

**Providing Clinical Services to Sex Offenders:
Burnout, Compassion, Fatigue and Moderating Variables**

by

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**PROVIDING CLINICAL SERVICES TO SEX OFFENDERS:
BURNOUT, COMPASSION, FATIGUE AND MODERATING VARIABLES**

BY

LAWRENCE A. ELLERBY

A Thesis/Practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

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Table of Contents

Introduction	9
The stressors and satisfactions associated with clinical practice	11
The stressors of clinical practice	11
The satisfactions of clinical practice	13
Conceptualization of therapist impact	14
Burnout	14
Compassion fatigue/secondary traumatic stress	16
Countertransference	22
Contrasting the models	23
Selection of clinician impact concepts and measures	24
Moderating variables of stress	24
Therapist variables	25
Practice setting variables	28
Client variables	29
Sex offender treatment: Stressors and impact	32
Stressors associated with the provision of sex offender treatment	33
The impact of providing clinical services to sex offenders	37
Shortcomings in the literature	42
Method	44
Mail survey respondents	45
Focus group participants	46
Procedure	47
Mail survey	47
Focus groups	50
Instruments	55
Results	59
Mail survey data	59
Characteristics of the sample	59
Measures of burnout, compassion fatigue and coping	68
Impact and moderating variables	79
Therapist variables	79
Practice setting variables	96
Client variables	106
Overall best predictors of burnout and compassion fatigue	116

Focus group data	120
Difficulties and stressors: Therapist issues	121
Difficulties and stressors: Practice setting issues	122
Difficulties and stressors: Client issues	123
Difficulties and stressors: System issues	127
The impact on the clinician	128
Coping with the stressors of a sex offender treatment practice	131
Satisfactions and rewards associated with sex offender treatment	136
Discussion	140
References	183
Appendices	195
Appendix A	195
Appendix B	196
Appendix C	207
Appendix D	208
Appendix E	209
Appendix F	210
Appendix G	211
Appendix H	259

List of Tables

Table 1	.....	Internal consistency correlation coefficients
Table 2	.....	Mean and standard deviations for the MBI sub-scales
Table 3	.....	Categorization of MBI scores, range of experience of burnout
Table 4	.....	Mean and standard deviations, CFST
Table 5	.....	Intercorrelations between sub-scales for the MBI and CFST
Table 6	.....	Means and standard deviations for the PRQ sub-scales
Table 7	.....	Range of coping skills on PRQ by gender
Table 8	.....	Intercorrelations between sub-scales of PRQ, MBI and CFST
Table 9	.....	Intercorrelations between therapist variables and MBI and CFST
Table 10	.....	Summary of stepwise regression, therapist variables and CFST
Table 11	.....	Summary of stepwise regression, therapist variable and MBI
Table 12	.....	Intercorrelations between practice setting variables MBI and CFST
Table 13	.....	Summary of stepwise regression, practice setting variables, CFST
Table 14	.....	Summary of stepwise regression, practice setting variable, MBI
Table 15	.....	Intercorrelations between client variables and MBI and CFST
Table 16	.....	Summary of stepwise regression, client variables and CFST
Table 17	.....	Summary of stepwise regression, client variable and MBI
Table 18	.....	Summary of stepwise regression, therapist, practice setting and client variables and CFST
Table 19	.....	Summary of stepwise regression, therapist, practice setting and client variables and MBI

List of Figures

Figure 1	.....	Sex offender caseload
Figure 2	.....	Years experience
Figure 3	.....	Training
Figure 4	.....	Organizational supports
Figure 5	.....	Organizational stressors
Figure 6	.....	Hours of clinical service
Figure 7	.....	Duration of treatment contacts
Figure 8	.....	Stress associated with type of client
Figure 9	.....	Risk for burnout & fatigue
Figure 10	.....	Burnout and fatigue by consult
Figure 11	.....	EE, DP, PA by consult
Figure 12	.....	Burnout and fatigue by continuing education
Figure 13	.....	Burnout and fatigue by depression
Figure 14	.....	EE, DP, PA by depression
Figure 15	.....	Burnout and fatigue by work depression
Figure 16	.....	EE, DP, PA by work depression
Figure 17	.....	Burnout and fatigue by administrative support
Figure 18	.....	Burnout and fatigue by collegial support
Figure 19	.....	Burnout and fatigue by organizational politics
Figure 20	.....	Burnout and fatigue by hours clinical service
Figure 21	.....	Burnout and fatigue by percent sex offender caseload
Figure 22	.....	Burnout and fatigue by perception of sex offender caseload

Providing Clinical Services to Sex Offenders: Burnout, Compassion Fatigue and Moderating Variables

Introduction

It has long been recognized that a clinician's experiences impact on his/her personal life (Green, 1968; Terkel, 1972). Given that psychotherapy routinely involves developing and maintaining a helping relationship with distressed or stress-engendering individuals, it is not surprising that there has been considerable interest in evaluating the impact of the therapeutic process on clinicians. Psychotherapy offers both intrinsic satisfactions and challenges (Greben, 1975; Rogow, 1970; Sussman, 1995a). Kottler (1993) comments that "the process of psychotherapy flows in two directions, obviously influencing the client but also affecting the personal life of the clinician. This impact can be for better or for worse, making the helping professions among the most spiritually fulfilling as well as the most emotionally draining human endeavors" (p.xi).

The provision of treatment services to sex offender clients is a challenging and demanding form of clinical practice. These clients are frequently unwilling consumers who present with a multitude of behavioral deficits and excesses which have the potential to pose a danger to society. In accepting the challenge of providing clinical services to this population, clinicians not only face the stressors associated with this particular client group, but also additional pressures from the criminal justice systems and communities associated with these clients

While anecdotal information exists on the impacts of providing sex offender treatment (Bengis, 1997; Freeman-Longo, 1997; Garrison, 1992; O'Connell, Leberg & Donaldson, 1990; Ryan

& Lane, 1991), little empirical research has investigated how therapists treating this population are affected by their work.

Several authors have written from a clinician's perspective about the "costs of caring" (Figley, 1982) and the "hazards of psychotherapy" (Sussman, 1995a). These costs of doing therapeutic work have been described in the research literature as including: a high risk for psychological symptoms, particularly depression and anxiety (Cerney, 1995; Deutsch, 1985; Thoreson, Budd, & Krauskopf, 1986; Willi, 1983), increased drug and alcohol abuse (Norcross & Prochaska, 1986; Thoreson, Miller & Krauskopf, 1989), and suicide (Knutsen, 1977; Mausner & Steppacher, 1973). The practice of psychotherapy has also been found to have a negative impact on marital relationships (Bermack, 1977; Farber, 1985; Guy, Poelstra & Stark, 1989), parent-child relationships (Cray & Cray, 1977; Guy, 1987; Maeder, 1989) and on friendships and general social functioning (Freudenberger & Robbins, 1979; Guy, 1987). Clinicians who have experienced periods of stress or burnout have also been found to be less effective in their interventions with clients (Cerney, 1995; Deutsch, 1985; Guy, Poelstra & Stark, 1989), and at greater risk of breaching ethical conduct (Kottler, 1993) and of sexual misconduct (Pope & Bouhoutsos, 1986).

Determining the impact of therapeutic practice on clinicians is a necessary step in order to inform clinicians about how they may be affected by their clinical practice, and to support the development of prevention and intervention programs for clinicians. To this end, the present study sought to describe the experience of burnout and compassion fatigue among sex offender treatment providers; to explore the therapist, practice setting and client variables that might modulate this impact; and to characterize the stressors that contribute to the experience of burnout and compassion

fatigue. The study also investigated variables that sustain sex offender treatment providers and keep them in their practice, such as the coping strategies that are most commonly employed to manage stressors, and the satisfactions associated with this type of clinical practice.

An increased understanding of how sex offender providers are affected by various aspects of their practice has the potential to raise awareness of the difficulties inherent in this type of practice, and may increase attention to issues such as clinical competency, appropriate client care, and therapist self-care. Information on the sources of stress and the variables that moderate therapist distress can also be utilized to identify and develop the most appropriate training, supervision, job design and support resources for clinicians who take on the challenge of working with this population.

In the following sections the literature on the stressors and satisfactions associated with psychotherapy will be reviewed. Conceptual frameworks for understanding therapist impact will be discussed and factors that moderate the level of impact will be described. The limited work on the impact of providing treatment services to sex offenders will then be reviewed. Finally, a study of therapists who provide clinical services to sex offenders in a variety of settings across North America will be described.

The Stressors and Satisfactions Associated with Clinical Practice

The Stressors of Clinical Practice

Freud (1964) was the first to describe the "dangers of analysis" for the analyst. Since that time a number of stressors associated with the conduct of psychotherapeutic practice have been described.

A number of stressors originate from the pressures inherent in the therapeutic relationship (Farber & Heifetz, 1981). These include the level of responsibility demanded by the therapeutic

relationship (Farber & Heifetz, 1981; Kline 1972; McCarley, 1975), the difficulty of managing the equilibrium of intimacy and objectivity during therapy (Farber & Heifetz, 1982; Freudenberger, 1986; Kline, 1972), the pressures of continual non-reciprocal attentiveness (Chessick, 1978; Daniels, 1974; Farber & Heifetz, 1982; Greben, 1975; Kottler, 1993), the need to control one's own emotions in sessions with clients (Bermak, 1977), and the experience of separation at the time of termination (Chessick, 1978; Fine, 1980).

Other authors have emphasized the emotional strain inherent in the counseling process including: the experience of isolation and aloneness/loneliness (Bermak, 1977; Boice & Myers, 1987; Chessick, 1978; Daniels, 1974; Fine, 1980; Freudenberger, 1986; Greben, 1975; Kline, 1972; Rogow, 1970), emotional depletion (Bermak, 1977; Boice & Myers, 1987; Chessick, 1978; Daniels, 1974; Farber & Heifetz, 1981; Fine, 1980), despair (Fine, 1980) and frustration (Chessick, 1978). The emotional strain has been reported to be further compounded by the difficulty of leaving issues related to clients and their struggles 'at the office' (Chessick, 1978; Farber & Heifetz, 1981).

The beliefs and expectations that clinicians hold about their responsibilities, abilities and capabilities also serve as modulators of psychological distress. Increased levels of distress have been linked with clinicians' attributions of responsibility for their clients lives (Farber & Heifetz, 1982; Kline 1972; McCarley, 1975), and unrealistic expectations that they (clinicians) must give maximum time, energy and attention immediately on demand by the client (Deutsch, 1984). Irrational beliefs about the level of competence and efficacy a therapist must achieve in their work (e.g., "I must be totally competent, knowledgeable, and be able to help everyone") further contributes to the experience of stress (Deutsch, 1984; Forney, Wallace-Schutzman and Wiggers, 1982).

Therapist concerns about the client's treatment progress and outcome also contribute to the experience of distress. Doubts about the efficacy of the treatment process (Farber & Heifetz, 1982), ambiguity in determining treatment progress (Bermak, 1977), lack of observable progress (Deutsch, 1984), an inability to help acutely distressed clients, and/or, lack of therapeutic success (Deutsch, 1984; Farber & Heifetz, 1982; Fine, 1980) have all been identified as contributing to clinician stress.

The Satisfactions of Clinical Practice

Although the satisfactions derived from clinical practice may contribute to a reduction of work related stress, fatigue or burnout, this important area has received little attention. As Sussman (1995b) points out, the joys and challenges of practicing psychotherapy appear to be easily overlooked, by researchers and perhaps clinicians as well.

In one study, satisfaction was associated with the perception of helping others and making a positive contribution to society (Rogow, 1970). In another, becoming intimately and helpfully involved in the lives of patients, promoting growth and change, and feeling proud and respected for being a competent professional within their profession were listed as sources of professional satisfaction by therapists (Farber & Heifetz, 1981). Some clinicians have also commented that therapeutic work provides them with an opportunity for personal development. In this regard, therapists have reported deriving satisfaction through the enhancement of their own sense of self-knowledge, self-awareness, self-assurance and personal growth (Farber, 1983; Farber & Heifetz, 1981).

Accurate description of the satisfactions of clinical practice is important since the risk for professional 'burnout', may be reduced if sources of satisfaction can be maximized such that they

outweigh the stressors (Farber & Heifetz, 1981; Koeske & Koeske, 1993; Maslach, 1982, Maslach & Jackson, 1981).

Unfortunately, the research literature investigating the satisfactions related to psychotherapy is underdeveloped, dated and methodologically flawed (e.g. relies on small heterogeneous samples with resultant over-generalization of results). As well, research in this area has not considered how various therapist, work setting or client variables may influence clinician satisfactions.

Conceptualizations of Therapist Impact

While much of the research on the impact of clinical practice on mental health workers is descriptive in nature, several conceptualizations have emerged which permit both an organization of the findings and guide for measurement strategies. Four such conceptualizations will be described, compared and contrasted, and their relevance and applicability to measuring the impact of providing treatment services to sex offenders discussed. Two of these conceptualizations, burnout and compassion fatigue, are explored in this study.

Burnout

Kottler (1993) describes 'burnout' as "the single most common personal consequence of practicing therapy" (p. 157). Accordingly, there is a sizeable literature identifying burnout among various mental health professionals (e.g., psychiatrists, psychologists, social workers) as a major professional concern (Ackerley, Burnell, Holder & Kurdek, 1988; Cherniss, 1980a; Farber, 1985; Farber & Heifetz, 1982; Freudenberger, 1974; Freudenberger & Horner, 1993; Kahill, 1986; Lalotis & Grayson, 1985; Ross, 1993; Pines and Maslach, 1978; Raquepaw & Miller, 1989; Robbins, 1979; Wood et al., 1985).

Burnout has been defined in various ways, however, the common theme in all definitions is that of emotional, psychological and physical depletion as well as exhaustion (Ackerley et al., 1988; Maslach, Jackson & Leiter, 1996; Pines and Maslach, 1978).

Maslach & Jackson (1981) characterize burnout, as it relates to the human service provider profession, as a multi-dimensional construct consisting of emotional exhaustion, depersonalization (feeling distant/detached from clients) and a reduced sense of personal accomplishment. It is assumed to be progressive over time and accelerate as a consequence of increased client contact. Burnout is assumed to result when an individual views his/her work as excessively demanding with a concomitant perception of an inadequate ability to cope with the stress experienced from these excessive demands (Cherniss, 1980b; Maslach, 1978; Maslach & Jackson, 1981). A related notion is that therapist burnout results, or is more likely, when therapists believe that the resolution of their client's problems lies beyond their professional capabilities (e.g., lack of perceived competence or efficacy; Figley, 1995).

A number of characteristics of burnout have been described (Freudenberger, 1990; Kahill, 1986; Ross, 1993; Ryan, 1990). These include physical symptoms (e.g., physical exhaustion, headaches, backaches, stomach problems, insomnia, colds and flu), emotional symptoms (e.g., chronic fatigue, anger, impatience, irritation, depression, anxiety, lack of motivation, feeling overwhelmed, helpless, guilty, and emotional/spiritual depletion), behavioral symptoms (e.g., frequent use of alcohol, drugs, tobacco or food, aggression, callousness, pessimism, defensiveness and cynicism), work-related symptoms (e.g., decrease in efficiency, late for meetings, absenteeism, low moral and job satisfaction, theft, quitting job) and interpersonal symptoms (difficulty empathizing with clients,

inability to concentrate/focus on clients, withdrawing from clients and co-workers, reluctance to socialize, unwillingness to get out of bed or go to work, and loss of intimacy with family and friends).

While many authors have written about the experience and prevalence of burnout among sex offender treatment providers, only one empirical study has been conducted. In a preliminary investigation into the impact of providing sex offender treatment on female therapists, Bachynski (1995) interpreted the results of the Maslach Burnout Inventory (Maslach & Jackson, 1981) for 15 female and 15 male sex offender therapists and 15 female therapists from community health centers, not providing sex offender treatment. It was found that female sex offender treatment providers tended to experience higher levels of depersonalization and lower levels of personal accomplishment than did female therapists who did not work with sex offenders. Although the mean differences between female and male sex offender treatment providers suggested that females experienced higher levels of emotional exhaustion, depersonalization and lower levels of personal accomplishment, the differences did not reach significance. It is clear that the phenomenon of burnout in sex offender treatment providers has not been adequately studied.

Compassion Fatigue/Secondary Traumatic Stress

A second conceptualization of negative impact focuses on the interrelated concepts of compassion fatigue and secondary traumatic stress (STS). Figley (1995) defines STS as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other - the stress resulting from helping or wanting to help a traumatized or suffering person" (p.7). In a psychotherapeutic context, STS may potentially result from protracted interactions with clients who recount numerous traumatic experiences and/or who have inflicted such

experiences on others. The roots of this concept lie within the diagnostic criteria for Post Traumatic Stress Disorder (PTSD), which indicate that PTSD may be experienced both as a result of direct, as well as indirect exposure to trauma. Figley (1995) states that there are fundamental differences between the sequelae during and following a traumatic experience for individuals who experience trauma directly and those who experience it indirectly. The diagnostic criteria for PTSD and what has been labeled as secondary traumatic stress disorder (STSD) are nearly identical, however, STSD is experienced by someone who has not directly experienced the trauma and primarily involves concern and worry for the traumatized or trauma inflicting person, rather than for the self.

In considering what places mental health professionals at risk for STSD, it has been noted that "prolonged" exposure to trauma clients is a risk factor for secondary trauma (Pearlman & Saakvitne, 1995a). It has also been noted that therapist empathy is associated with increased vulnerability to secondary trauma or compassion fatigue. The empathic connection with trauma clients appears significant as emotional arousal, emotional depletion and therapist vulnerability have all been associated with an empathic relationship (Figley, 1995; Pearlman & Saakvitne, 1995a). Since the necessity of this empathic connection/therapeutic alliance has been described as a necessary condition for effective interventions with traumatized individuals (Gutkin, Ellerby, & Foss, 1994; Figley, 1995; Pearlman & Saakvitne, 1995a), Figley (1995) adopted the term compassion fatigue (Joinson, 1992) and used it in place of STS. The term compassion fatigue has been adopted as it does not have connotations suggestive of pathology as do the terms STS and STSD. As well, compassion fatigue reflects the connection between the nature of the work (the need to be empathic with trauma clients)

and the condition (experiencing fatigue or distress from being exposed to and absorbing the suffering of trauma clients).

The symptomatology associated with compassion fatigue or STS is similar to the symptoms used to define burnout. According to Yessen (1995), the symptoms include the following domains: physical (e.g., somatic reactions, breathing difficulties, rapid heartbeat, impaired immune system), emotional (e.g., powerlessness, anxiety, guilt, anger, depression, feeling overwhelmed and depleted), behavioral (e.g., clingy, impatient, irritable, withdrawn, sleep disturbances, appetite changes, substance misuse), interpersonal (e.g., withdrawn, decreased interest in intimacy or sex, mistrust, isolation from friends, impact on parenting), cognitive (e.g., diminished concentration, confusion, preoccupation with trauma, apathy, rigidity, whirling thoughts) and spiritual (e.g., questioning the meaning of life, loss of purpose, anger at God, questioning of religious beliefs).

Figley (1995) differentiates between compassion fatigue and burnout by noting that compassion fatigue can have a more sudden onset and a faster recovery rate. As well, the author suggested that the symptomatology associated with compassion fatigue can often be disconnected from real causes.

Since the secondary trauma model assumes that clinicians who work with trauma clients are most vulnerable, there may be some question about the appropriateness of extending the model to sex offender clients. After all, sex offenders typically inflict trauma on others. While this is a valid argument, it can also be argued that providing treatment to sexual and violent offenders can be conceptualized as a form of trauma therapy (Dutton & Rubinstein, 1995; Tick, 1995). More specifically, secondary trauma may be experienced by a therapist who not only listens to individuals

who experience trauma but also by listening to those who inflict it on others (Figley, 1995). The acting-out of sexual abuse/aggression as well as other forms of physically aggressive and self-destructive behaviors has been described as consistent with traumatic expression (Pearlman & Saakvitne, 1995a). Other parallels have been drawn between the impact of the trauma material to which sex offender therapists are exposed to (e.g., details related to sexual and non-sexual offending behavior) and the impact of the trauma material to which other trauma therapists are exposed to (e.g., survivor therapists being exposed to details of clients' victimization). Finally, since a great number of sexual offenders have themselves been victims of various forms of abuse (e.g., neglect, verbal, emotional, physical and sexual), in addition to their perpetrator behavior, they disclose the same types of trauma/victimization issues as faced by survivor therapists.

To date, there has been no empirical investigation into the experience of STS or compassion fatigue among sex offender treatment providers. While the literature on STS has noted that therapists who work with violent or sex offenders are involved in trauma therapy and may be vulnerable to STSD or compassion fatigue, the research has focused primarily on therapists who deliver clinical services to adult survivors of childhood sexual abuse.

Another conceptualization of therapist impact is that secondary traumatization may be acquired vicariously. In this regard, Pearlman & Saakvitne (1995a) define vicarious traumatization as "the transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material" (p.31). McCann & Pearlman (1990a) have described the cumulative effect upon the trauma therapist of working with survivors of traumatic life events, in particular, adult survivors of childhood sexual abuse.

This model suggests that working with traumatized individuals exposes clinicians to a number of distressing and disruptive issues/experiences. These experiences include the need to confront the reality of severely disturbed and destructive human beings; coming to terms with the fragility and tenuousness of life; and being reminded of personal pain (for therapists who have themselves been survivors of abuse/trauma). In addition, the therapist must engage with clients who are highly defended, mistrusting and who may re-enact their painful, abusive relationship history within therapy, or, who may project expectations from past relationships onto the therapist (seeing her/him as malevolent, dangerous or exploitive). Finally, the therapist is often placed in the position of a helpless bystander while hearing stories of past abuse, cruelty and damage and witnessing current re-enactments of traumatic memories (Pearlman & Saakvitne, 1995 a, b). These experiences with trauma clients potentially result in profound changes to the clinician's frame of reference, identity, world view, spirituality and beliefs, which may be permanent (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995a, b).

