listserves for sex offender therapists may also serve a similar function, and may also provide more immediately accessible support and feedback for isolated therapists. Future research should investigate the specific characteristics that constitute "supportive" peer environments, and whether the positive, resilience-building attributes of these environments may also be accessed through web-based communities.

Kearns (1995) has suggested that lack of support from colleagues may discourage sex offender therapists from processing negative reactions they may have to their clients and their work. The results of this study suggest that a supportive peer community may provide sex offender therapists with an arena for the mutual provision of validation and reinforcement that may, in turn, contribute to effective self-care. Subsequently, the role of peer support should not be discounted when conducting research with, or providing clinical supervision for, therapists working with sex offenders.

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