A recent preliminary investigation into the experience of vicarious traumatization among trauma therapists, including clinicians who reported "encountering perpetrators", was conducted by Rich (1997). The study investigated the differences in responses to a true/false questionnaire, comparing and contrasting between subjects who responded 'true' to the question "I believe I suffer vicarious traumatization" and those who responded 'false' to this question. In the study, 62% of the respondents reported being vicariously traumatized. These individuals were described as reporting more frequent experiences of intrusive imagery connected with clients (e.g., flashbacks, dreams, images), more safety concerns (e.g., higher anxiety, worried about families, feeling less safe at work),

being less trusting (e.g., more cynical), having less personal power (e.g., more depression, easily discouraged, lowered perception of their own masculinity/femininity,) and more intimacy deficits (e.g., feeling more isolated, removed from family and friends, at odds with the world, over identifying with clients) than respondents who did not see themselves as vicariously traumatized. Individuals who did not report experiencing vicarious traumatization appeared to have more functional adaptation or coping skills to assist them in managing the impact of their trauma work.

The relevance of the findings to sex offender treatment providers is unclear for a number of reasons. Firstly, the term perpetrator was not defined (e.g., sex offender?, violent offender?) and the manner in which respondents encountered perpetrators was also undefined (e.g., in the context of being a case manager?, treatment provider?). As well, less than five percent of the sample described encountering perpetrators exclusively. The sample was a mixture of individuals whom, in the course of their work, reported encountering survivors and perpetrators (64%), survivors only (27%) perpetrators only (2%) and a group of therapists who either did not respond to this question or did not work with either survivors or offenders (7%). This study also did not focus on objectively evaluating the experience of vicarious traumatization, but rather relied on the subjects' self-report/self-diagnosis, without the provision of an operational definition for the construct of interest.

While the previously summarized research was a preliminary effort to investigate an important area, the absence of an objective or standardized measurement instrument to evaluate vicarious traumatization, the lack of information about the type of client contacts, the small number of respondents only encountering perpetrators, and the failure to investigate possible moderating variables (e.g., therapist, practice setting and client variables) do not permit an assessment of the

degree to which sex offender treatment providers experience vicarious traumatization and limits the extent to which the results apply to this specific therapist group.

Countertransference

Historically, the psychodynamic concept of countertransference is the earliest attempt to conceptualize how therapists are impacted by the process of psychotherapy. While there are a range of definitions of countertransference, and debates about what constitutes countertransference, the basic concept involves the therapist's emotional reaction to a client. Within psychoanalytic theory, the therapist's response to the client is assumed to be unconscious, based on his/her own history, and may be a reaction to the client's transference (Jacobs, 1991; Little, 1957). The experience of countertransference has the potential to inhibit the clinician's ability to be therapeutic with the client. In the trauma field, countertransference has been labeled traumatic (Herman, 1992) or destructive countertransference (Corey, Corey & Callanan, 1993). Traumatic countertransference is experienced as feelings of being overwhelmed by the painful images and thoughts presented by the client and interferes with the therapist's ability to be objective, accurate and present.

Several recent authors have discussed the countertransference issues therapists may encounter when working with sex offenders. Mitchell and Melikian (1995) describe the reactions of a female therapist to her clinical work with a male incest offender. The authors describe the clinician as recognizing her own sadistic thoughts and indicate the need for professionals working with this population to examine their thoughts/fantasies. The need to address the therapists thoughts and fantasies, as part of the countertransference reaction, has also been noted by Pence (1995). Other countertransference issues recently reported include the experience of a voyeuristic counter-

transference response among new, inexperienced trauma therapists working in the area of sexual abuse (Neumann & Gamble, 1995), and the need for clinicians to deal with their own feelings of abuse and personal experiences of abuse as a means of moderating the experience of counter-transference when working with victims and perpetrators of sexual abuse (Berkowitz, 1995).

Contrasting the Conceptual Frameworks

In comparing and contrasting vicarious traumatization, burnout and compassion fatigue, there are some significant areas of overlap as well as some fundamental differences. The concepts all appear to focus on the role and relationship between empathic connections and emotional depletion and how this predisposes clinicians to experience distress. As well, there are considerable parallels between the symptomatology associated with each of these constructs.

Compassion fatigue differs from vicarious traumatization in that it is more symptom oriented. Vicarious traumatization, however, focuses on the context and etiology of the symptoms and conceptualizes them in terms of adaptation. Vicarious traumatization differs from burnout in that it is related specifically to the impact on trauma therapists and focuses on the interaction between a host of clinician and trauma client variables. Burnout, on the other hand, can be applied to therapists in general, including trauma therapists, and focuses on the therapist's experience of the situation, rather than the personality of the clinician.

Vicarious traumatization also differs from burnout and compassion fatigue in that despite identifying moderating variables that may impact on the experience of vicarious traumatization, this form of trauma has been described as inevitable among trauma therapists and while the symptoms may be manageable, there is no recovery (Pearlman & Saakvitne, 1995a).

Countertransference differs from the other concepts describing therapist trauma in that the emphasis is on individual therapeutic relationships. As a consequence, the cumulative impact across relationships/clients is not considered.

Selection of Clinician Impact Concepts and Measures for the Present Study

This research project focuses on the experience of burnout and compassion fatigue among a large sample of sex offender treatment providers. The 'burnout' construct was chosen for three reasons. First, this conceptualization of impact has multiple behavioral referents. Second, a psychometrically validated measure for assessing burnout has been developed (Maslach & Jackson, 1981). Third, a number of the markers of burnout such as emotional depletion, depersonalization and personal achievement fit with the investigator's perception of how clinicians who treat sex offenders often are impacted by their practice. Compassion fatigue was chosen as a second conceptual framework because of its focus on trauma workers, the face validity of the self-report measure and apparent overlap between the concepts of compassion fatigue and burnout. While these concepts overlap, there is some basis for distinguishing them. Valent (1995) relates that one may experience a high level of compassion fatigue, without experiencing burnout, suggesting that compassion fatigue may be a precursor to, and signal the potential onset of burnout.

Moderating Variables of Stress

In considering how clinicians are affected by their clinical practice, this investigation focused on the variables that might moderate the experience of burnout and compassion fatigue. A number of variables have been identified as influencing therapists' resilience or vulnerability to the impact of clinical practice. In reviewing the literature describing moderating variables there appear to be three

primary variable domains: therapist, practice setting and client variables. Each of these will be discussed with attention to how these relate to therapist impact, and, in particular to trauma therapists.

Therapist Variables

A range of therapist characteristics have been proposed to have an impact on clinicians' experience of stress. These include age, years of experience, gender, professional training, coping styles, personal history and access to supervision.

As one might expect younger clinicians and/or those with fewer years of experience report higher levels of distress (Boice & Myers, 1987; Deutsch, 1984; Rodolfa, Kraft & Reilley, 1988) and greater levels of personal depletion (Farber & Heifetz, 1981). Younger, less experienced trauma therapists have also been found to evidence higher degrees of depersonalization and trauma related symptoms than their older more experienced counterparts (Arvay & Uhlemann, 1996).

Therapist gender has also been identified as playing a role in the experience of stress among clinicians. Relative to male therapists, females report greater feelings of emotional depletion, depersonalization and distress as a result of contact with resistant clients (Boice & Myers, 1987; Deutsch, 1984; Farber & Heifetz, 1981). Although Bachynski (1995) did not find significant differences between how female and male sex offender therapists were affected by their work, this author noted some tendencies for females to experience higher levels of emotional depletion, depersonalization and lower levels of personal accomplishment, however, not at a level reaching significance. Pearlman & Saakvitne (1995a) related that women trauma therapists may be more vulnerable in part because they may be more likely to identify with the victimized groups, and they

may be more vulnerable to assault than are male therapists. Another contribution may be that female therapists are more self-disclosing of their distress than are male therapists.

Parental status has been found to moderate distress as well. More specifically, trauma therapists who are parents of young children often experience anxiety about their children's safety and, as a consequence, become overprotective of them. In this regard, Pearlman & Saakvitne (1995b) have stated that "it can be unbearable to learn of danger to children when one is connected with and responsible for children on a full-time basis" (p.312).

A clinician's professional training/background also appears to moderate therapist impact. For example, psychiatrists, who enjoy a higher status than other mental health professionals, have been found to experience lower levels of stress and personal depletion than do social workers and psychologists (Farber & Heifetz, 1981). In addition, the level of education may also impact the experience of stress. Pearlman & MacIain (1994) found that trauma therapists with master's level training experienced more psychological distress than did those with doctoral training, while Arvay & Uhlemann (1996) reported that trauma therapists educated at a level below a master's degree had the highest levels of stress and burnout. It should be acknowledged that the relationship between professional training and impact is most often confounded by financial factors, with higher levels of training being associated with increased salary. It is difficult therefore to unambiguously interpret the relationship between professional training and therapist impact.

Among therapists who are frequently exposed to trauma clients, the therapist's range and style of coping is assumed to influence the level of experienced distress. In particular, two categories of

healthy coping strategies have been found to moderate the experience of stress; personal and professional (Antonovsky, 1990; Dutton & Rubinstein, 1995).

Personal coping strategies include attending to physical, emotional and spiritual needs, taking time for play (recreational activities, hobbies, entertainment), developing supportive personal relationships and loving relationships, taking time for self-exploration, and participating in personal therapy or support groups (Dutton & Rubinstein, 1995; Edelwich, 1980; Grosch & Olson, 1995; Pearlman & Saakvitne, 1995b). It has also been noted that it is important for some therapists to become involved in therapy to address their idealized expectations about their capabilities and excessive feelings of responsibility for their client's lives; the negative impact of their clinical practice; and the need to address and resolve family of origin issues and personal trauma histories (Dutton & Rubinstein, 1995; Grosch & Olson, 1995; Pearlman & Saakvitne, 1995b; Schatzow & Yassen, 1991). The need for therapists to become involved in therapy is thought to be especially important for trauma/offender therapists who have themselves experienced traumatic events as a child or adult. Their contact with trauma clients has the potential to re-activate personal distress that may impact on their personal and professional functioning (Farrenkopf, 1992; Pearlman & Saakvitne, 1995b).

Professional coping strategies largely involve having balance and diversification within a clinical practice, building professional connections and participating in clinical supervision (Dutton & Rubinstein, 1995; Grosch & Olson, 1995; Pearlman & Saakvitne, 1995b). There appears to be a consensus in the literature, particularly as it relates to trauma therapists, that supervision and consultation with colleagues, both formal and informal, relieves stress among mental health professionals and has the potential to diminish the negative impact of clinical practice (Cerney, 1995;

Figley, 1995; Grosch & Olson, 1995; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a,b; Savicki & Cooley, 1987). In contrast, the use of "negative coping" by mental health professionals has been correlated with the experience of trauma symptoms among clinicians (Follette, Polusny, & Milbeck, 1994).

Practice Setting Variables

The contribution of the work context in which mental health professionals practice, to the distress experienced by therapists, has been identified as a significant factor contributing to burnout among clinicians (Edelwich, 1980; Norcross & Prochaska, 1986). A range of practice setting variables have been described as moderating stress including the type of practice, practice setting, collegial support, financial considerations and organizational politics.

Clinicians who practice in an agency or clinic setting have been found to experience greater levels of distress and emotional exhaustion relative to those in an independent practice (Arvay & Uhlemann, 1996; Deutsch, 1984; Pearlman & MacIan, 1994; Raquepaw & Miller, 1989). Further, it has been reported that clinicians who practice in an institutional (in-patient setting) experience greater levels of distress than those in a community (out-patient) setting (Farber & Heifetz, 1981). This institutional setting effect could be due to a number of factors such as an altered therapeutic relationship in an inpatient setting (often psychiatric admissions are involuntary), more severe psychiatric symptoms of mental health inpatients, and the environmental working conditions.

Relative to practicing in isolation, a practice setting in which there are other clinicians available for information, consultation and support has been reported to reduce distress among therapists, particularly trauma therapists (Dutton & Rubinstein, 1995; Farber, 1983; Pearlman &

Saakvitne, 1995b). As previously described, therapists were at greater risk for distress in organizations where supervision was not available (Pearlman & Saakvitne, 1995a,b).

Financial and organizational concerns have also been found to influence therapist distress. Not surprisingly, limited or tenuous funding for programs and inadequate salaries have been identified as stressors for therapists (Norcross & Prochaska, 1986; Pearlman & Saakvitne, 1995). Similarly, work place issues such as organizational politics, difficulty in relationships with colleagues, power struggles, excessive work load and time pressures have been identified as sources of stress among clinicians (Bermak, 1977; Boice & Myers, 1987; Chessick, 1978; Daniels, 1974; Farber, 1979; Freudenberger and Robbins, 1979; Greben, 1975; Kottler, 1993; Norcross & Guy, 1989).

Client Variables

A range of factors related to the client population served by clinicians have been identified as moderating the experience of stress/distress among mental health providers. These include such things as client characteristics, size of case loads, frequency and duration of client contact, and the level of exposure to a client's traumatic material.

Providing services to 'difficult' clients has repeatedly and consistently been identified as a significant source of therapist stress (Greben, 1975; Hellman, Morrison & Abramowitz, 1987; Chessick, 1978; Daniels, 1974; Farber, 1979; Freudenberger and Robbins, 1979; Rogow, 1970). Stressful client behaviors appear to cluster into two distinct categories, resistant behaviors and overtly psychopathological symptoms.

Patient apathy or lack of motivation has been identified by therapists as a significant stressor (Deutsch, 1984; Farber & Heifetz, 1981). In addition, clinicians have noted that providing clinical

services to mandated clients is stressful, as these clients are often lacking internal motivation to change and, at the same time are resisting the external influences directing them to participate in a therapeutic process to bring about change (Stenson, 1978; Strasburger, 1986). Both client apathy and mandated treatment are commonplace among clients who are sex offenders.

Severe psychopathology has repeatedly been identified as a stressor among clinicians (Deutsch, 1984; Farber & Heifetz, 1981; Hellman, Morrison & Abramowitz, 1987). Patients suffering severe depression (Deutsch, 1984), borderline states and narcissistic personalities (Fine, 1980) and who engage in suicidal preoccupation and expression of anger, aggression and passive-aggression (Deutsch 1984; Farber & Heifetz, 1981; Hellman, Morrison & Abramowitz, 1987; Menninger, 1990) have been described as the most stress-engendering clients. Other client characteristics/behaviors identified as stress engendering include: lying, having hidden agendas, being manipulative, poor impulse control, literal/concrete, non-verbal, extreme dependency, seductive, ignoring boundaries, and clients contacting their therapist at home by telephone (Deutsch, 1984; Kottler, 1992, 1993; Robbins, Beck, Mueller, & Mizener, 1988). Providing clinical services to clients who are socially stigmatized has also been identified as a source of stress (Egan, 1993). Once again, many of the aforementioned characteristics are typified by sex offender clients.

While the literature provides useful and important information about generic stressors associated with providing general psychological services, there is a need to investigate and detail stressors unique to working with special client populations (Bennett, Evans & Tattersall, 1993; Evans & Fischer, 1993). Accordingly, efforts have been made to identify and describe the stressors and less often, the satisfactions, associated with providing treatment to special populations. This has included

describing the experiences and the impact of treating children (Bennett, Evans & Tattersall, 1993), the elderly (Steinberg & Salamon, 1995), suicidal patients (Garfunkel, 1995; Jobes & Maltzberger, 1995), AIDS patients (Oktay, 1992; Shernoff, 1995) and fellow therapists (Bridges, 1995). These clinicians and researchers have related the unique ways in which serving these populations have affected treatment providers and, in some cases, resulted in higher levels of stress and burnout than observed in providing clinical services to other populations.

Particular attention has recently been given to detailing the impact on clinicians who provide clinical services to trauma victims. While the focus of this work has investigated the impact on therapists who provide treatment to adult survivors of childhood sexual abuse, trauma clients have also been identified as holocaust survivors, Vietnam war veterans, victim/survivors of physical abuse and violent and sexual offenders (Danieli, 1982, Dutton & Rubinstein, 1995; Tick, 1995). The process of psychotherapy with these clients is described as having the potential to make therapists particularly vulnerable to distress and trauma-related symptomatology.

In reviewing the impact of a clinical practice with trauma clients, some noteworthy client related stressors are identified. Not surprisingly, the volume of services provided to special populations appears to influence impact. Therapists with high case loads of trauma clients, including potentially violent clients, have been found to experience higher levels of distress, particularly when they perceive their case loads as unmanageable (Arvay & Uhlemann, 1996; Cerney, 1995; Harris, 1995; Raquepaw & Miller, 1989). Similarly, when treatment contacts are more frequent and extended over a long duration, clinician distress is increased (Ball & Kuipers, 1992). The frequency and intensity of client contact with trauma clients in particular has been related to levels of distress among

trauma therapists (Arvay & Uhlemann, 1996; Cerney, 1995). Finally, the extent to which therapists are exposed to graphic details of trauma material (e.g., child molestation, rape, sadism) and the level of brutality associated with the trauma material has been described as increasing the potential for therapist distress (Figley, 1995; Pearlman & Saakvitne, 1995b).

Sex Offender Treatment: Stressors and Impact

The literature which focuses on the stressors and impact specifically related to the provision of clinical services to sex offender clients is sparse. This literature tends to identify a range of additional stressors faced by sex offender treatment providers, in addition to the generic stressors associated with psychotherapy. As well, there are some accounts, both anecdotal and empirical as to the way in which clinicians are affected as a result of their clinical practice with sex offender clients.

Stressors Associated with the Provision of Sex Offender Treatment

Sex offender clients tend to be individuals with multiple problems and may also be unmotivated and resistant to treatment. Alternatively they may give the appearance of wanting treatment either for ulterior motives (e.g., to minimize a sentence or attempt to gain an early release from prison) or because they are mandated (e.g., by the provincial courts or National Parole Board of Canada). During treatment contacts sex offenders typically present as deceptive, manipulative, narcissistic and, at times, antisocial. They may also exhibit behavior that is: angry, controlling, and at times sexualized, or they may present as needy, dependent and demanding. Sex offenders tend to lack empathy for the damage they have inflicted onto their victims and typically deny, minimize, rationalize or project in order to avoid culpability for their actions. The client population served by

sex offender treatment providers exhibit many of the characteristics recognized as being among the most stressful for clinicians. In addition, although there is stigma associated with all forms of mental health problems, sex offenders may be the most unpopular and socially stigmatized of any client group.

In addition to facing a myriad of stressful client characteristics, individuals providing sex offender treatment repeatedly listen to, read about (and sometimes directly encounter) a wide range of inappropriate and deviant sexual behaviors (offending and non-offending behaviors), including accounts of sexualized and non-sexualized violence and deviant sexual fantasies and arousal, as a result of the high level of deviant arousal experienced by some sex offenders (Barbaree & Marshall, 1989). In addition, therapists are often exposed to pornography and issues related to victimization such as degradation, dehumanization, control and abuse (neglect, verbal, physical, sexual, psychological). The task of having to address sex crimes with offenders has been described as a difficult aspect of providing sex offender treatment (Freeman-Longo, 1997; Ryan & Lane, 1991). Kearns (1995) identifies sex abuse therapists as inevitably experiencing strong emotional and cognitive responses to offending behavior, while Peaslee (1995), discusses the need for treatment providers to process this emotion-evoking information. Abel (1983) has commented 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" (cited in Farrenkopf, 1992, p. 216-217).

The intensity and duration of treatment contacts clinicians have in treating sex offenders is another potential source of therapist stress. While there is much variability between programs, Wormith & Hanson (1992) found, in their review of sex offender treatment programs in Canada, that the duration of treatment programs ranged from three to 36 months and the level of intensity of hours of clinical intervention ranged from one hour per week to 33 hours per week. As well, 36% of the programs in Canada were identified to be in-patient, where mental health professionals are typically in contact with clients on a daily basis, while another 18% of the programs provided both in-patient and out-patient services. Long term interventions with violent offenders are seen to be particularly stress provoking as the trauma therapist is exposed to traumatic events repeatedly and over a significant period of time (Dutton & Rubinstein, 1995).

How sex offender clients present in treatment can be challenging and stressful. Stress may be experienced due to client tendencies to understate their problem behavior and to minimize/deny their risk for relapse (O'Connell, Leberg & Donaldson, 1990). As well, over the course of therapy, clinicians may have to adjust to the client's deficits and risk being greater than first known, as clients enhance their level of self-disclosure (e.g., identify a further history of sexual offending, other paraphilias, a history of non-sexual aggression). At times clinicians are faced with offenders who are overconfident about their ability to manage their risk. Intervention with these clients can be stressful as they tend to be more resistant to ongoing treatment, and less willing to invest energy in monitoring and managing their risk factors. As well, such offenders often place themselves in high-risk situations to prove their ability to manage their various problem areas (e.g., deviant arousal, substance abuse, anger) and in doing so ultimately increase their level of risk.

It is generally accepted that one does not "cure" sexual offending behavior and that self-monitoring and self-management are life-long processes, (Gordon, Holden & Leis, 1991; Pithers, Marques, Gibat, & Marlatt, 1983). Due to the fact that relapse is associated with danger to society, it is not surprising that a major source of distress among treatment providers occurs as a result of the more than usual uncertainty about treatment effectiveness/outcome, and as a result of client recidivism. It has been noted that the rate of re-offence among sexual offenders is known to be very high and that within some subgroups of sex offenders, the majority of offenders eventually re-offend (Marshall, Laws, & Barbaree, 1990). Long term follow up studies tracking recidivism reduce confidence in the efficacy of sex offender treatment, and may contribute to therapist distress, as the probability of re-offending appears to escalate over extended follow up (Hanson & Steffy, 1991). High levels of recidivism have been identified as a significant stressor for trauma therapists (Dutton & Rubinstsein, 1995), and this is a reality that may be experienced by sex offender treatment providers. Clearly, in this type of intervention, the magnitude of the consequences of a return to the target behavior clinicians are attempting to assist the patient modify is considerable. The aftermath of a client re-offending (emotional, societal, political, and professional implications) can potentially be greater and more extensive than treatment failures in many other types of practice. Freeman-Longo (1997) describes how the frustration and self-blame associated with treatment failures can be contributing factors to the potential experience of burnout.

Sex offender treatment providers face the additional stress of being under a great deal of pressure from various agents of the criminal justice system and the community to be responsible for accurately evaluating and managing risk. Thus, clinicians are placed in the position of balancing the

best interests of the client, in most cases the interests of the agency of referral (e.g., courts, correctional institutions, parole/probation) and the safety of the community.

Another source of clinician distress stems from the community reaction to sex offenders. Therapists live and work in communities in which there is a powerful stigma attached to the client group they serve. Part of this stigma extends to the therapist as there is little understanding, support or appreciation for working with this population. Rather, the most common public attitude is 'why bother, just lock em up and throw away the key'. As a consequence, sex offender therapists have often described feeling alienated from the community or workplace and discouraged by society's "too little too late" reactive approach and the lack of preventive programs (Ellerby, Gutkin, Smith & Atkinson, 1993; Farrenkopf, 1992; Freeman-Longo, 1997; Ryan & Lane, 1991). Clinician stress may also increase as a result of what has been described as society's reluctance, at times, to face and address issues related to sexual abuse, at times ignoring or minimizing perpetrating behavior and the importance of addressing sexual abuse and sex offender treatment (Marshall & Barrett, 1990).

Concerns about the criminal justice system also becomes a source of stress for some practitioners. Marshall and Barrett (1990) detail a host of systemic issues and deficits which have resulted in the mishandling of sex offenders' cases, sometimes with disastrous results. Sex offender therapists have reported being disillusioned with the inconsistencies of the justice system and punitive correctional staff attitudes (Farrenkopf, 1992), the inhumanity of the correctional institution environment (Freeman-Longo, 1997) as well as by the systems' inability to protect potential victims and its failure to remove dangerous offenders from the community (Ryan & Lane, 1991). Jackson, Holzman, Barnard and Paradis (1997) report that 62% of the sex offender treatment providers who

responded to their mail survey indicated having become more disenchanted with the criminal justice system, and as coming to see it as less effective since becoming involved in the provision of services.

Given the range of potential stressors that may be faced by sex offender therapists it is understandable why Scott (1989) has commented that psychotherapy with criminals is the most demanding task in the entire area of mental health.

The Impact of Providing Clinical Services to Sex Offenders

While there has been some speculation and discussion about the potential stressors associated with providing clinical services to sex offender clients, the focus on how these stressors affect treatment providers is relatively recent. To date, much of what is known about the impact of providing sex offender treatment comes from anecdotal reports and survey research. While this literature is quite limited, there appear to be some re-occurring themes.

In describing the impact of a clinical practice with sex offenders, it has been proposed that it is common for treatment providers to be profoundly affected by their sex offender practice. One of the impacts has been described as clinicians experiencing a shift in perception about the world around them. Bengis (1997) relates,

"Once treatment providers have chosen to work in sex offender treatment, we enter what I can best describe as a 'twilight world'. This world alters our perceptions of daily events and, even more disturbingly, may change our inner-lives sometimes irrevocably. What we see when we walk down the street, what we think about in public places, what we fantasize, feel and/or fear often differs markedly from the experiences of others who do not experience the worlds in which we immerse ourselves" (p. 31).

In a candid personal account of his own experiences, Freeman-Longo (1997) describes a parallel phenomena and provides a number of examples of this altered state of perception. These include: an enhanced level of mistrust/suspiciousness (seeing every one as a potential sex offender and questioning the appropriateness of innocuous adult-child interactions), having a heightened sense of concern for safety issues, a heightened awareness of being a male in society and becoming hypersensitive in interactions with women, and, for a period of time, feeling uncomfortable in physical contacts with children and changes in sexual interest and behavior (e.g., shifts from decreased fantasy and sexual behavior to increased sex drive).

Bengis (1997) outlines similar experiences among sex offender treatment providers and identifies five common dimensions of impact he has observed and received feedback on from questionnaires distributed at training workshops. These dimensions include: 1) mistrusting others' sexual behavior, especially people with regular access to children; 2) projecting possible abusive motivation onto innocuous interactions and events; 3) managing a range of feelings, including sadness for victims; fear, rage and disgust towards offenders; and distress in response to incidents of sexually abusive behavior occurring around us; 4) experiencing titillation or sexual arousal while listening to descriptions of abuse; and 5) experiencing impulses to act out in sexually deviant ways.

These authors have identified a range of experiences they have identified in themselves and their colleagues. There is support for these observations of therapist impact through the small empirical literature that exists and through other anecdotal reports on the effects of providing sex offender treatment on clinicians.

Exposure to deviant sexuality appears to have a profound impact on some therapists' sexuality. Jackson et al., (1997) report that 67% of the 98 sex offender treatment providers who responded to their mail survey reported experiencing visual images of the sexual assaults committed by clients. The experience of these images was described as disturbing (21%), repulsive (19%) and/or arousing (1%), however, 18% of the respondents identified experiencing a combination of these reactions. This may account for the lower number of clinicians acknowledging these images to be arousing, as the experience may likely be arousal combined with distress.

Clinicians have also described questioning the normality of their own sexuality, sexual fantasies and sexual experiences after having provided treatment to sex offenders (Ellerby et al., 1993; Ryan & Lane, 1991). Changes in sexual drive and behavior have also been noted. Jackson et al., (1997) note almost half of the sex offender therapists in their sample reported changes in their own sexual behavior since beginning their practice with sex offenders. Treatment providers have reported a reduction of sexual behavior (Farrenkopf, 1992; Jackson et al., 1997), disruptions in sexual performance (Ellerby et al., 1993) and a loss of interest in sex (Garrison, 1992). Conversely, some therapists do not report reduced sexual interest and indicate that they have become more considerate of their partners sexually (Farrenkopf, 1992).

As previously noted, some sex offender therapists have also reported the experience of sexual arousal to clients' accounts of deviant sexual behavior. Ellerby et al., (1993) reported that of the 48 clinicians who responded to a mail survey, 42% of the male sex offender therapists and 16% of the female therapists sampled, reported experiencing sexual arousal in response to clients' descriptions

of deviant and sexual offending behaviors. Mitchell & Melikian (1995) also highlight the need for the recognition of one's own sadistic fantasies.

As earlier noted, sex offender therapists have also reported emotional shifts and symptoms which they attribute to their practice. Farrenkopf (1992), interviewed and/or surveyed a sample of 24 experienced therapists who provided sex offender treatment to determine the personal impact of their work. Of this sample, 42% of respondents reported a hardening or dulling of emotions. Therapists described an increase in their experience of anger and frustration, a decrease in their sense of humor and related becoming more confrontational and less tolerant of others' behavior, in both their professional and personal/social interactions. A smaller number (17%) described feeling an increased sensitivity toward others and greater empathy for human suffering. Bird Edmunds (1997) in a survey distributed at the thirteenth annual national treatment and research conference of the Association for the Treatment of Sexual Abusers (ATSA), found that over half of the 276 respondents who completed and returned the survey reported an increase in the experience of fatigue and frustration. One-third of the respondents described an increase in cynicism and general irritability, while one-fourth of the survey respondents cited an increase in depression and/or depressive episodes.

Disruptions in therapists' feelings of safety were also common. This is consistent with the identified impact of treating trauma clients (Pearlman & Saakvitne, 1995). Sex offender therapists have described becoming hypervigilant, suspicious of others and protective of their own, or their family's personal safety (Ellerby et al., 1993; Farrenkopf, 1992; Jackson et al., 1997; Ryan & Lane, 1991). Female therapists in particular were prone to increased feelings of vulnerability or threat of

abuse, more concerned about their personal safety and the safety of their children and more vigilant in their daily lives (Ellerby et al., 1993; Farrenkopf, 1992).

A significant impact of treating sex offenders for some female therapists was becoming re-sensitized to their own past experiences of victimization by men and, in some cases, this has led to an increase in their negative attitudes towards males in general (Farrenkopf, 1992).

Some therapists have noted changes in the way in which they responded to their sex offender clients in treatment, and, in their attitudes towards sex offender treatment. Ryan & Lane (1991) described therapists as developing ambivalent emotions about clients and their behavior, demonstrating victim or aggressor identification and coming to accept offenders' attempts to minimize or rationalize their behaviors. Farrenkopf (1992) reported that over half the clinicians he surveyed expressed diminished hopes and expectations in relation to treating sex offenders and described becoming more pessimistic about the prospect of client change. The author viewed therapists as going through a series of phases in terms of their reaction to their clients and their work. He relates that ultimately, over time, clinicians who treat sex offenders experience increasing feelings of anger, resentment, intolerance, depression and exhaustion that in some cases lead to burnout, and at times result in therapists discontinuing their work with sex offenders. In other cases therapists experience a stage of adaptation in which they regain their work motivation and therapeutic compassion and continue in the field. It is noteworthy that 25% of the clinicians surveyed reported feelings of generalized high stress, exhaustion, depression or burnout.

The high number of stressors involved in the treatment of sex offenders and the way in which exposure to offenders' trauma and trauma expressions can affect clinicians both professionally and

personally likely account for why there has been recent attention to attending to self-care among sex offender therapists (Freeman-Longo, 1997; Mitchell & Melikian, 1995; Pence, 1995; Rich, 1994).

Shortcomings of the Literature

As is evident from the aforementioned review, most of what has been written about the experience of stress among sex offender treatment providers is anecdotal. Although these often personalized accounts are helpful in developing hypotheses about potential stressors and moderating influences, there are a number of limitations to this approach. Firstly, the validity of the descriptive/impressionistic reports are hampered by the lack of details about the sample on which the information is based. Typically, these papers describe personal accounts, corroborated by similar experiences shared by the writers' colleagues, or through discussion with other treatment providers in the area. Little or no information is provided about the sample size and composition of the clinicians on whom the information is based (e.g., age, years experience, type of practice, training, profession) or the number of clinicians who have shared their personal experiences. A second problem is that while many of the reviewed articles describe therapists as experiencing stress, fatigue and burnout, this information is based on the subjective interpretation based on the authors' own clinical experiences, and/or that of their colleagues. It is therefore not known how representative these experiences are. Furthermore, these descriptive accounts most often do not offer a theoretical conceptualization of distress or impact, nor do they utilize measures to assess and quantify therapist impact. As a result, it is not known to what degree clinicians who work with sex offenders experience stress or impairment, and the descriptive literature fails to discuss factors that may modulate impact.

Rather, the impact is described in general terms and as something that is likely to be experienced by all therapists providing sex offender treatment.

The research literature investigating the impact on sex offender treatment providers is extremely limited. Studies by Farrenkopf (1992), Ellerby et al., (1993), Bachynski (1995), Edmunds (1997) and Jackson et al., (1997) represent the few empirical investigations. While these efforts represent important first steps in developing an understanding of the impact of providing clinical services to sex offender clients, there have been some shortcomings to these studies.

Overall, the empirical research to date on the impact of providing clinical services to sex offenders suffers from some fundamental problems which limit the generalizability of the findings. The samples for these studies have been poorly defined and sample sizes have been small. Furthermore, self-report measures and standardized questionnaires to evaluate distress, fatigue or burnout were largely absent, or have been used inconsistently, leaving most studies reliant on therapist self-report. Finally, for the most part, these studies have not taken into account investigating factors that moderate therapist impact, but rather have discussed the impact of providing sex offender treatment in global/non-specific terms.

While a number of authors have written about the prevalence of distress, fatigue or burnout among sexual offender therapists, at this time, there is little empirical basis for such claims. The current empirical literature in this area has yet to detail objective measures of distress, discuss distress on a continuum in terms of levels of impairment or to highlight factors which might moderate the experience of distress.

The present study has sought to address past deficits in this area of research. To this end, the study surveyed a large defined sample of sex offender treatment providers in Canada and the United States and conducted focus groups with a sub-sample of these providers. This study also utilized the theoretical models for burnout and compassion fatigue as a means of conceptualizing and measuring clinician impact. In considering the impact of a sex offender treatment practice, this study not only examined the levels of distress experienced by sex offender treatment providers, but also investigated the role of moderating variables on therapist impact. In addition, two research methodologies were employed, a mail survey methodology (designed to elicit quantitative data for a large number of sex offender treatment providers), and a focus group methodology (to access qualitative data from a small group of practitioners). This approach reduced reliance on a single methodology and provided an opportunity to compare and contrast the quantitative and qualitative data.

This study has sought to 1) evaluate the level of burnout and compassion fatigue among sex offender treatment providers, 2) to assess the coping skills of sex offender treatment providers, 3) to identify the moderating impact of therapist, practice setting and client variables on the level of burnout and compassion fatigue, and 4) to identify the primary stressors and satisfactions associated with providing sex offender treatment services.

METHOD

Participants

Research participants were drawn from the Association for the Treatment of Sexual Abusers (ATSA) membership list.

ATSA is a non-profit, interdisciplinary organization that was incorporated in 1984. ATSA was founded to foster research, facilitate the exchange of information, further professional education and provide for the advancement of professional standards and practices in the field of sex offender evaluation and treatment. ATSA is an international organization with a membership of over 1000 professionals committed to the prevention of sexual assault through effective management of sex offenders.

Mail Survey Respondents

A mail survey was forwarded to 1,139 ATSA members. Of this, 12, or 1% of the surveys were 'returned to sender' for reasons including insufficient address, the individual no longer being employed at that address, or in one case, the individual being deceased. Of the remaining 1,127 surveys, 838 or 74% of the surveys were returned. This response rate suggests a keen interest in this research area by ATSA members.

The majority of the returned surveys, 690 (82%) were completed by therapists, across North America, who provide direct clinical services to sex offender clients. Of these, four surveys (.06%) were returned unusable as the respondents had only partially completed different portions of the various measures, and, as a result, these surveys could not be scored. Another 148, or 18% of the surveys were returned by ATSA members indicating that they did not meet the criteria for inclusion in the study, as they did not provide three or more hours of sex offender treatment per week. A number of these respondents identified themselves as holding administrative positions in sex offender treatment programs and no longer providing direct client service. This left 26% (n=289) of the survey sample that did not respond.

To further detail the specific response pattern, the majority of the surveys were received in response to the first mail out and the reminder card sent out in the second mailing (77%, $n=644$). Of these, 555 (86%) were service providers and 89 (14%) did not meet the criteria for inclusion. The remaining 190 surveys (23%) were returned after the third mailing. Of these, 131 (69%) were service providers while the remaining 59 (31%) did not meet the criteria for inclusion. This yielded an n of 686 direct treatment providers. The process for the mailings is outlined in the procedure.

After the initial mailing, an error was discovered in the scale provided for one of the standardized measures. In response to this, the follow up third mailing was revised prior to being sent out. All those respondents, who met the criteria for inclusion in the study and who had completed and returned the initial survey were sent a revised copy of this one measure ($n=555$). Of the 555 revised measure surveys that were sent out, 412 (74%) were returned completed, while 143 (26%) of the respondents did not complete and return the revised measure. As a result, the analysis for this measure is based on a sample size of 543 ($412+131=543$), rather than the full sample size of 686 treatment providers. The process employed to address this error is detailed in the procedure.

Focus Group Participants

Participants for the two focus groups were gathered through the ATSA membership list and from conference participants at the annual ATSA conference. Two focus groups were conducted at the 14th annual national treatment and research conference of ATSA, in Chicago, Illinois. A total of 10 clinicians attended the two focus groups.

The first focus group consisted of six participants, four males and two females. The participants' experience treating sex offenders ranged from one to 12 years, with the average years

of experience being six years. Focus group participants identified themselves as psychologists, masters level therapists, counsellors, and a polygrapher/counsellor. This group consisted of a mixture of community and institutional treatment providers. The clinicians provided services to a range of sex offender clients including adult male offenders, juvenile male offenders and developmentally delayed offenders.

The second focus group consisted of four participants, one male and three female. The group members experience with sex offender clients ranged from one to 12 years and averaged 8 years. Clinicians in this group consisted of a psychologist, an educator, a program specialist and a therapist. Again, there was a mix in terms of community and institutional treatment providers and the type of sex offender clients served.

Procedure

As has previously been identified, two research methodologies were employed for data collection. The procedures for conducting the mail survey and the focus groups will be described.

Mail Survey

In conducting the mail survey, the procedures developed by Dillman (1978; 1994) were followed. All members listed on the 1996 ATSA membership list were mailed a survey package consisting of a cover letter, the Sex Offender Treatment Provider Survey (SOTPS), and a return addressed envelope with postage. Also included was an invitation to participate in the focus groups, at ATSA's 14th annual national treatment and research conference, for those who planned to attend.

The cover letter was designed to engage the participant and briefly stated the objective of the research project, explained the tracking system, assured confidentiality and related that their

participation would be greatly appreciated (see Appendix A). Following the method suggested by Dillman (1994) to enhance response rates, the cover letter was brief and each one was personalized, dated and had a handwritten signature.

The SOTPS consisted of the Maslach Burnout Inventory: Human Services Survey (MBI), (Maslach & Jackson, 1981), the Compassion Fatigue Self Test for Psychotherapists (Figley, 1993), the Personal Resources Questionnaire (PRQ), (Osipow & Spokane, 1981) and a selection of demographic and background variables compiled by the researcher from the literature on therapist stress (see Appendix B).

Each survey package had an identification number located on the front of each questionnaire with a corresponding number next to the appropriate name on the mailing list. This system enabled the researcher to track those persons who had returned their questionnaire and those who required a follow-up mailing. Having an identification number on questionnaires has been reported to have minor, if any, effects on response rates and eliminates the need to send out reminders or follow-up packages to those respondents who have completed and returned the survey (Salant & Dillman, 1994). This appeared to be the case with this mail survey.

One week after the initial mail out, a postcard follow-up note was sent to all members of the sample (see Appendix C). This follow up note thanked those who had already responded and encouraged those who had not to complete and return the survey.

Upon receiving the initial completed surveys, through a review of respondents' comments, it was discovered that an error had been made in the reprinting of the MBI. A scale consisting of four response points (never, sometimes, always and don't know) had been used rather than the correct

seven point scale (never, a few times a year, once a month or less, a few times a month, once a week, a few times a week, everyday). Some respondents had commented that the scale on the MBI was too restrictive. In response to this error, using the tracking system, each respondent who had met the criteria for inclusion in the study and who had returned their completed survey was sent an "eat crow" letter (see Appendix D), identifying the mistake and requesting that they take the time to respond to the corrected version, which was sent along with this cover letter and a return addressed, stamped envelope. As the completed versions of the revised MBI were received, they were matched up, using the tracking number, to the rest of that respondent's survey.

If required, three weeks after the second mail-out, a new personalized cover letter (see Appendix E) with a handwritten signature, survey package (with the corrected scaling for the MBI), and a return addressed envelope with postage was sent to all members of the sample who had not yet responded.

In designing the layout of the SOTPS, efforts were made to design the measure to enhance response rates as recommended by Salant and Dillman (1994). For example, a title and title page was developed for the survey (to spark peoples' interest and curiosity); the more interesting questions/measures were placed first with more mundane questions interspersed into the latter parts of the survey; instructions were constructed so they were consistent and easy to follow; the layout was left uncluttered and attention was given to the ordering and transition of the various measures/questions, individual page design and scale design (for ease of data entry). A back cover was included, thanking respondents and allowing for comments. Although the SOTPS was rather lengthy

for a mail survey, an attempt was made to be concise and to keep the response time to under one half hour.

Consistent with the recommendation by Salant and Dillman (1994), advice was obtained from potential respondents about the SOTPS. A group of 10 sex offender therapists were asked to review and complete the measure and make comments related to overall design and structure, ease of responding, face validity and time to complete. The suggestions made by these clinicians were incorporated into the final version of the survey.

As previously noted, a brightly coloured flyer was also included in the mail package indicating that an additional component of the research project would include focus groups (see Appendix F). The flyer outlined the days and times of the focus groups, the duration of each focus group and the objectives of the focus groups. Individuals interested in participating were requested to contact the researcher either by telephone, facsimile or Email in order to sign up in advance for one of the two focus groups. Once again, ATSA members were informed that their participation would be greatly appreciated.

Focus Groups

In an effort to gather qualitative data to supplement the quantitative data collected through the SOTPS, two focus groups were conducted.

Focus groups involve group interaction based on a selected topic. The focus group participants discuss a particular topic or question under the direction of a moderator who promotes interaction and guides the discussion (Richter, Bottenberg & Roberto, 1991). The fundamental data that focus groups produce are transcripts of the group discussions which are analysed for their

content. While focus groups may be used on their own as a means of data collection, they have also been identified as useful in supplementing data gathered through quantitative methods (Morgan, 1988). The strength of focus groups lies in their ability to explore topics in greater depth than a survey, to collect data from group interaction and to bring forward material that would not come out in response to a researcher's preconceived questions (Morgan, 1988).

Two focus groups were conducted, each lasting approximately one hour. The first focus group was attended by six clinicians and the second was attended by four. The number of focus groups conducted, duration of the focus groups and group size were consistent with recommendations outlined by Morgan (1988, 1993) regarding focus group methodology.

As previously indicated, the focus groups were held at the ATSA conference in Chicago, Illinois on November 14 and 15th, 1996 and were scheduled on two separate evenings (5:30 p.m. - 6:30 p.m.) following the conclusion of conference seminars for that day. The focus groups were conducted in a small conference room provided by the ATSA conference planning committee.

Holding the focus groups at the conference was determined to be conducive to the research project as it provided a convenient location for both participants and the researcher to come together at a central and neutral site.

Consistent with research methodology on focus groups, a small number of general and open ended questions were asked during the focus groups. The focus group questions were as follows:

- 1) What are the difficulties/stressors you have experienced as a result of providing direct clinical services to sex offenders?,
- 2) How do you cope with the difficulties/stressors associated with

providing sex offender treatment? and 3) What are the most important factors that contribute to make your clinical practice with sex offenders satisfying?

These questions were specifically designed to be broadly stated to allow and encourage the respondents to provide the information they felt to be most important/relevant, rather than having them respond to the researcher's perceptions related to the topic areas. Leaving the questions open, also allows respondents to provide information not previously considered by the researcher. Additionally, open and general questions have been described as appropriate for this type of group study because of privacy issues. Within focus groups, participants are not only sharing their thoughts and feelings with the researcher, but also with other participants within the group. As a result, general questions allowed respondents the ability to discuss only what they were comfortable sharing. The focus groups began with opening statements by the moderator, who in this study was the researcher. The topic of the research was introduced and the overall research project was described.

Prior to proceeding, issues related to confidentiality and privacy were raised and discussed. The participants were informed that the focus groups would be taped and that the audio tapes would be reviewed and transcribed, solely for the purposes of this research project. They were also informed that the transcripts would be anonymous and that their names would not appear, either in the transcripts or be connected to data utilized from the analysis of the transcripts. Participants were informed that the audio tapes would be destroyed once transcribed.

Once confidentiality issues had been covered to the group participants' satisfaction, some ground rules for the discussion were outlined and group members were encouraged to share their thoughts, opinions and experiences and reminded of the importance of their participation by

indicating to them that the researcher is there to learn from them, a strategy recommended in focus group methodology (Bellenger, Danny, Kenneth, Bernhardt & Goldstrucker, 1976, Morgan, 1988).

The groups then proceeded with introductions. Each participant provided some background information about themselves and their involvement in sex offender treatment (e.g., profession, type of sex offender practice, years of clinical experience with sex offenders, type of clients served). Introductions were viewed as a means of "breaking the ice" and engaging the participants prior to beginning the actual group discussion.

Once the introductions were completed, the first question was posed and the discussion began. The questions were posed by the moderator and were recited from memory. Morgan (1988) recommends that the research questions be committed to memory so that participants are not holding back waiting to respond to the researcher's agenda as he/she refers to a printed list of topics. Raising the questions without having to refer to a list also allowed the discussion to unfold in a more free flowing and natural manner.

The methodology on conducting focus groups indicates that the level of moderator involvement can be viewed on a continuum, ranging from moderators having a very low level of involvement to playing a very active role. The preference for social science research is for the moderator to have a low level of involvement and to attempt to keep their comments as non-directive as possible (Morgan, 1988). Morgan (1988) states that if the goal is to learn something new from the participants, it is best to let them speak for themselves. Low moderator involvement minimizes moderator bias, focuses attention on the participants' thoughts and allows the researcher to see if participants organize their discussions around the same issues the researcher believes to be important.

Consistent with this, the moderator's level of involvement during the focus groups for this study was very low and specifically focused on explaining the purpose and objectives of the focus group, asking the questions of interest, facilitating a smooth and natural transition between the questions, following up on new topics that were raised by group members, pacing the discussion in terms of the amount of time spent on each question and, when necessary, probing more deeply or skipping over areas that have already been covered.

In addition to the moderator, a research assistant also participated in the focus groups. The research assistant's responsibilities were to make note of group dynamics, members' styles of presentation and themes observed over the course of the group discussion.

The end of each focus group was signalled by the moderator identifying the approaching end of the focus group and asking each person to provide any final comments or summary statements related to the various topic areas discussed. This was done to allow participants to make contributions that they have been holding back during the open discussion. It also brought closure to the discussion in a way that acknowledged the participation of each of the participants.

The principle way of capturing the observations in a focus group is through audio taping the groups discussion (Morgan, 1988). The focus groups were audio taped using a tape recorder, a mixer and sound board, along with two extension microphones, specifically designed for audio taping in a group setting, to enhance the clarity of the audio taping. This specialized equipment was rented in Winnipeg and transported to Chicago for the purpose of taping the focus groups. Prior to each focus group, the audio taping equipment was set up and a sound check was done to ensure that the equipment was functioning and that the sound levels were set appropriately. A second research

assistant manned the mixer during the course of the focus group and was responsible for monitoring the sound levels and adjusting them accordingly, depending on the level of different group participants' voices and background noise.

Morgan (1988) indicates that typically participants are not concerned about the need to audio tape the focus group and that they quickly become relaxed and engaged in the process, ignoring the tape recorder and microphones. Audio taping is recommended over video taping as it is less intrusive. This appeared to be the case with this research as none of the participants objected to the audio taping, once confidentiality and anonymity were discussed, and discussion proceeded in a free, open and candid manner.

Upon the conclusion of the focus group, the audio tapes were brought back to Winnipeg, were transcribed for analysis and then destroyed. The transcripts of the two Focus Groups are contained in Appendix G.

Additional qualitative data was gathered through the back page of the SOTPS, where respondents were able to provide written comments related to their experiences as a sex offender treatment provider. While analysis of respondents' comments was not intended to be a part of the current study, because of the valuable information provided by respondents, these comments were categorized into major theme areas and are included in Appendix H.

Instruments

The Sex Offender Service Provider Survey consists of three standardized measures and a number of background questions (Appendix B).

Maslach Burnout Inventory: Human Services Survey (MBI-HSS)

The MBI-HSS (Maslach & Jackson, 1981) is a 22 item self-report measure which evaluates the experience of burnout among human service providers involved in interactions with clients that are centred on the client's problems (psychological, social, or physical). Three sub-scales measure three aspects of the burnout syndrome: Emotional Exhaustion (EE, feelings of being emotionally overextended and exhausted by one's work), Depersonalization (DP, an unfeeling and impersonal response towards the recipients of one's service, care, treatment or instruction) and Personal Accomplishment (PA, feelings of competence and successful achievement in one's work with people). Respondents indicate how frequently they experience the statements on the measure on a 7 point Likert-type scale ranging from Never (0) to Every Day (6). The scores for each of the sub-scales are considered separately, and, as a result, three separate scores are computed for each respondent. Higher scores on the EE and DP scales correspond to experiencing higher degrees of burnout while lower scores on the PA scale are associated with higher degrees of burnout. Test-retest reliability for the sub-scales are EE = .82; DP = .60; PA = .80. Reliability coefficients (Cronbach alphas) for the sub-scales are .90, .79 and .71 respectively. The standard error of measurement for the sub-scales are 3.80 for EE, 3.16 for DP, and 3.73 for PA. Demographic norms are provided by the authors for the MBI sub-scales.

Permission to reproduce this measure for the purpose of this dissertation was requested and obtained from Consulting Psychologists Press, Inc.

Compassion Fatigue Self Test for Psychotherapists

This 40 item self-report measure was developed by Figley (1993) to evaluate the experience of compassion fatigue and to discriminate between the experience of compassion fatigue and burnout among trauma workers. This measure has two sub-scales which are separately scored, one for burnout and the other for compassion fatigue. Each of the items on the measure is answered on the basis of the frequency with which the respondent experiences the statements on a Likert-type scale from Rarely/Never (1) to Very Often (5). The higher the scores on the compassion fatigue and burnout sub-scales, the greater the experience of that syndrome. The psychometric properties of this scale have been reported by Stamm and Vara (1993). Alpha reliability scores ranged from .94 to .86. A structural analysis yielded one stable factor which is characterized by a depressed mood in relationship to work accompanied by feelings of fatigue, disillusionment and worthlessness. Structural Reliability of this factor, as indicated by Tucker's Coefficient of Congruence is .91.

Several items on this measure were altered so that they would apply to a sex offender treatment provider population. Of the 13 modifications to the measure, all but one entailed replacing the term "client" with the term "sex offender client". For example, an item originally reading "I have felt a sense of hopelessness associated with working with clients" was modified to read "I have felt a sense of hopelessness associated with working with sex offender clients". The other modification was to an item reading, "While working with a victim I thought about violence against the perpetrator", which was modified to read, "While addressing a sex offender's victimization issues I have thought about violence against their perpetrator". These changes to the measure were discussed with the author of the Compassion Fatigue Self Test for Psychotherapists and made with his consent.

Personal Resources Questionnaire (PRQ)

The PRQ is one of the domains from the Occupational Stress Inventory (Osipow & Spokane, 1981). This measure can be utilized on its own as a stand alone measure assessing coping resources related to managing occupational stress. The PRQ is composed of four sub-scales: Recreation (RE, the extent to which an individual makes use of and derives pleasure and relaxation from regular recreational activities), Self-care (SC, the extent to which an individual regularly engages in personal activities which reduce or alleviate chronic stress), Social Support (SS, the extent to which an individual feels support and help from those around him/her) and Rational/Cognitive Coping (RC, the extent to which an individual possesses and uses cognitive skills in the face of work-related stresses). Responses are made using a 5 Likert-type scale which assess the frequency with which an item applies to the respondent from Rarely or Never (1) to Most of the Time (5).

The authors report the internal consistency reliability coefficients (alpha) for the sub-scales of the PRQ to be: RE, .71; SC, .73; SS, .83; RC, .78 and for the total PRQ, .88. The standard errors of measure were reported as 3.54, RE; 3.38, SC; 2.98, SS; 3.09, RC. Normative data are available from a sample of 909 adult subjects employed primarily in technical, professional and managerial positions in schools, service organizations and manufacturing settings.

Permission to reproduce this measure for the purpose of this dissertation was requested and obtained from Psychological Assessment Resources, Inc.

Background Information

The background information included in the survey was derived from the literature related to factors moderating the experience of clinician stress, burnout, compassion fatigue and vicarious

traumatization. The background variables represent the independent variables of this study. The background information is divided into three subsections: therapist background variables (e.g., gender, age, educational background, profession, experience), practice setting variables (e.g., work setting, workplace support, program funding, salary) and client contact/exposure variables (e.g., case load, hours of clinical contact with clients, type of clients seen).

RESULTS

Mail Survey Data

Characteristics of the Sample

The majority of the sex offender treatment providers sampled consisted of male therapists (62%) while the remaining 38% were female clinicians.

The mean age category of respondents was ages 41-50. Six percent of the respondents were age 30 and younger, 22% were between the ages 31-40, 48% between ages 41-50 and 24% were age 51 and over.

The majority of respondents, (91%) were from the United States while the remaining 9% were from Canada.

With reference to educational background, the majority of sex offender clinicians reported having a Masters level degree (62%), followed by a Doctorate level degree (31%) and a Bachelor of Arts Degree (5%). A small number of respondents reported an educational background in medicine (1%). Two percent of respondents endorsed the 'other' category and specified having achieved an educational degree (e.g., Ed.D.) as their highest level of education. Less than one percent of the

respondents reported that their highest level of education was completion of a high school or community college.

In describing their primary profession, sex offender therapists most often identified themselves as Master level therapists (41%), psychologists (32%) and social workers (15%). A smaller number were probation/parole officers (1%), psychiatrists (1%) and nurses (1%). A number of respondents (9%) endorsed the 'other' category. A range of professions were specified by these clinicians including: minister, sexologist, police officer/ therapist, marriage and family therapist, mental health worker/therapist, college professor, correctional counsellor, residential counsellor and licenced professional counsellor.

The majority of the sex offender treatment providers surveyed were married or living in a common law relationship (75%). The remaining clinicians described themselves as single (15%) or separated or divorced (10%). Over half of the clinicians reported having children (60%, n=409).

Over half of the sex offender treatment providers conducted their practice in the context of their employment with an agency or organization (59%) while the remaining 41% were in independent practice. Three quarters of the respondents identified providing sex offender treatment as part of a clinical team practising within a specialized sex offender treatment program (76%).

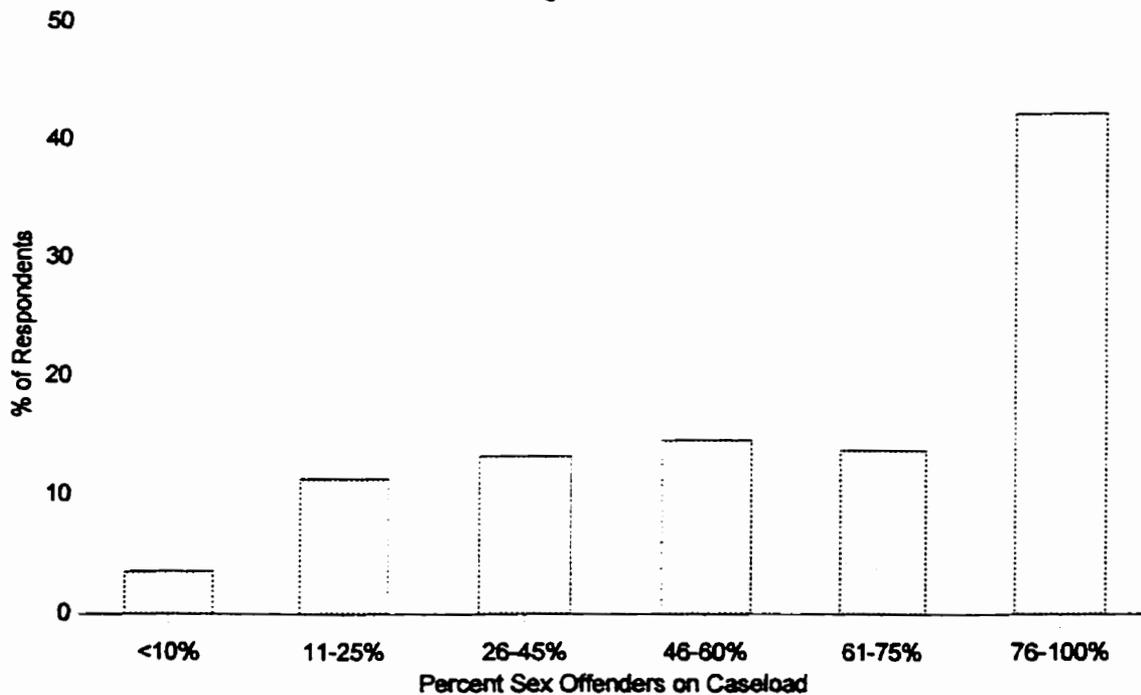
Clinicians reported delivering sex offender programming in a variety of settings. The majority of respondents provided sex offender treatment in community based treatment programs (57%). Fourteen percent delivered programming within correctional institutions, while another 14% of respondents described practising in both community and correctional institution settings. Other areas

of practice included providing treatment in a residential setting (10%) and within a hospital setting (3%).

Sex offender clients account for the bulk of the clinician's client case load for the majority of treatment providers in this sample. Fifty seven percent of the clinicians reported that over 60% of their case load consisted of sex offender clients. Only 15% reported that 25% or less of their case load was made up of sex offenders. Sex offender client caseloads are illustrated in Figure 1.

Sex Offender Caseload

Figure 1

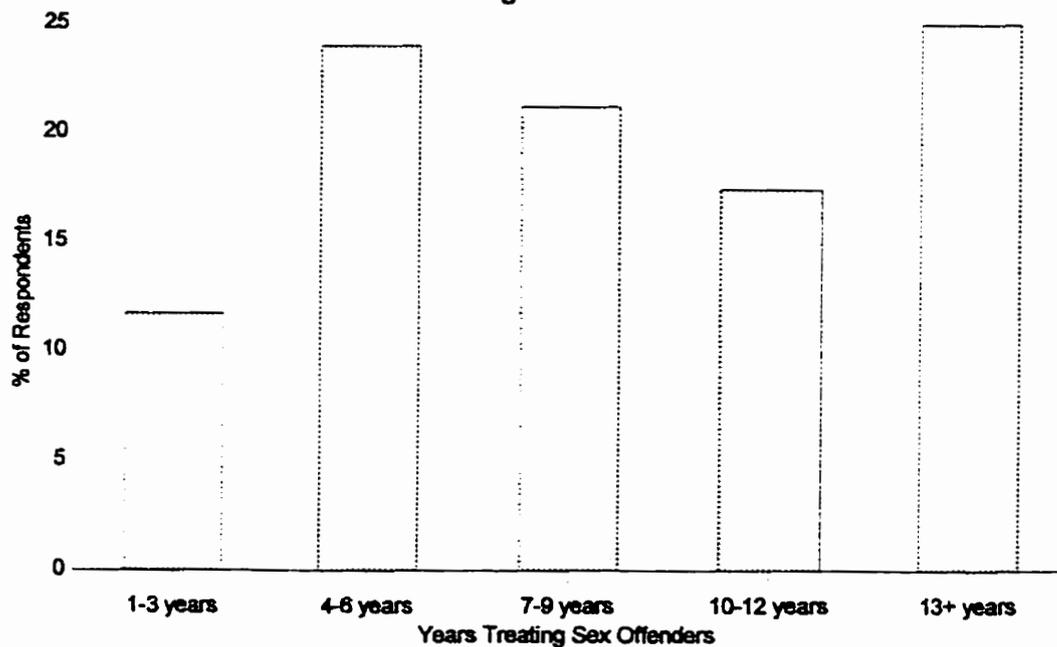


Consistent with this, the clinicians sampled spent, on average, between 16-25 hours per week providing direct services to sex offenders. A number of treatment providers (40%) spent over 25 hours per week providing direct services to sex offenders.

Most of the sex offender treatment providers in this sample had a number of years experience providing clinical services to sex offenders. The mean category of years experience delivering sex offender programming was 7-9 years. Close to one half (42%) of the clinicians had provided treatment services to a sex offender population for 10 or more years. Only about 20% had less than three years experience in the field. Figure 2 outlines the years experience.

Years of Experience

Figure 2

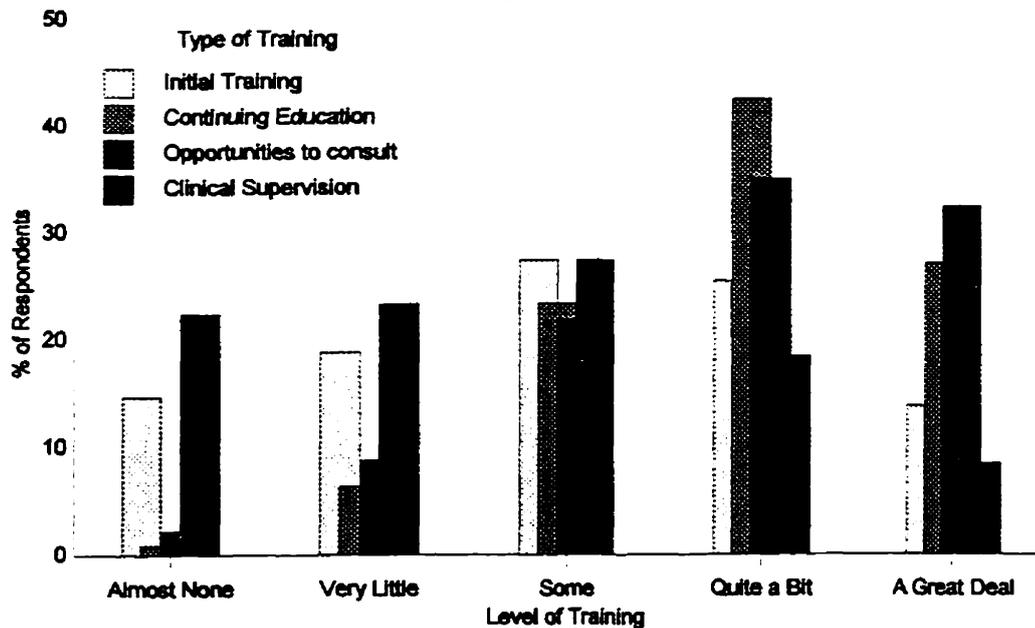


Demographic Variables Related to Therapist, Practice Setting and Client Population

While the majority of the respondents (61%) reported that they did not have extensive specialized training before beginning clinical work with sex offender clients, most said that they received such training once in the field. The majority of respondents reported considerable opportunities to participate in continuing education activities (70%) and opportunities to consult with more experienced clinicians with expertise in sex offender treatment (70%). Fewer therapists reported having opportunities for ongoing clinical supervision, with only a little over a quarter of respondents saying that they were receiving ‘quite a bit’, or ‘a great deal’ of ongoing clinical supervision. Respondents' levels of training are summarized in Figure 3.

Type and Level of Training

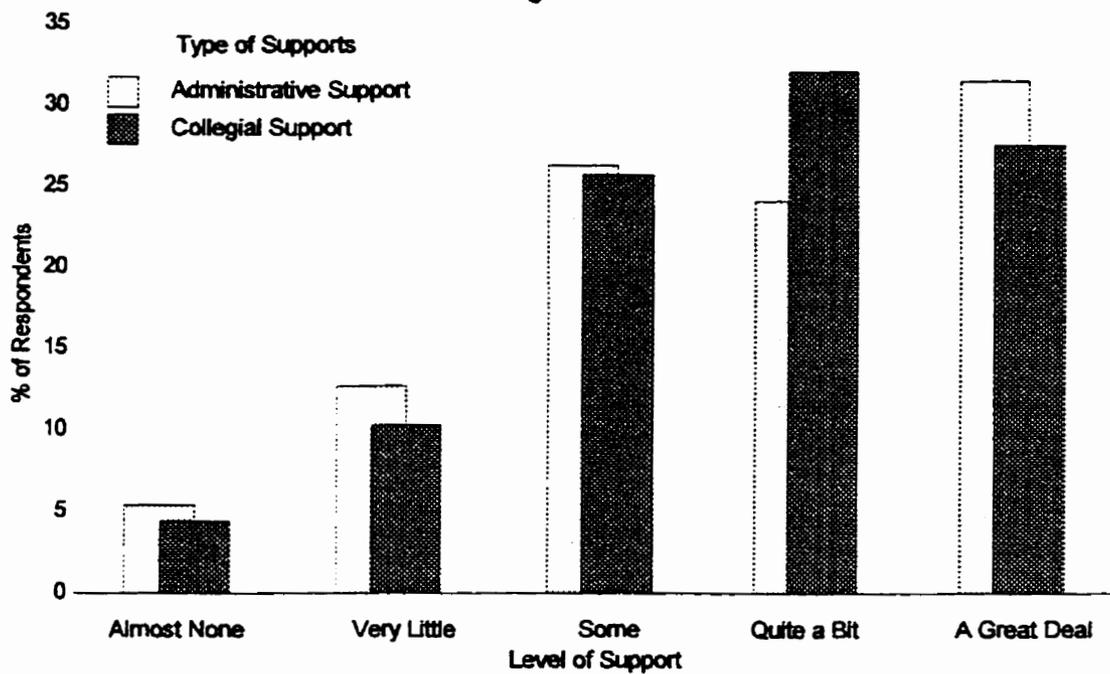
Figure 3



An overview of the organizational supports and stressors of the sample is summarized in Figures 4 and 5. Most respondents received ‘quite a bit’ to ‘a great deal’ of support at their place of work from administrators (56%) and colleagues (60%). Despite these supports, a number of respondents reported experiencing stress associated with organizational politics (42%). The lack of stable funding was another area of significant concern for almost half of the therapists (49%).

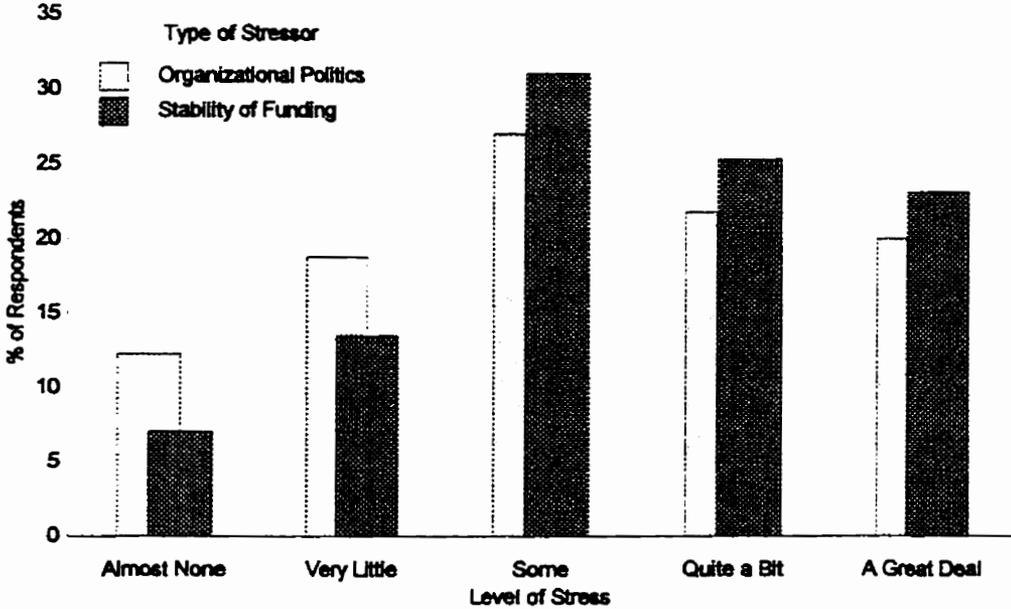
Organizational Supports

Figure 4



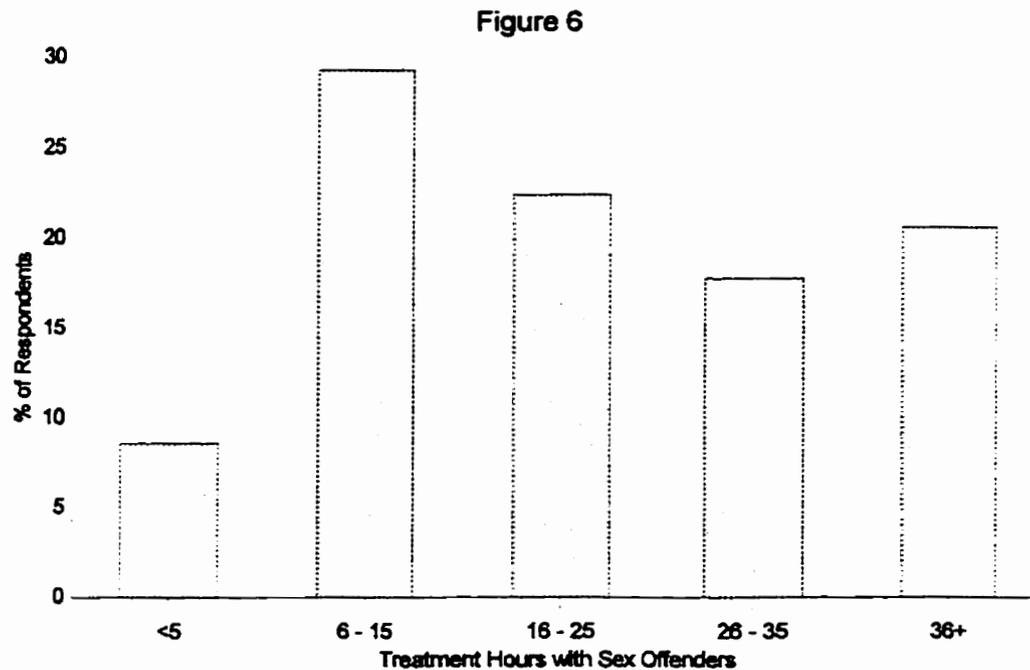
Organizational Stressors

Figure 5



As previously noted, the respondents spend a great deal of time providing direct clinical services to sex offender clients. Over 60% of the respondents delivered 16 hours or more, of clinical services per week to sex offenders. The range of clinical hours of service delivery with sex offender clients is summarized in Figure 6.

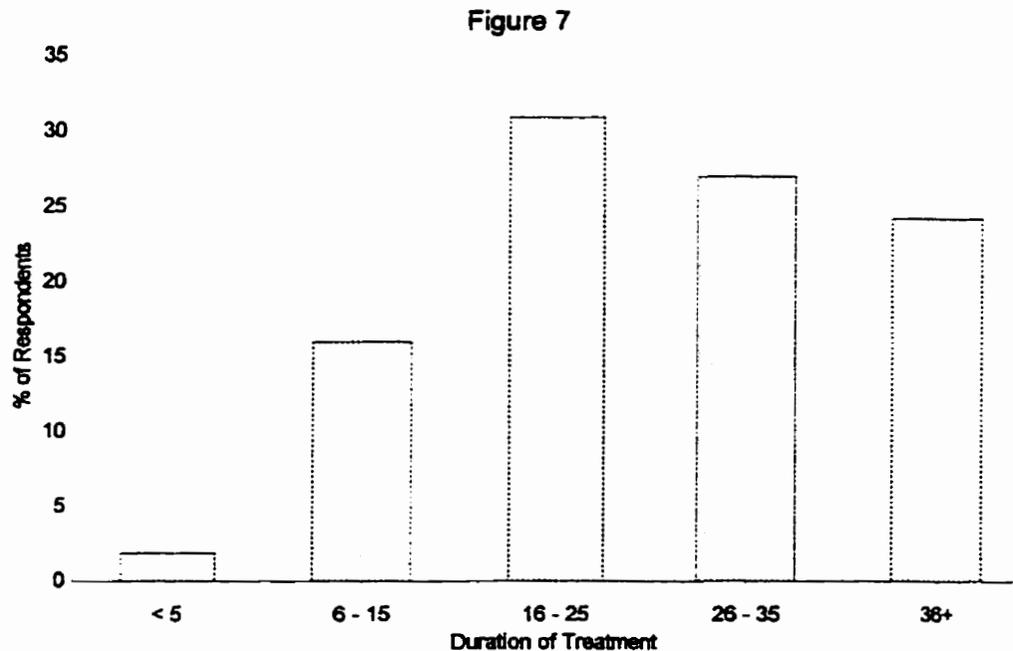
Hours of Clinical Services



Despite clinicians reporting that the majority of their caseload was made up of sex offender clients and the reported high level of clinical hours provided to these clients, the vast majority of respondents describe their caseloads as manageable (86). Only a small number see themselves as having too many sex offender clients (10%).

The vast majority of respondents, (82%) reported providing clinical services to sex offender clients for over a one year period. The mean category of time in treatment with sex offenders was 16-25 months in duration. The length of time spent in treatment with sex offenders is outlined in Figure 7.

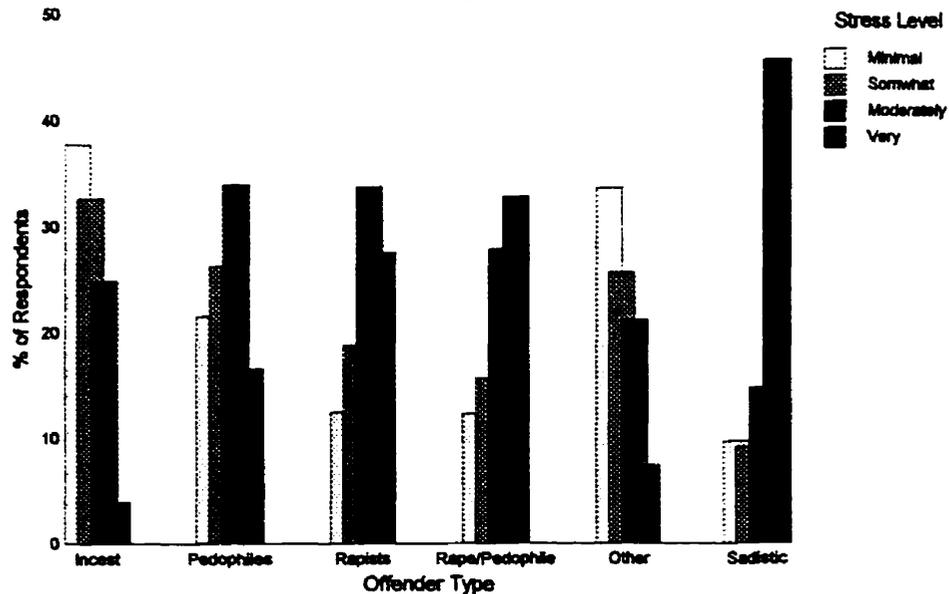
Length of Treatment with Clients



Clinicians were asked to rate the extent to which they found working with specific groups of sex offenders stressful. Sadistic sex offenders were seen to be the most stressful sex offender group to work with, followed by rapist/pedophiles, offenders who had histories of committing sexual offences against both adult and child victims. Incest offenders and sex offenders in the 'other' category were rated as the least stressful to work with. In specifying the type of offenders in the 'other' category, clinicians identified exhibitionists, voyeurs, frotteurs, obscene telephone callers, female offenders, professional sexual misconduct, sexually reactive children, sexual addicts and zoophilia. Clinicians' ratings of the stress associated with specific categories of sex offenders are listed in Figure 8.

Level of Stress by Type of Client

Figure 8



Measures of Burnout, Compassion Fatigue and Coping

To assess the internal consistency of each of the self report measures and the sub-scales Chronbach alpha's were calculated. This was done on the three sub-scales of the MBI, the two sub-scales of the Compassion Fatigue Self Test for Psychotherapists, and the four sub-scales of the PRQ. Each of the measures demonstrated acceptable internal consistency with alphas > .70. With the exception of the compassion fatigue sub-scale alphas, which are a bit lower than published values, the alphas are very comparable to that previously reported. The results for each of the sub-scales of the three measures are summarized in Table 1.

Table 1		
Internal Consistency Correlation Coefficients (Chronbach's Alphas)		
Maslach Burnout Inventory		
Sub-scales	Reported Alphas (Maslach, Jackson & Leiter, 1996)	Current Study
Emotional Exhaustion	0.9	0.91
Depersonalization	0.79	0.73
Personal Accomplishment	0.71	0.74
Compassion Fatigue Self-Report Test for Psychotherapists		
Sub-scales	Reported Range of Alphas (Stamm & Vara, 1993)	Current Study
Burnout	.94-.86	0.79
Compassion Fatigue	.94-.86	0.79
Personal Resource Questionnaire		
Sub-scale	Reported Alphas (Osipow & Spokane, 1983)	Current Study
Recreation	0.71	0.77
Self-care	0.73	0.76
Social Support	0.83	0.84
Rational/Cognitive Coping	0.78	0.8

The means and standard deviations for the three sub-scales of the MBI are summarized in Table 2, and the observed results are compared to normative data for a large group of mental health service providers (Maslach & Jackson, 1981). The current sample of sex offender clinicians scored similarly to the mental health service providers (psychologists, psychotherapists, counselors, mental hospital staff, psychiatrists) studied by Maslach and Jackson (1981).

Table 2 Means and Standard Deviations for the MBI Sub-scales		
Sub-scale	Mental Health Providers (Maslach & Jackson, 1981)	Sex Offender Clinicians
Emotional Exhaustion		
<i>M</i>	16.89	17.36
<i>SD</i>	8.90	9.35
Depersonalization		
<i>M</i>	5.72	7.65
<i>SD</i>	4.62	4.93
Personal Accomplishment		
<i>M</i>	30.87	40.38
<i>SD</i>	6.37	5.38

While the sex offender treatment providers on average, did not differ from mental health providers on the scale for emotional exhaustion, they report a slightly higher mean score on the depersonalization scale, and a higher mean score on the personal accomplishment scale.

Maslach, Jackson & Leiter (1996) provide a Table categorizing MBI scores on each of the sub-scales into ranges (low, medium and high) for the experience of burnout. Table 3 outlines the established cut off points provided by these authors for the group of mental health providers and illustrates how the sex offender treatment providers sampled fit into these categorizations.

While the majority of sex offender therapists score in the average or low range for emotional exhaustion (68.9%) and depersonalization (55.6%), about one third of the treatment providers (31.1%) scored in the high range for emotional exhaustion and 44.4% scored in the high range for depersonalization. Only 2.6% of the sex offender treatment providers scored in the high range for burnout on the personal accomplishment scale.

The means and standard deviations for the two sub-scales of the Compassion Fatigue Self Test for Psychotherapists are presented in Table 4.

Although Figley (1995) does not provide normative data for this scale, categorizations for the two sub-scales scores are provided. The scales are categorized based on the degree of risk clinicians are at for experiencing burnout and compassion fatigue. The mean response on the burnout scale for sex offender therapists falls within the 'extremely low risk for burnout' category. The mean score on the compassion fatigue scale falls within the 'low risk for compassion fatigue'.

Figure 9 presents the categorizations and the range of respondents' scores on these two sub-scales.

Table 3
Categorization of MBI Scores
Range of Experience of Burnout

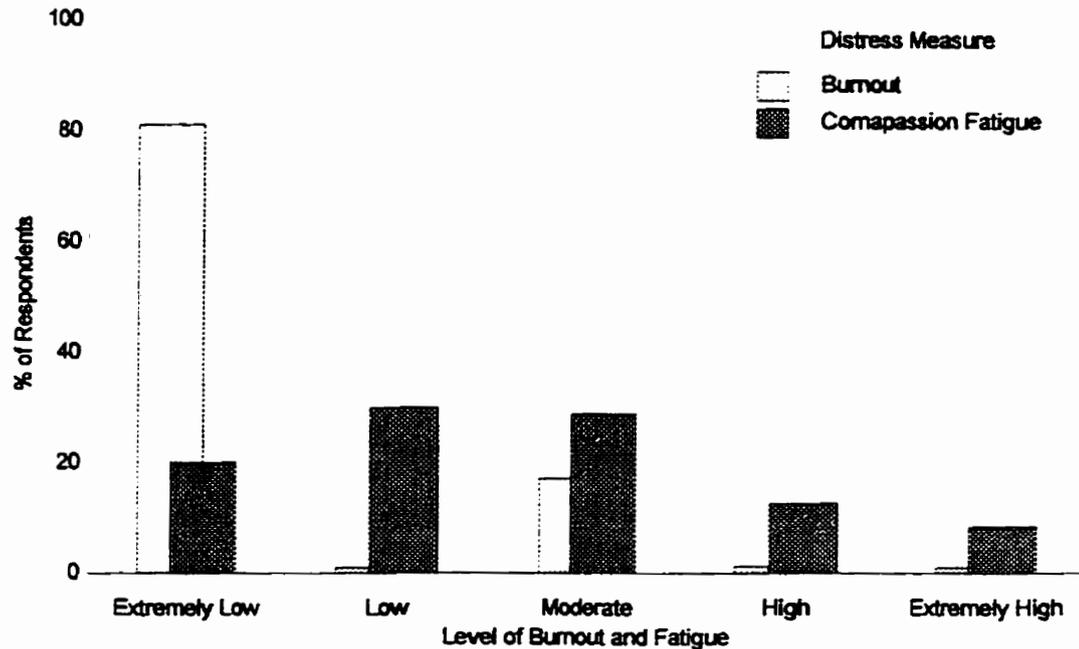
Sub-scale	Mental Health Providers (Maslach, Jackson & Leiter, 1996)	Sex Offender Clinicians
Emotional Exhaustion High Average Low	≥ 21 14-20 ≤ 13	31.1% 29.7% 39.2%
Depersonalization High Average Low	≥ 8 5-7 ≤ 4	44.4% 26.7% 28.9%
Personal Accomplishment High Average Low	28 33-29 ≥ 34	2.6% 7.5% 89.9%

Table 4
Means and Standard Deviations
Compassion Fatigue Self Test for Psychotherapists

Sub-scale	Sex Offender Clinicians
Burnout <i>M</i> <i>SD</i>	30.33 7.17
Compassion Fatigue <i>M</i> <i>SD</i>	31.64 6.42

Risk for Burnout & Fatigue

Figure 9



Overall respondents were at low risk for both burnout and compassion fatigue, however some elevated responses occurred. Moderate levels or risk were noted for both burnout (17%) and compassion fatigue (29%). While only a small number of respondents scored as being at high to extremely high risk for burnout (2%), a greater number, (21%) scored as being at high to extremely high risk for compassion fatigue.

One of the research questions and areas of interest was the potential association between the concepts and measurement of burnout and compassion fatigue. In order to explore this association,

a correlational analysis was examined between the sub-scales of the MBI and the Compassion Fatigue Self-Test for Therapists was conducted. The two concepts and measures were significantly associated ($p \geq .001$ in all cases), and the correlations between these two measures are listed in Table 5.

Compassion Fatigue Sub-scales	MBI Sub-scales		
	Emotional Exhaustion	Depersonalization	Personal Accomplishment
Burnout	.60	.47	-.36
Compassion Fatigue	.52	.46	-.26

The means and standard deviations for the four scales of the PRQ are reported in Table 6 and are compared to a comparison group of 549 working adults (Osipow & Spokane, 1983). The two groups appeared comparable on each of the four sub-scales.

Osipow and Spokane (1981) describe a range and categorization of scores for each of the sub-scales, which delineates the degree to which respondents evidence either deficits or strengths in the style of coping measured by the particular sub-scale. While the cut off points for each of the categories is consistent for male and female respondents, conversions from raw scores to the t-scores

utilized for categorizing, are different for female and male respondents. The different categorizations for the PRQ sub-scales and the breakdown of how the male and female sex offender treatment providers fit into these categories are listed in Table 7. Overall, there did not appear to be any difference between the coping skills of the male versus the female sex offender treatment providers. The vast majority of clinicians demonstrated average to superior coping skills on each of the coping areas assessed: use of recreation, self-care, social supports and rational/cognitive coping.

Table 6
Means and Standard Deviations For the PRQ Sub-scales

Sub-scale	Working Adults (Osipow & Spokane, 1983)	Sex Offender Clinicians
Recreation <i>M</i> <i>SD</i>	28.38 6.57	29.35 6.88
Self-care <i>M</i> <i>SD</i>	27.34 6.51	29.45 7.02
Social Support <i>M</i> <i>SD</i>	41.16 7.23	43.12 6.78
Rational Cognitive Coping <i>M</i> <i>SD</i>	37.72 6.59	38.63 5.93

Table 7
Range of Coping Skills on PRQ by Gender

Sub-scale	Male Sex Offender Clinicians	Female Sex Offender Clinicians
Recreation		
Significant Deficits	2.1%	.4%
Mild Deficits	1.3%	12.6%
Average Skills	57.7%	60.2%
Strong Skills	27.2%	26.8%
Self-care		
Significant Deficits	1.9%	1.2%
Mild Deficits	7.3%	8.2%
Average Skills	63.9%	62.9%
Strong Skills	26.9%	27.7%
Social Support		
Significant Deficits	4.7%	1.2%
Mild Deficits	5.9%	5.1%
Average Skills	60.2%	66.0%
Strong Skills	29.2%	27.7%
Rational Cognitive Coping		
Significant Deficits	1.9%	2.0%
Mild Deficits	6.8%	4.6%
Average Skills	67.0%	64.1%
Strong Skills	24.3%	29.3%

Associations between coping skills and the experience of burnout and compassion fatigue were investigated. Higher scores, indicating stronger coping skills, on the sub-scales of the PRQ were associated with lower levels of emotional exhaustion, depersonalization, a greater degree of personal accomplishment and lower levels of burnout and compassion fatigue. These correlations are listed in Table 8. The strongest associations appeared between having a high level of social supports and low burnout scores, $r(675) = -.41, p \leq .0001$, and good recreational outlets and low burnout scores, $r(675) = -.40, p \leq .0001$.

Table 8				
Intercorrelations Between Sub-scales of the PRQ and the MBI and Compassion Fatigue Self-Test for Psychotherapists				
	PRQ			
MBI & Compassion Fatigue Sub-scales	RC	RE	SC	SS
MBI				
EE	-.34	-.37	-.35	-.29
DP	-.19	-.11	-.23	-.21
PA	.31	.25	.30	.25
Compassion Fatigue				
Burnout	-.33	-.40	-.30	-.41
Compassion Fatigue	-.27	-.25	-.20	-.27

Impact and Modulating Variables

I. Therapist Variables

Correlates of Burnout and Compassion Fatigue and Difference in the Experience of Distress

A number of therapist variables demonstrated modest, yet significant associations with the experience of the constructs of Burnout and Compassion Fatigue. Therapist variables were conceptualized as demographic, personal and professional development, and emotional stability variables. The associations between therapist variables and emotional exhaustion, depersonalization, personal accomplishment and burnout and compassion fatigue are summarized in Table 9. While, the magnitude of the correlations is modest, all are significant at the $p \leq .05$ level.

Age was negatively associated with markers of distress. Since it is possible that education and years of professional experience may be confounding variables, correlations for age were re-run controlling for education and years experience. When these variables were controlled in a partial correlation, age was found to be associated with the experience of emotional exhaustion, $r(531) = -.13, p \leq .01$ and depersonalization, $r(531) = -.10, p \leq .05$. Younger therapists (age 26-30) experienced a significantly higher degree of emotional exhaustion than did older therapists (age 31 and older), $F(8, 514) = 3.90, p \leq .001$.

Education level was associated with personal accomplishment, with higher educated clinicians reporting a greater degree of personal accomplishment, $r(540) = .13, p \leq .05$. As above, a correlation was conducted controlling for age. Education was still significantly associated with personal accomplishment.

Years experience was related both to the experience of depletion and satisfaction. Clinicians with fewer years experience providing clinical services to sex offenders experienced higher levels of emotional exhaustion, $r(531) = -.10, p \leq .05$, while clinicians with more years experience reported a greater sense of personal accomplishment, $r(531) = -.14, p \leq .05$.

Small associations were found between type of profession and the sub-scales for the measures of Burnout and Compassion Fatigue. The direction of these associations suggest that higher status professions, as defined by higher educational level, experience lower levels of emotional exhaustion and depersonalization and are at less risk for burnout and compassion fatigue. Profession was also related to respondents' sense of personal accomplishment. Masters and Doctoral level therapists reported a significantly greater sense of personal accomplishment associated with their sex offender practice than did probation and parole officers, $F(6, 533) = 2.77, p \leq .01$.

Therapist variables such as gender, relationship status and being a parent did not influence any of the sub-scales of the Burnout and Compassion Fatigue measures.

Personal and professional development variables were significantly associated with therapist burnout and compassion fatigue. These associations are listed in Table 9 and all associations reported were significant at $p \leq .05$. In this regard it is important to note that clinicians who received more initial training prior to beginning their work with sex offenders, as well as clinicians who had greater opportunities to participate in continuing education, reported lower levels of emotional exhaustion, depersonalization, burnout and compassion fatigue, and experienced a greater level of personal accomplishment. Additionally, sex offender treatment providers who had greater opportunities to consult with other experts in the field of sex offender treatment and who had more extensive clinical

Table 9
Intercorrelations Between Therapist Variables and Sub-scales of the
MBI and Compassion Fatigue Self-Test for Psychotherapists

Therapist Variables	MBI			Compassion Fatigue	
	EE	DP	PA	Burnout	Fatigue
<i>Demographic Variables</i>					
Age	-.17	-.13	N.S.	N.S.	-.09
Education	N.S.	N.S.	.13	N.S.	N.S.
Profession	-.10	-.13	N.S.	-.08	-.11
Years Experience	-.10	N.S.	-.14	N.S.	N.S.
<i>Personal/Professional Development</i>					
Initial Training	-.11	-.14	.14	-.09	-.10
Continuing Education	-.16	-.12	.17	-.17	-.11
Consultation	-.16	N.S.	.16	-.17	-.12
Supervision	-.10	N.S.	N.S.	-.11	N.S.
<i>Emotional Health</i>					
Depression (General, over last 6 months)	-.55	-.38	.30	-.57	-.48
Depression (Related to work as Therapist)	.54	.35	-.29	.64	.51

supervision experienced lower levels of emotional exhaustion and burnout. Access to consultation was also associated with lower levels of compassion fatigue and a greater sense of personal accomplishment. These findings underscore the importance of education and support in buffering against burnout and compassion fatigue.

Given the modest level of the correlations for some of the associations of interest, particularly personal and profession development variables and emotional health variables, it was believed that these associations were not linear. As a result, F tests were conducted to determine and illustrate information not contained in the correlatons. This added information and shows how the groups at the tails of the distribution differ from each other.

Therapists who reported having received 'quite a bit' of training prior to providing sex offender treatment experienced significantly lower levels of depersonalization than did clinicians who reported having very little training prior to entering the field, $F(4, 537) = 3.09, p \leq .05$.

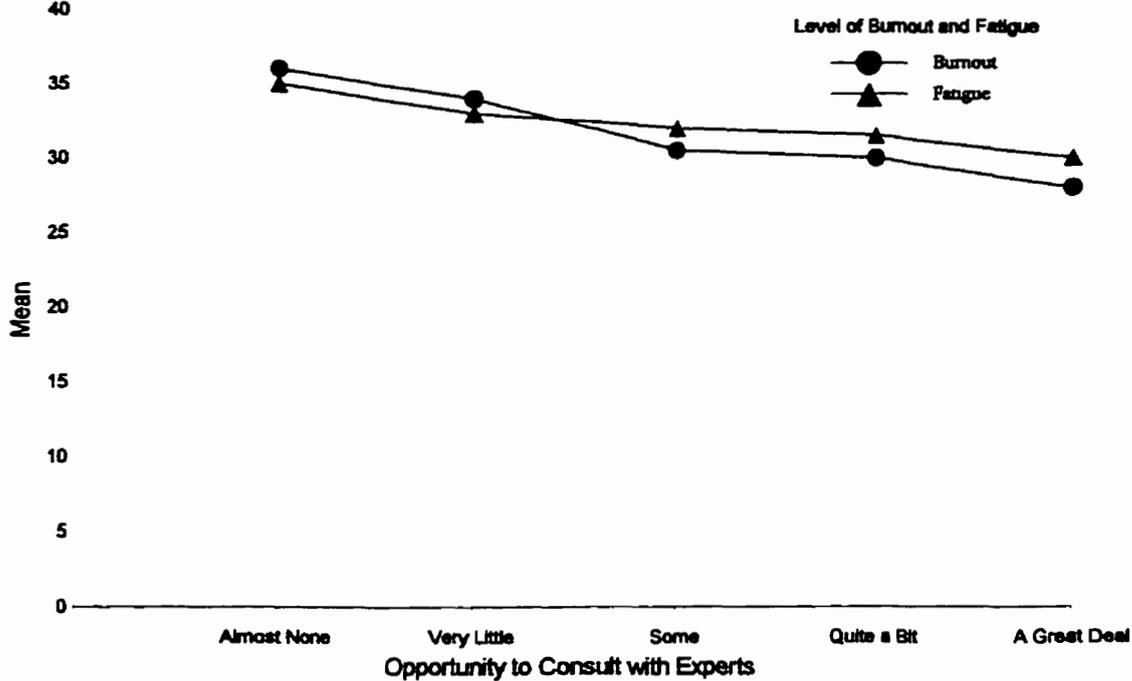
The associations between the level of opportunity to consult and the experience of burnout, compassion fatigue, emotional exhaustion, depersonalization and personal accomplishment are displayed in Figures 10 and 11.

Clinicians who reported having 'almost none' and 'very little' opportunity to consult with other clinicians with expertise in the field were at significantly greater risk for burnout, $F(4, 672) = 7.11, \leq .0001$, relative to clinicians who reported having 'some' to 'a great deal of opportunity' to consult. Respondents who had 'almost none' or 'very little' opportunity to consult were at significantly greater risk for compassion fatigue than therapists with 'quite a bit', to 'a great deal of opportunity' to consult, $F(4, 673) = 3.72, p \leq .01$.

Clinicians who had 'almost no opportunity' to consult experienced significantly higher levels of emotional exhaustion than clinicians who consulted 'a great deal of the time', $F(4, 573) = 4.04$, $p \leq .01$. Sex offender treatment providers who frequently consulted demonstrated a greater sense of personal accomplishment than those who had little opportunity to consult, $F(4, 537) = 4.03$, $p \leq .001$.

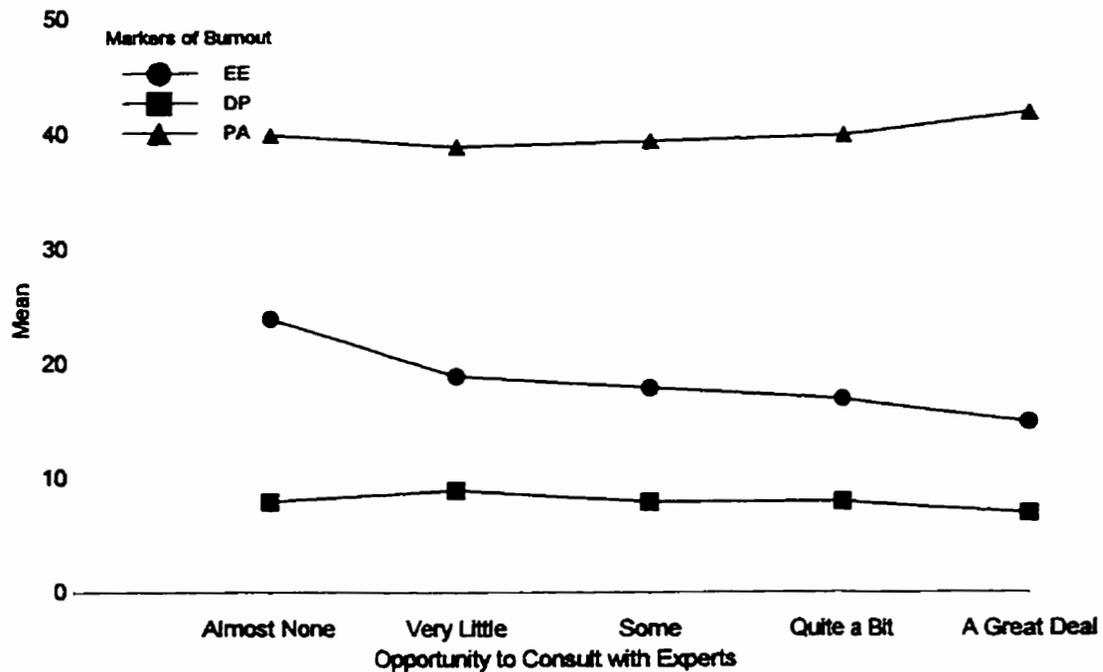
Burnout and Fatigue by Consultation

Figure 10



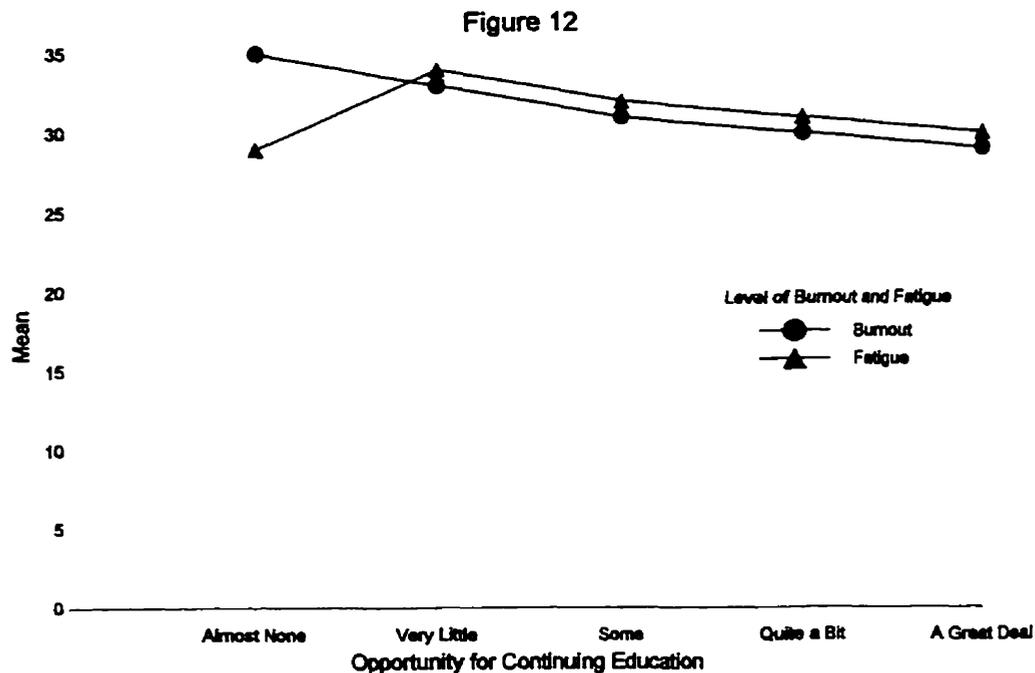
EE, DP, PA by Consultation

Figure 11



Therapists who had 'very little opportunity' to participate in continuing education were at greater risk for burnout, $F(4, 672) = 5.17, p \leq .001$, and for compassion fatigue, $F(4, 673) = 3.65, p \leq .01$, compared to those who reported having 'quite a bit', to 'a great deal' of opportunity for continuing education. These associations are displayed in Figure 12.

Burnout and Fatigue by Continuing Ed

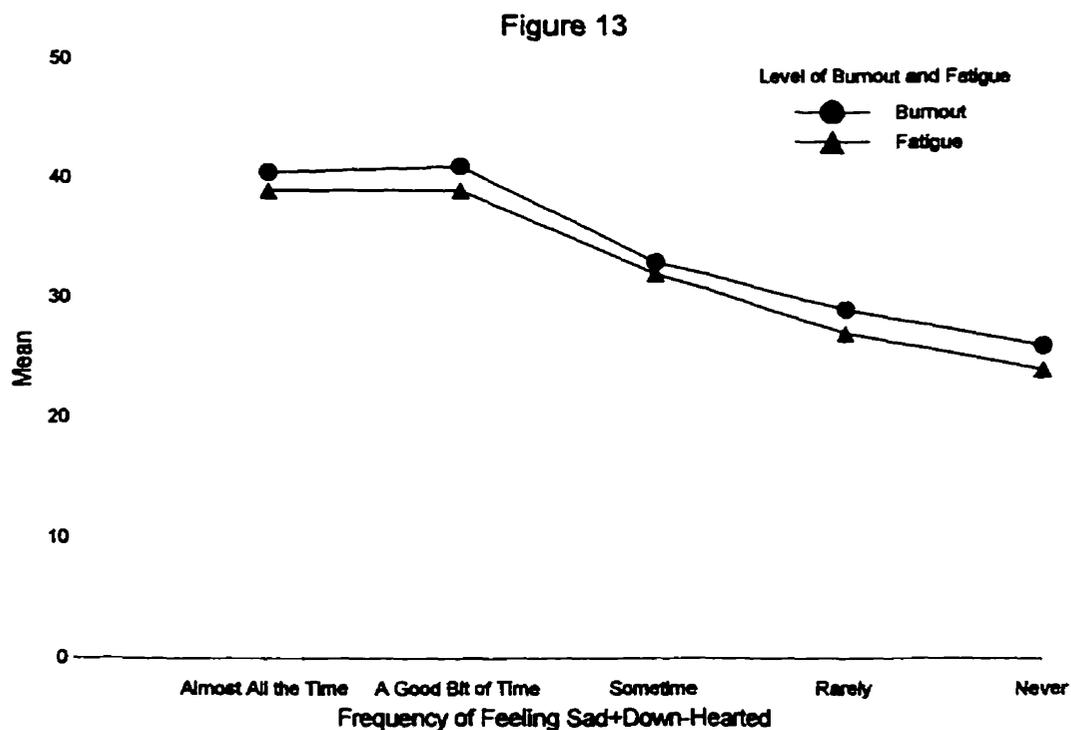


In addition, clinicians who had little opportunity to participate in continuing education experienced higher levels of emotional exhaustion, $F(4, 573) = 3.95, p \leq .01$, than did therapists with 'a great deal' of continuing education opportunities, and evidenced a lower sense of personal accomplishment, $F(4, 537) = 4.26, p \leq .01$, compared to therapists with 'quite a bit' to 'a great deal' of opportunity for continuing education.

Sex offender treatment providers who had almost no opportunity to receive clinical supervision experienced higher levels of emotional exhaustion, $F(4, 534) = 2.93, p \leq .05$, and were at greater risk for burnout than therapists who received 'some' clinical supervision, $F(4, 668) = 3.27, p \leq .05$.

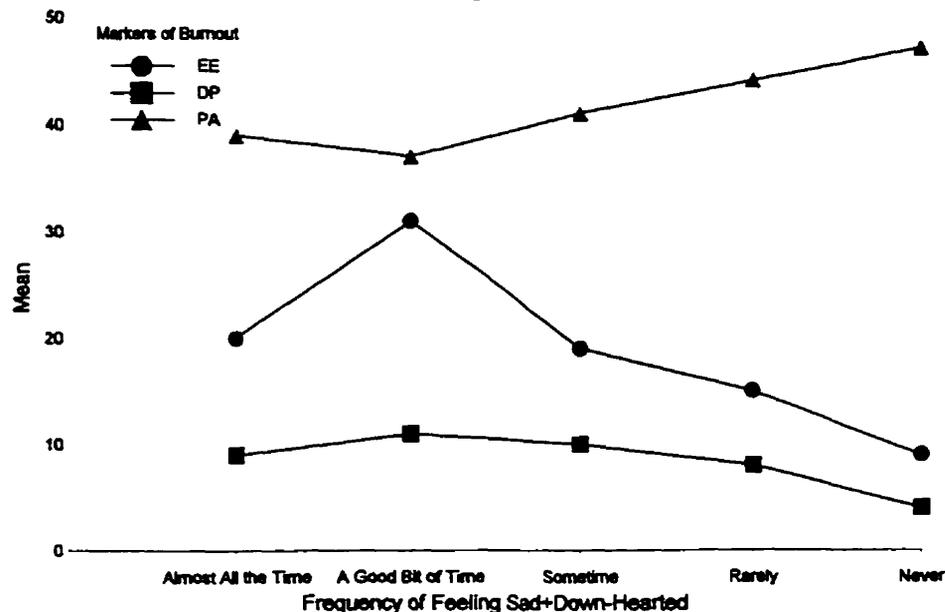
Therapists' emotional health was most strongly associated with the experience of burnout and compassion fatigue. Therapists were asked to what extent they had felt sad and down-hearted over the last 6 months. The more frequent these depressed symptoms were reported, the greater the level of burnout, compassion fatigue, emotional exhaustion and depersonalization, and the lower the level of personal accomplishment. The degree to which clinicians reported having felt depressed over the last six months was significantly related to all of the sub-scales of the MBI and Compassion Fatigue Self -Test for Psychotherapists at $p \leq .0001$ level. These associations are displayed in Figures 13 and 14.

Burnout and Fatigue by Depression



EE, DP, PA by Depression

Figure 14



Therapists who reported having felt depressed 'almost all the time' and 'a good bit of the time' were at significantly greater risk for burnout, $F(4, 675) = 88.30, p \leq .0001$, and compassion fatigue, $F(4, 676) = 55.73, p \leq .0001$, than were those therapists who reported 'never', or 'rarely' having felt depressed in the last six months.

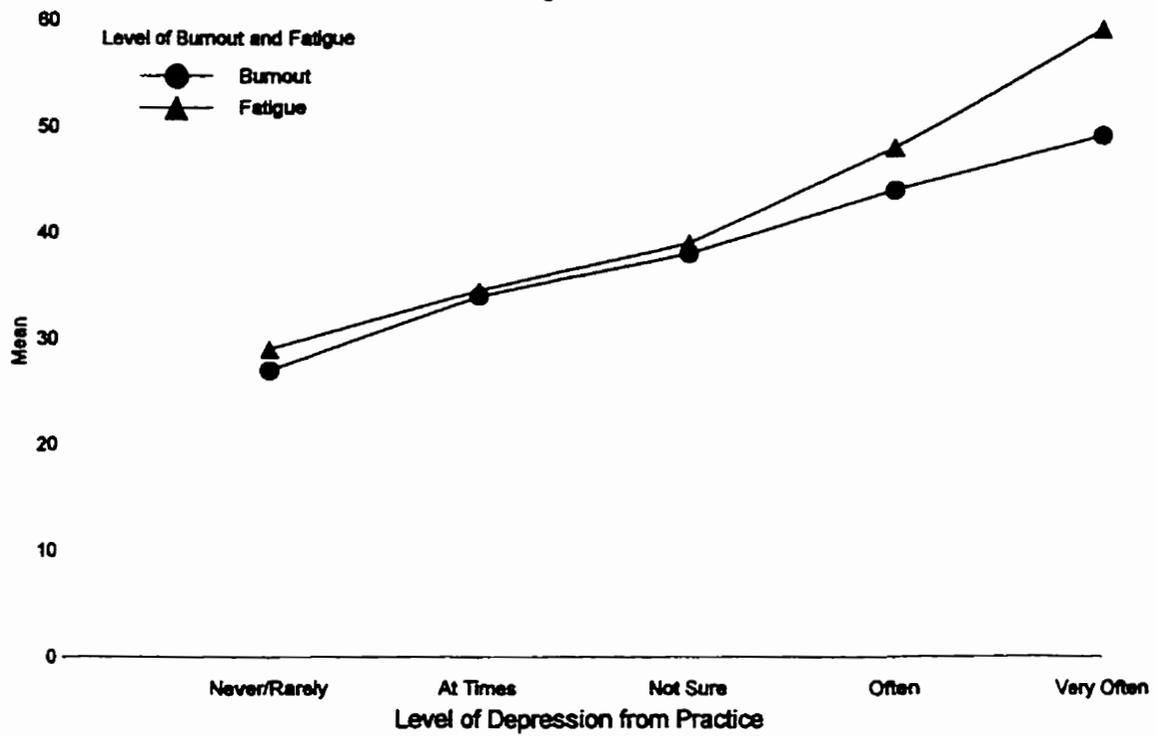
Those therapists who reported depression also experienced significantly higher levels of emotional exhaustion, $F(4, 538) = 70.11, p \leq .0001$, and depersonalization, $F(4, 538) = 24.95, p \leq .0001$ than those respondents who had 'never' or 'rarely' been depressed in the last six months. As well, sex offender practitioners who did not describe depressive symptoms experienced greater

feelings of personal accomplishment, $F(4, 538) = 14.81, p \leq .0001$, than those therapists who had recently felt depressed 'a good bit of the time' or 'almost all the time'.

One of the items on the Compassion Fatigue Self-Test for Psychotherapists asks more specifically, to what extent clinicians have felt depressed as a result of their work as a sex offender therapist. High levels of work-related depression were associated with burnout and compassion fatigue. These correlations are found in Table 9. Clinicians who reported often, or very often having felt depressed as a result of their work as a therapist, were at significantly greater risk for burnout, $F(4, 675) = 116.09, p \leq .0001$, and compassion fatigue, $F(4, 676) = 59.19, p \leq .0001$, than therapists who reported never/rarely feeling depressed as a result of their work. This association is illustrated in Figure 15. As well, clinicians who reported often feeling depressed as a result of working as a sex offender therapist experienced significantly higher levels of emotional exhaustion, $F(4, 534) = 55.12, p \leq .0001$, and depersonalization, $F(4, 534) = 19.36, p \leq .0001$, compared to treatment providers who never/rarely or at times experienced work related depression. Sex offender treatment providers who described never/rarely feeling depressed as a result of their work as a therapist experienced a significantly higher sense of personal accomplishment compared to those who often felt depressed by their work, $F(4, 534) = 13.17, p \leq .0001$. These associations are depicted in Figure 16.

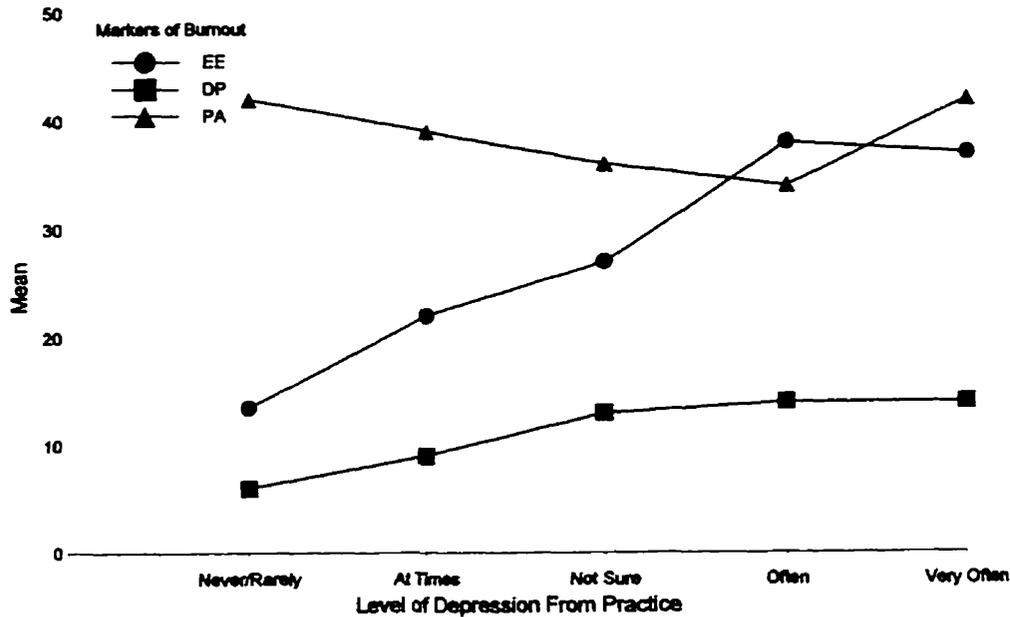
Burnout and Fatigue by Work Depression

Figure 15



EE, DP, PA by Work Depression

Figure 16



Other items embedded in the Compassion Fatigue Self-Test for Psychotherapists were of interest. For example, the question about clinicians' experience of feeling weak, tired, and run down as a result of their work as a therapist was explored. Higher scores on this item were associated with the experience of burnout, $r(686) = .62, p \leq .0001$ and compassion fatigue, $r(681) = .42, p \leq .0001$. In addition, feeling weak, tired and run down due to working as a sex offender therapist was associated with the experience of emotional exhaustion, $r(539) = .57, p \leq .0001$, depersonalization, $r(539) = .31, p \leq .0001$, and lower levels of personal accomplishment, $r(539) = -.30, p \leq .0001$.

This questionnaire also asked clinicians about having experienced traumatic events as an adult and as a child, and about clinicians' perceptions that they have had to "work through" traumatic

experiences in their lives. Clinicians who reported experiencing childhood and adult trauma experienced greater levels of burnout, $r(680) = .11, p \leq .01$; $r(680) = .13, p \leq .001$, and compassion fatigue, $r(681) = .40, p \leq .0001$; $r(681) = .35, p \leq .0001$. Clinicians who reported needing to address traumatic experiences in their life reported greater levels of emotional exhaustion, $r(539) = .13, p \leq .01$, burnout $r(680) = .21, p \leq .0001$, and compassion fatigue, $r(681) = .46, p \leq .0001$.

Predictors of Burnout and Compassion Fatigue

In order to examine those therapist variables that accounted for a significant portion of the variance on each of the sub-scales of the Compassion Fatigue Self-Test for Psychotherapists and the MBI, a stepwise multiple regression analysis was undertaken. Given the absence of a formal model, the more exploratory step-wise procedure was chosen over a hierarchical procedure. A summary of the stepwise regression analysis for therapist variables predicting the dependent variables is found in Table 10 and 11. With the stepwise procedure, order of entry of the variables is determined by the statistical analysis.

Overall, those variables which assessed the emotional stability of respondents accounted for the greatest amount of variance on all dependent measures.

The overall model for the Burnout sub-scale of the Compassion Fatigue Self-Test for Psychotherapists was highly significant, accounting for 53% of the variance. Clinicians' feeling depressed as a result of their "work as a therapist" was entered into the first equation, accounting for 40% of the variance on the Burnout sub-scale. On the second step, feeling weak, tired and rundown, as a result of working as a therapist, was added to the equation. The addition of this second variable accounted for an additional 9% percent of the variance. On the third step, feeling sad and down-

hearted within the last six months was added to the equation. The addition of this third variable accounted for an additional 4% of the variance. While some demographic variables were significant (e.g., participation in continuing education and gender), the percentage of variance accounted for was minimal.

The overall model for the Compassion Fatigue sub-scale of the Compassion Fatigue Self-Test for Psychotherapists was highly significant, accounting for 33% of the variance. Clinicians' feeling depressed as a result of working as a therapist accounted for 26% of the variance. On the second step, feeling sad and down-hearted within the last six months was added to the equation. The addition of this second variable resulted in an additional 7% of the variance. Background variables, such as profession and having sex offender specific training prior to providing clinical services to this population, were significant, however, again, the percentage of the variance accounted for was minimal.

In looking at the sub-scales of the MBI, the overall model for Emotional Exhaustion was significant, accounting for 41% of the variance. Clinicians' 'feeling weak, tired and rundown as a result of working as a therapist' was entered into the first step and accounted for 31% of the variance. The second step in the equation was, 'feeling sad and down-hearted within the last six months', which accounted for an additional 10% percent of the variance. Finally, the third step, 'feeling depressed as a result of their work as a therapist' accounted for an additional 3% of the variance. Although some demographic variables were significant predictors in the overall model (e.g., participation in continuing education, age and level of supervision), the percentage of variance accounted for was minimal.

Table 10 Summary of Stepwise Regression Analysis for Therapist Variables Predicting Sub-Scales of the Compassion Fatigue Self Test for Psychotherapists (Burnout and Compassion Fatigue)				
Burnout (Overall Model) $F= 254.39$, $df = 665$, $p \leq .0001$, Total Adjusted $R^2= .53$				
Variable	<i>B</i>	<i>T</i>	<i>p</i>	R^2
Step 1 Depressed as a therapist	.63	21.14	.0000	.40
Step 2 Feeling weak, tired, and rundown as therapist	.37	10.75	.0000	.09
Depressed as therapist	.41	12.06	.0000	-
Step 3 Feeling weak, tired, and rundown as therapist	.29	8.50	.0000	-
Depressed as therapist	.33	9.60	.0000	-
Having felt downhearted, last 6 months	-.26	-7.98	.0000	.53
Compassion Fatigue (Overall Model) $F= 163.74$, $df = 667$, $p \leq .0001$, Total Adjusted $R^2= .33$				
Variable	<i>B</i>	<i>T</i>	<i>p</i>	R^2
Step 1 Depressed as a therapist	.51	15.21	.0000	.26
Step 2 Depressed as therapist	.35	9.48	.0000	.07
Having felt downhearted, last 6 months	-.31	-8.47	.0000	

Table 11				
Summary of Stepwise Regression Analysis for Therapist Variables Predicting				
Sub-Scales of the MBI				
(Emotional Exhaustion, Depersonalization and Personal Accomplishment)				
Emotional Exhaustion (Overall Model)				
$F = 188.38, df = 530, p \leq .0001, \text{Total Adjusted } R^2 = .41$				
Variable	<i>B</i>	<i>T</i>	<i>p</i>	<i>R</i> ²
Step 1				
Feeling weak, tired, and rundown as therapist	.56	15.63	.0000	.31
Step 2				
Feeling weak, tired, and rundown as therapist	.38	10.01	.0000	
Having felt downhearted, last 6 months	-.36	-9.54	.0000	.10
Depersonalization (Overall Model)				
$F = 56.65, df = 530, p \leq .0001, \text{Total Adjusted } R^2 = .17$				
Step 1				
Having felt downhearted, last 6 months	-.37	-9.31	.0000	.14
Step 2				
Depressed as therapist	.22	4.79	.0000	.03
Having felt downhearted, last 6 months	-.27	-5.84	.0000	-
Personal Accomplishment (Overall Model)				
$F = 35.35, df = 530, p \leq .0001, \text{Total Adjusted } R^2 = .11$				
Step 1				
Feeling weak, tired, and rundown as therapist	-.30	-7.24	.0000	.09
Step 2				
Feeling weak, tired, and rundown as therapist	-.21	-4.37	.0000	-
Having felt downhearted, last 6 months	.19	4.09	.0000	.03

The overall model for the Depersonalization sub-scale of the MBI was significant and accounted for 17% of the variance. The first variable to be entered into the equation was 'experiencing depressive symptoms within the last six months', accounting for almost 14% of the variance. Clinicians 'feeling depressed as a result of working as a therapist' was added in the second step and accounted for an additional 3% of the variance. Once again, demographic variables such as profession, having sex offender specific training prior to providing clinical services to sex offenders, age and gender were also significant, however, the percentage of variance accounted for was minimal.

The overall model for the Personal Accomplishment sub-scale of the MBI was significant and accounted for 11% of the variance. The first variable to be entered was a negative predictor 'clinicians feeling weak, tired, and rundown as a result of working as a therapist', and accounted for 9% of the variance. On the second step, 'feeling sad and down-hearted within the last six months' was added to the equation, accounting for an additional 3% percent of the variance. Other significant variables included participation in continuing education, feeling depressed as a result of working as a therapist, education and having sex offender specific training prior to providing clinical services to this population, however, the percentage of the variance accounted for was minimal.

II. Practice Setting Variables

Correlates of Burnout and Compassion Fatigue and Difference in the Experience of Distress

The setting in which participants practiced had a significant impact on therapist distress. The associations between practice setting variables and emotional exhaustion, depersonalization, personal accomplishment and burnout and compassion fatigue are summarized in Table 12. While the magnitude of the correlations is modest, all those reported in Table 12 are significant at the $p \leq .05$ level, unless otherwise specified.

It was found that providers who practice out of an agency, experienced more distress than did those in private practice. Sex offender treatment providers who practiced within an agency ($M = 18.58, SD = 9.93$) were seen to experience a greater level of emotional exhaustion than did private practice clinicians ($M = 15.55, SD = 8.08$), $t(515) = 13.10, p \leq .001$. Therapists working out of an agency ($M = 39.76, SD = 5.56$) also experienced higher levels of depersonalization than those in independent practice ($M = 41.34, SD = 4.93$), $t(492) = 4.86, p \leq .05$. Consistent with this pattern, clinicians employed by an agency ($M = 32.25, SD = 6.82$), were at significantly greater risk for compassion fatigue than private practice clinicians ($M = 30.73, SD = 5.70$), $t(652) = 4.57, p \leq .05$.

Practice setting was also associated with elements of burnout and compassion fatigue. Therapists providing treatment services in correctional institutions experienced greater levels of depersonalization, $F(5, 536) = 3.2577, MSE = 23.9, p \leq .01$, than community treatment providers or clinicians who practiced in both community and institutional settings. As well, clinicians who practiced out of community based treatment programs experienced higher levels of personal accomplishment than those who worked in correctional institutions, $F(5, 536) = 3.25, p \leq .01$.

Table 12					
Intercorrelations Between Practice Setting Variables and Sub-scales of the MBI and Compassion Fatigue Self-Test for Psychotherapists					
Practice Setting Variables	MBI			Compassion Fatigue	
	EE	DP	PA	Burnout	Fatigue
<i>Type of Setting</i>					
Private Practice vs Agency Practice	.13	.13	-.12	N.S.	.10
<i>Support within Setting</i>					
Administrative Support	-.19	-.11	.17	-.21	-.12
Colleague Support	-.24	-.16	.25	-.29	-.19
<i>Stability of Setting</i>					
Concern Associated with Organizational Policies	.26	.19	N.S.	.27	.20
Concern Associated with Stability of Funding for Services	.11	.10	N.S.	.14	.08

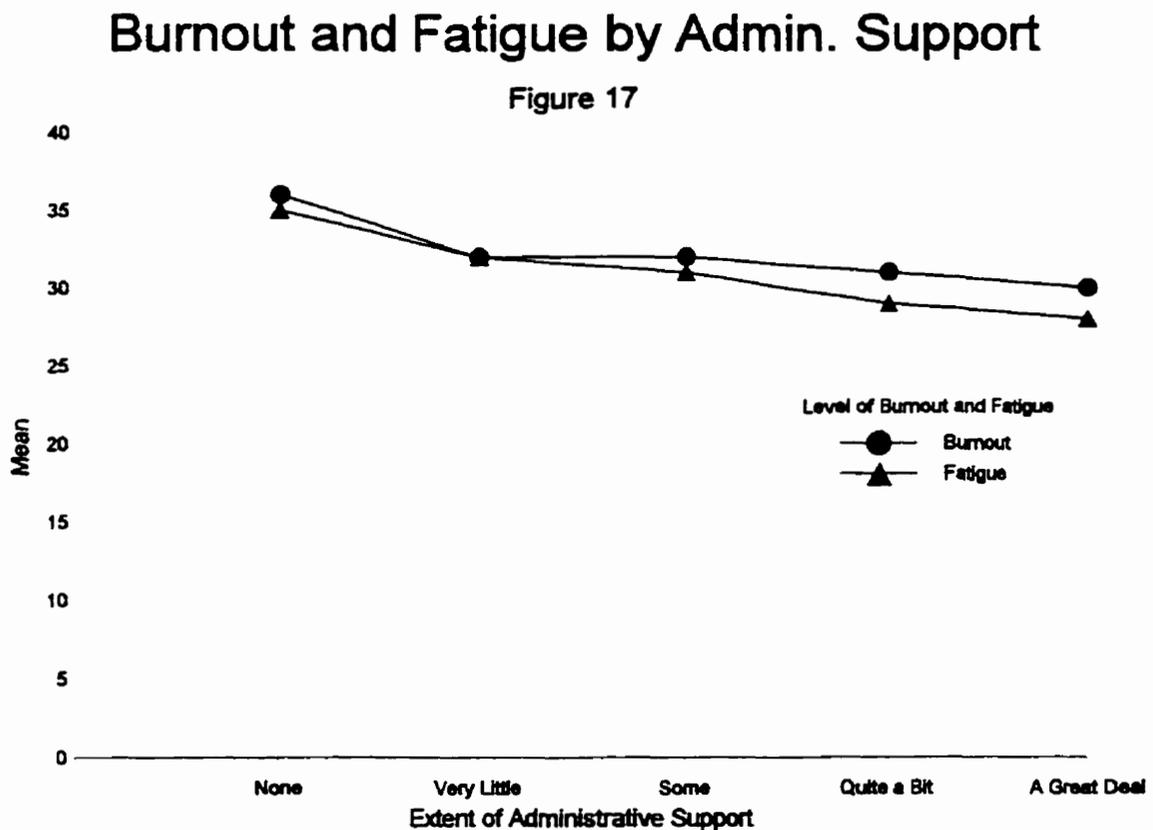
The level of support clinicians received within their practice was associated with burnout and compassion fatigue. Specifically, those therapists who reported receiving greater levels of administrative and colleague support reported lower levels of emotional exhaustion, depersonalization, burnout, compassion fatigue and a greater sense of personal accomplishment.

Sex offender therapists who indicated that they received 'almost no' administrative support for their work with sex offenders were at greater risk for burnout, $F(4, 637) = 8.38, p \leq .0001$, compared to those who reported receiving 'some', 'quite a bit' or 'a great deal' of administrative support. Those clinicians who reported receiving 'very little' or 'some' administrative support experienced higher levels of emotional exhaustion, $F(4, 509) = 5.82, p \leq .0001$, than those who received 'a great deal' of support and were also at greater risk for compassion fatigue, $F(4, 638) = 3.53, p \leq .0001$. Clinicians who received 'a great deal' of administrative support experienced a higher sense of personal accomplishment than did those who only reported having 'very little' or 'some' support.

Collegial support was also an important moderating variable. Clinicians who reported receiving 'almost no support' were at greater risk for burnout, $F(4, 670) = 17.56, p \leq .0001$, and for compassion fatigue, $F(4, 671) = 7.35, p \leq .0001$ than clinicians who had 'quite a bit' or 'a great deal' of colleague support. Sex offender practitioners who did not have collegial support experienced higher levels of emotional exhaustion than clinicians who had 'some', 'quite a bit' or 'a great deal' of support from colleagues, $F(4, 534) = 8.64, p \leq .0001$. Practitioners who reported 'very little' or 'some' collegial support experienced higher levels of depersonalization than those who had 'a great deal' of support from colleagues, $F(4, 534) = 3.96, p \leq .01$. Collegial support was also related to

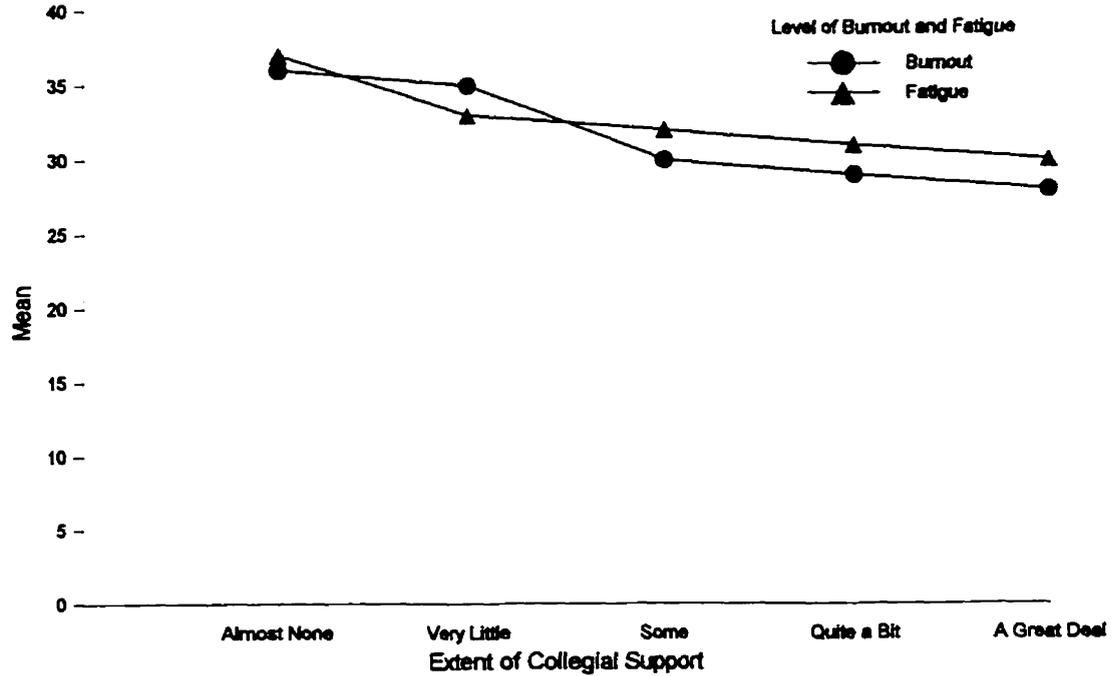
treatment providers' sense of personal accomplishment. Therapists who reported having a great deal of collegial support reported higher levels of personal accomplishment, $F(4, 534) = 8.8417$, $MSE = 27.30$, $p \leq .001$.

The associations between administrative and collegial support and burnout and compassion fatigue are illustrated in Figures 17 and 18.



Burnout + Fatigue by Collegial Support

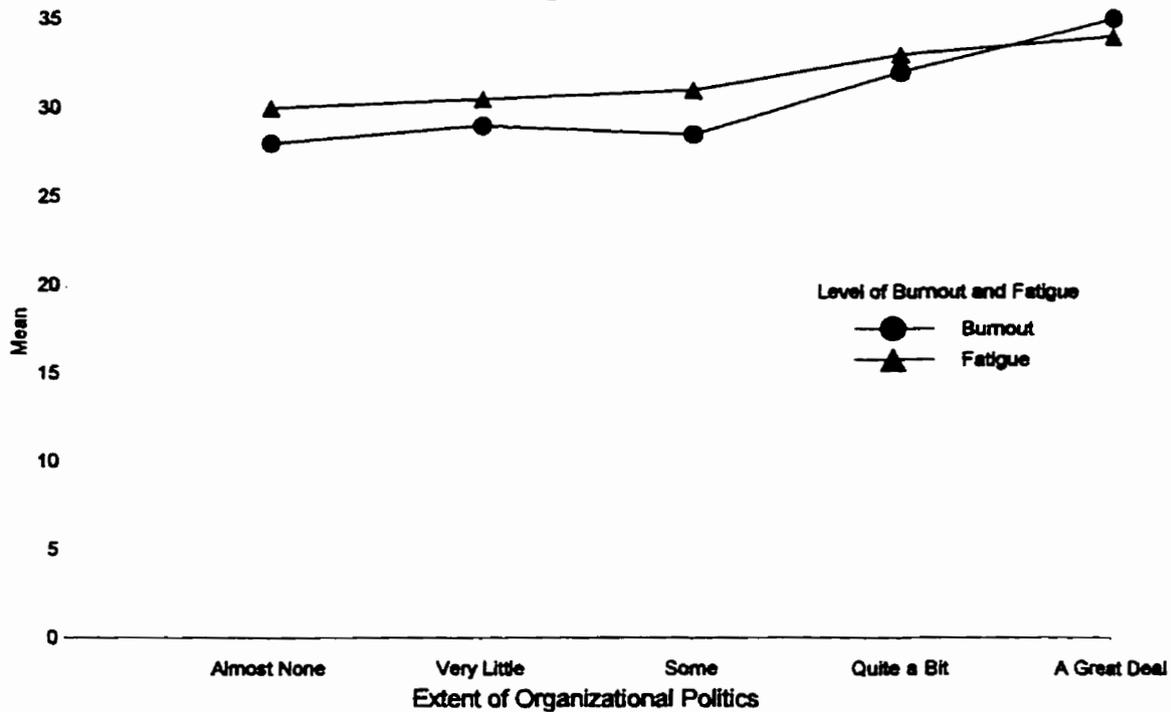
Figure 18



The increased instability of the practice setting was also associated with increased therapist impact. More specifically, clinicians who reported greater levels of stress as measured by higher levels of emotional exhaustion, depersonalization, burnout and compassion fatigue, also reported higher levels of organizational politics. These correlations are reported in Table 12 and the association between organizational politics and burnout and compassion fatigue is illustrated in Figures 19.

Burnout + Fatigue by Org. Politics

Figure 19



Clinicians who reported experiencing a high level of concern about the stability of ongoing funding for their sex offender treatment practice/program experienced a similar negative impact. These correlations are reported in Table 12. Practitioners who reported experiencing 'a great deal of concern' about funding for their sex offender practice experienced higher levels of emotional exhaustion, $F(4, 670) = 3.37, p \leq .01$, and depersonalization, $F(4, 534) = 3.04, p \leq .05$, than did

those who reported 'almost no concern' about funding. Therapists who had 'a great deal of concern' about funding were also at significantly greater risk for burnout than clinicians who experienced only 'some' or 'no concern' about funding, $F(4, 670) = 6.70, p \leq .0001$, and were at greater risk for compassion fatigue, $F(4, 671) = 2.39, p \leq .05$, than clinicians who experienced only 'some' concern about funding.

Predictors of Burnout and Compassion Fatigue

To explore the practice setting variables which predicted scores on the sub-scales of the Compassion Fatigue Self-Test for Psychotherapists and the MBI, a stepwise multiple regression analysis was undertaken. A summary of the stepwise regression analysis for practice setting variables predicting the dependent variables is found in Table 13 and 14. Overall, the level of collegial support and the level of stress experienced as a result of organizational politics accounted for the greatest percentage of the variance on all dependent measures. It should be noted however, that the percentage of the variance accounted by practice setting variables tended to be low.

The overall model for the Burnout sub-scale of the Compassion Fatigue Self-Test was significant and accounted for 13% of the variance. The level of collegial support was entered into the first equation and accounted for 8% of the variance. On the second step, the level of stress associated with organizational politics was added to the equation. The addition of this second variable accounted for an additional 5% percent of the variance. Other variables that were seen to be significant included the adequacy of the clinician's wage, and the stability of the funding for the clinician's sex offender treatment services, however, the percentage of the variance accounted for was minimal.

Table 13				
Summary of Stepwise Regression Analysis for Practice Setting Variables Predicting				
Burnout and Compassion Fatigue				
(Compassion Fatigue Self-Test for Psychotherapists)				
Burnout (Overall Model)				
$F = 48.24, df = 632, p \leq .0001, \text{Total Adjusted } R^2 = .13$				
Variable	<i>B</i>	<i>T</i>	<i>p</i>	<i>R</i> ²
Step 1				
Collegial Support	-.29	-7.61	.0000	.08
Step 2				
Collegial Support	-.26	-6.73	.0000	-
Organizational Politics	.22	5.95	.0000	.05
Compassion Fatigue (Overall Model)				
$F = 20.80, df = 633, p \leq .0001, \text{Total Adjusted } R^2 = .06$				
Step 1				
Organizational Politics	.20	5.12	.0000	.04
Step 2				
Collegial Support	-.15	-3.86	.0000	-
Organizational Politics	.17	4.48	.0000	.02

Table 14				
Summary of Stepwise Regression Analysis for Practice Setting Variables Predicting Emotional Exhaustion, Depersonalization and Personal Accomplishment (MBI)				
Emotional Exhaustion (Overall Model)				
<i>F</i> = 29.27, <i>df</i> = 503, <i>p</i> ≤ .0001, Total Adjusted <i>R</i> ² = .10				
Variable	<i>B</i>	<i>T</i>	<i>p</i>	<i>R</i> ²
Step 1				
Organizational Politics	.25	5.81	.0000	.06
Step 2				
Collegial Support	-.21	-4.82	.0000	.04
Organizational Politics	.22	5.04	.0000	-
Depersonalization (Overall Model)				
<i>F</i> = 13.05, <i>df</i> = 503, <i>p</i> ≤ .0001, Total Adjusted <i>R</i> ² = .05				
Step 1				
Organizational Politics	.18	4.11	.0000	.03
Step 2				
Collegial Support	-.13	-2.99	.0000	.02
Organizational Politics	.16	3.58	.0000	-
Personal Accomplishment (Overall Model)				
<i>F</i> = 18.97, <i>df</i> = 503, <i>p</i> ≤ .0001, Total Adjusted <i>R</i> ² = .07				
Step 1				
Collegial Support	.25	5.81	.0000	.06
Step 2				
Collegial Support	.24	5.65	.0000	-
Practice	-.086	-1.99	.0000	.01

The overall model for the Compassion Fatigue sub-scale of the Compassion Fatigue Self-Test for Psychotherapists was significant and accounted for 6% of the variance. The first variable to be entered into the equation was organizational politics, accounting for about 4% of the variance. On the second step, the level of collegial support was added to the equation and accounted for a modest additional 2% of the variance. Adequacy of salary was also added to the equation but accounted for only a small percentage of the variance.

The overall model for the Emotional Exhaustion sub-scales of the MBI was significant and accounted for 10% of the variance. The level stress associated with organizational politics was entered into the first equation and accounted for 6% of the variance. On the second step, the level of collegial support was added to the equation. The addition of this second variable accounted for an additional 4% percent of the variance. Adequacy of wage was also significant, however, the percentage of the variance accounted for was minimal.

The overall model for the Depersonalization sub-scale of the MBI was significant and accounted for 5% of the variance. The level of stress associated with organizational politics was entered into the first equation and accounted for 3% of the variance. On the second and final step, the level of collegial support was added to the equation, accounting for an added 2% of the variance.

The overall model for the Personal Accomplishment sub-scale of the MBI was significant and accounted for 7% of the variance. The level of collegial support was entered into the first equation and accounted for 6% of the variance. On the second and final step, the type of practice (private practice versus agency practice) was added to the equation. The addition of this second variable accounted for 1% percent of the variance.

III. Client Variables

Correlates of Burnout and Compassion Fatigue and Difference in the Experience of Distress

The extent to which clinicians provide direct clinical services to sex offenders is associated with therapist impact such that the more hours a clinician spends providing direct clinical services to sex offenders, and the greater percentage of sex offender clients they have on their case load, the greater the experience of burnout, compassion fatigue, emotional exhaustion and depersonalization. These correlations are reported in Table 15, and are all significant at the $p \leq .05$ level

The number of hours respondents provided direct client services was associated with elements of Burnout and Compassion Fatigue. Clinicians providing more hours of treatment to sex offender clients experienced greater levels of emotional exhaustion, depersonalization and compassion fatigue.

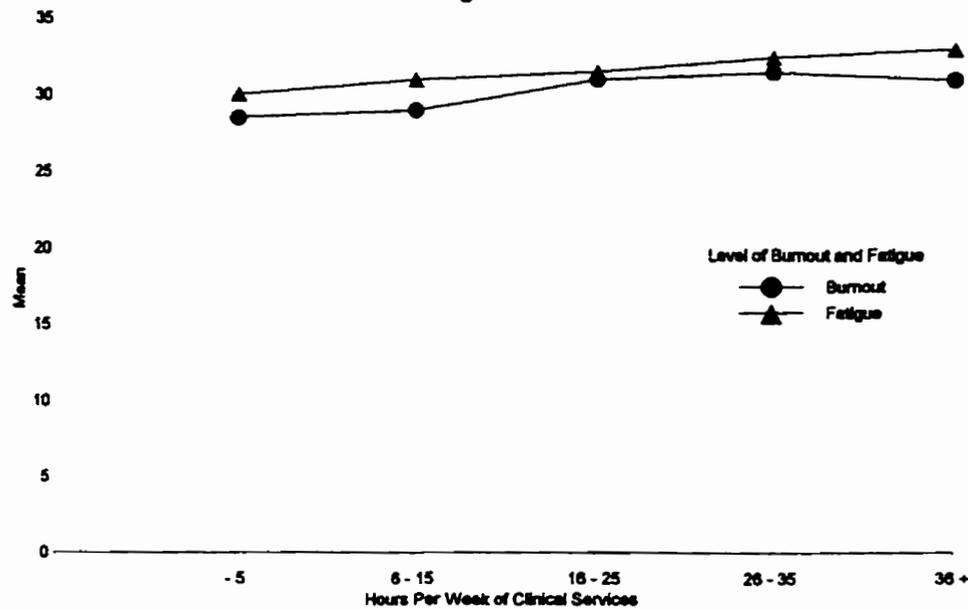
Sex offender treatment providers who reported providing 25-35 hours of clinical services to sex offender clients per week experienced significantly higher levels of emotional exhaustion than clinicians who provided 6-15 hours of sex offender treatment weekly, $F(4, 530) = 3.06, p \leq .05$. Treatment providers who described providing 25 or more hours of treatment to sex offender clients per week experienced higher levels of depersonalization than clinicians who provided 15 or less hours of sex offender treatment per week, $F(4, 530) = 4.76, p \leq .0001$. In addition, treatment providers who provided 36 or more hours of clinical services to sex offenders per week were at significantly greater risk for compassion fatigue, $F(4, 668) = 3.80, p \leq .01$ than clinicians who provided 15 or less hours of sex offender treatment per week. The association between hours of clinical service to sex offender clients and burnout and compassion fatigue are illustrated Figures 20.

Table 15
Intercorrelations Between Client Variables and Sub-scales of the
MBI and Compassion Fatigue Self-Test for Psychotherapists

Client Contact Variables	MBI			Compassion Fatigue	
	EE	DP	PA	Burnout	Fatigue
<i>Client Contact</i>					
Hours Per Week Providing Direct Services to Sex Offender Clients	.12	-.18	N.S.	.11	.15
Percentage of Sex Offenders on Caseload	.15	.17	N.S.	.11	.12
Manageability of Sex Offender Caseload	.30	.24	-.12	.23	.24
Years Providing Sex Offender Treatment	-.10	N.S.	.14	N.S.	N.S.
<i>Offender Specific Issues</i>					
Hours Per Week Providing Direct Clinical Services to Incest Offenders	.11	.15	N.S.	N.S.	N.S.

Burnout + Fatigue by Clinical Hours

Figure 20

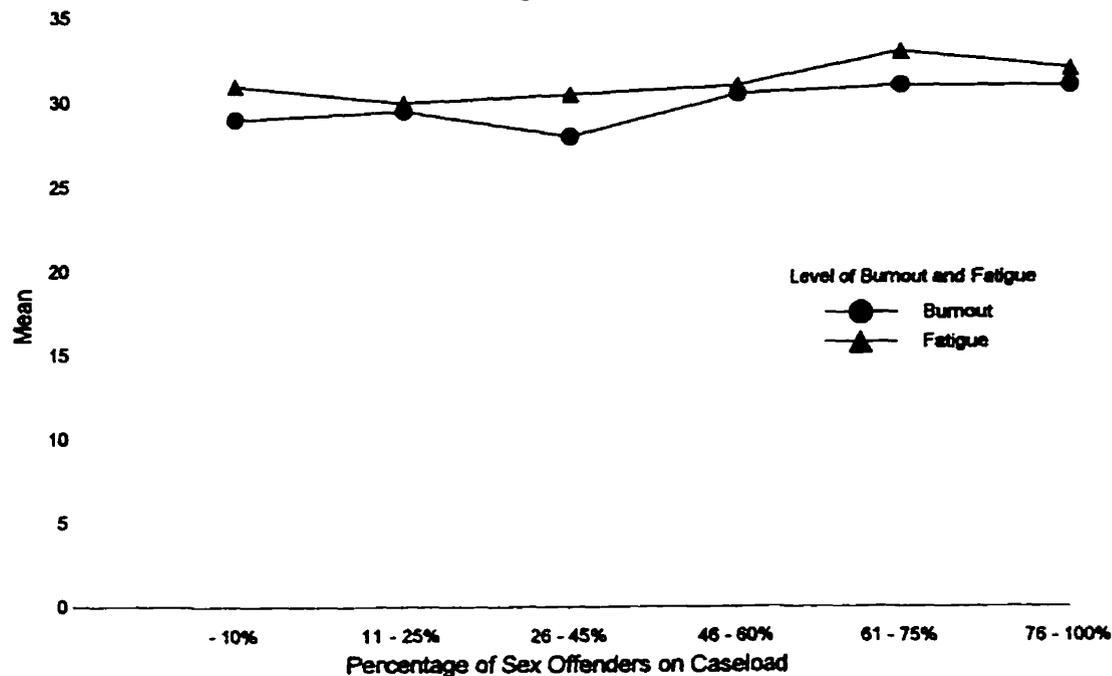


Clinicians whose case load consisted of over 60% sex offender clients were at significantly greater risk of burnout than clinicians whose case load of sex offenders was between 26-45%, $F(5, 668) = 2.80, p \leq .05$. The association between the size of sex offender caseload and the experience of distress as measured by the sub-scales of the Compassion Fatigue Test for Psychotherapists are illustrated in Figure 21.

The duration of treatment for sex offender clients was not associated with burnout or compassion fatigue.

Burnout + Fatigue by % SO Caseload

Figure 21



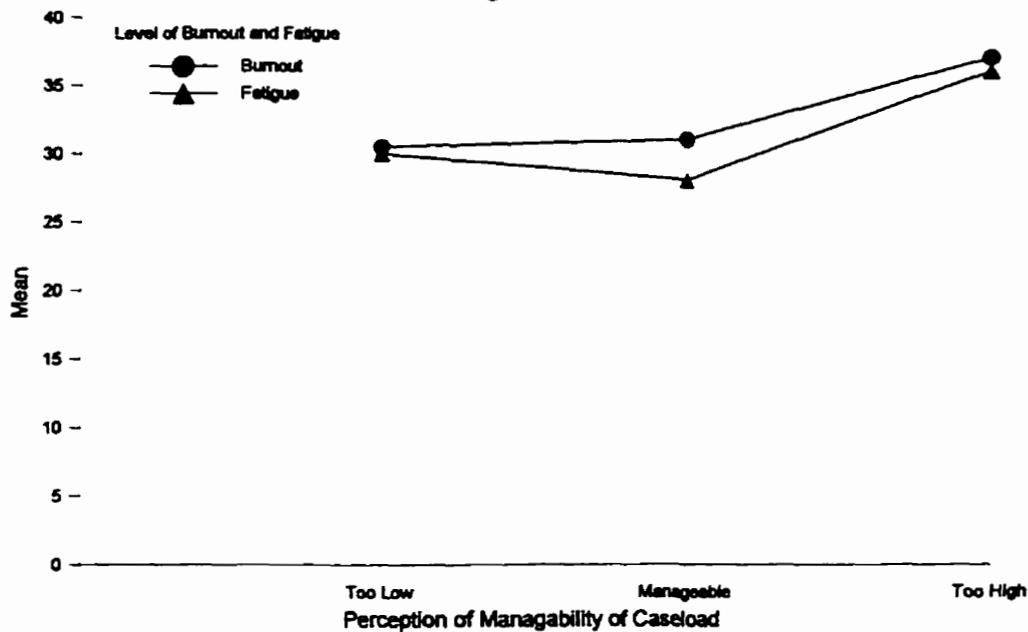
The clinicians' perception of their caseload appears to be another important variable related to therapist impact. Clinicians who saw their sex offender caseload as being too high report greater levels of emotional exhaustion, depersonalization and less sense of personal accomplishment. They are also at greater risk for burnout and compassion fatigue. This is illustrated in Figures 22.

Sex offender treatment providers who reported that their case loads were too high experienced significantly higher levels of emotional exhaustion, $F(2, 536) = 31.84, p \leq .0001$, depersonalization, $F(2, 536) = 20.24, p \leq .0001$, and were at greater risk for both burnout, $F(2,$

666) = 33.00, $p \leq .0001$, and compassion fatigue, $F(2, 667) = 26.27, p \leq .0001$, than clinicians who saw their caseloads as being either too low or manageable. Sex offender practitioners who reported that their case loads were manageable had a significantly higher sense of personal accomplishment, compared to clinicians who saw their case load as being too high, $F(2, 536) = 6.18, p \leq .01$.

Burnout + Fatigue by SO Caseload

Figure 22



The number of years experience providing sex offender treatment was negatively associated with emotional exhaustion and personal accomplishment. Clinicians with fewer years experience reported higher levels of emotional exhaustion, $r(541) = -.10, p \leq .05$, and clinicians with a greater

number of years experience reported a higher level of personal accomplishment, $r(541) = .1354$, $p \leq .01$. Clinicians who had provided sex offender treatment services from between 7-9 years, and over 13 years, reported significantly greater levels of personal accomplishment than sex offender treatment providers with 4-6 years experience, $F(5, 535) = 4.19$, $p \leq .001$.

The number of service hours that respondents provide to particular categories of sex offenders was also associated with therapist impact. A positive correlation was observed between the number of treatment hours provided to incest offenders and emotional exhaustion, $r(510) = .11$, $p \leq .05$, and depersonalization, $r(510) = .15$, $p \leq .001$. Clinicians who provided 25-35 hours of clinical service delivery to incest offenders experienced higher levels of emotional exhaustion than clinicians who provided five hours or less of treatment services to this population, $F(4, 505) = 3.16$, $p \leq .05$, and higher levels of depersonalization than therapists who provided less than 15 hours of services to incest offenders. Therapists who provided 16-25 hours per week of clinical services to rapists experienced higher levels of emotional exhaustion compared to clinicians who provided either less than 15 hours or over 36 hours of treatment to this client group per week, $F(4, 481) = 4.44$, $p \leq .01$.

Clinicians who provided 16-25 hours of treatment to rapists per week were also at greater risk for burnout than therapists who provided five hours or less hours of treatment to this client group or 36 hours of treatment or more, $F(4, 592) = 3.12$, $p \leq .05$. Sex offender treatment providers who provide 16-25 hours of treatment to rapists per week are also at greater risk for compassion fatigue than those clinicians who provide less than five hours of treatment to rapists per week, $F(4, 593) = 4.00$, $p \leq .01$. Treatment providers who delivered 16-25 hours of treatment services per week to

sadistic sex offenders are at greater risk for compassion fatigue than were therapists who provide less than five hours of treatment per week to this population, $F(4, 532) = 2.40, p \leq .05$.

Predictors of Burnout and Compassion Fatigue

To explore those client variables which predict compassion fatigue and burnout, and emotional exhaustion, depersonalization and personal accomplishment a stepwise multiple regression analysis was undertaken. A summary of the stepwise regression analysis for client variables predicting the dependent variables is found in Table 16 and 17. While a number of client variables were significant in accounting for a portion of the variance on all dependent measures, and the overall analysis was significant, overall, the percentage of the variance accounted for tended to be quite low.

The overall model for the Burnout sub-scale of the Compassion Fatigue Self-Test for Psychotherapists was significant and accounted for 10% of the variance. The stress associated with providing treatment to incest offenders was entered into the first equation and accounted for 7.5% of the variance. On the second step, the stress associated with providing clinical services to 'other' types of sex offenders (e.g., exhibitionists, voyeurs) was added to the equation accounting for an additional 3% percent of the variance. The level of stress associated with treating rapists, and the manageability of clinicians' sex offender caseload were also significant, however, these variables accounted for a minimal percentage of the variance.

The overall model for the Compassion Fatigue sub-scale of the Compassion Fatigue Self-Test for Psychotherapists was significant and accounted for 14% of the variance. The number of hours of clinical service delivery provided to sex offenders was entered into the first equation, accounting for about 6% of the variance. On the second step, the stress associated with providing clinical

Table 16
Summary of Stepwise Regression Analysis for Client Variables Predicting
Burnout and Compassion Fatigue
(Compassion Fatigue Self-Test for Psychotherapists)

Burnout (Overall Model)				
<i>F</i> = 15.83, <i>df</i> = 263, <i>p</i> ≤ .0001, Total Adjusted <i>R</i> ² = .10				
Variable	<i>B</i>	<i>T</i>	<i>p</i>	<i>R</i> ²
Step 1				
Stress Associated with Incest Offenders	.28	4.73	.0000	.07
Step 2				
Stress Associated with Incest Offenders	.23	3.70	.0000	-
Stress Associated with 'other' Offenders	.18	2.95	.001	.03
Compassion Fatigue (Overall Model)				
<i>F</i> = 15.21, <i>df</i> = 263, <i>p</i> ≤ .0001, Total Adjusted <i>R</i> ² = .14				
Step 1				
Hours per week of Sex Offender Treatment	.26	4.36	.0000	.06
Step 2				
Hours per week of Sex Offender Treatment	.25	4.38	.0000	-
Stress Associated with Pedophiles	.23	4.03	.0001	.05
Step 3				
Caseload	.17	2.88	.01	.03
Hours per week of Sex Offender Treatment	.20	3.44	.001	-
Stress Associated with Pedophiles	.24	4.15	.0000	-

Table 17
Summary of Stepwise Regression Analysis for Client Variables Predicting
Emotional Exhaustion, Depersonalization and Personal Accomplishment
(MBI)

Emotional Exhaustion (Overall Model)				
$F = 21.16$, $df = 219$, $p \leq .0001$, Total Adjusted $R^2 = .15$				
Variable	<i>B</i>	<i>T</i>	<i>p</i>	R^2
Step 1 Stress Associated with Incest Offenders	.34	5.41	.0000	.11
Step 2 Caseload Stress Associated with Incest Offenders	.21 .31	3.41 5.03	.001 .0000	.04 -
Depersonalization (Overall Model)				
$F = 18.80$, $df = 219$, $p \leq .0001$, Total Adjusted $R^2 = .14$				
Step 1 Stress Associated with 'other' Offenders	.31	4.79	.0000	.09
Step 2 Percent of Caseload Sex Offenders Stress Associated with 'other' Offenders	.23 .29	3.65 4.59	.001 .0000	.05 -
Personal Accomplishment (Overall Model)				
$F = 5.35$, $df = 219$, $p \leq .05$, Total Adjusted $R^2 = .04$				
Step 1 Years Providing Sex Offender Treatment	.15	2.28	.05	.02
Step 2 Caseload Years Providing Sex Offender Treatment	-.15 .16	-2.33 2.47	.05 .05	.02 -

services to pedophiles was added to the equation, accounting for an additional 5% of the variance. On the third and final step, the manageability of client caseload was added to the equation accounting for an additional 3% of the variance.

The overall model for the Emotional Exhaustion sub-scale of the MBI was significant and accounted for 15% of the variance. The stress associated with providing treatment to incest offenders was entered into the first equation accounting for 11% of the variance for the emotional exhaustion sub-scale of this measure. On the second step, the manageability of client caseload was added to the equation, accounting for an additional 4% of the variance. The stress associated with providing clinical services to 'other' types of sex offenders and to pedophiles was also added to the equation and found to be significant, however, the percentage of the variance accounted for was minimal.

The overall model for the Depersonalization sub-scale of the MBI was significant and accounted for 14% of the variance. The stress associated with providing clinical services to 'other' types of sex offenders was entered into the first equation, accounting for 9% of the variance. On the second step, the percentage of sex offender clients on the clinicians' caseload was added to the equation, accounting for an additional 5% of the variance. Other variables including the stress associated with providing clinical services to incest offenders, the manageability of the clinician's caseload, and years of practice with sex offenders were added to the equation and found to be significant, but accounted for a minimal percentage of the variance.

The overall model for the Personal Accomplishment sub-scale of the MBI was significant and accounted for 4% of the variance. Years of clinical practice with sex offenders was entered into the

first equation accounting for 2% of the variance. On the second step, caseload manageability was added to the equation accounting for an additional 2% of the variance.

Overall Best Predictors of Burnout and Compassion Fatigue

To examine the best predictors from each of the independent variable domains (therapist variables, practice setting variables and client variables) and the sub-scales of the Compassion Fatigue Self-Test for Psychotherapists and the MBI a stepwise multiple regression analysis was conducted. A summary of the stepwise regression analysis for therapist, practice setting and client variables predicting the dependent variables is found in Table 18 and 19. It should be noted that this analysis was exploratory in nature and, given the number of independent variables entered into the regression equation there is a greater potential for Type 1 errors.

The overall model for the Burnout sub-scale of the Compassion Fatigue Self-Test for Psychotherapists was significant and accounted for 60% of the variance. Clinicians "feeling depressed as a result of working as a therapist" was entered into the first equation and accounted for 45% of the variance. On the second step, 'feeling sad and downhearted in the last 6 months' was added to the equation, accounting for an additional 11% of the variance. On the third step, 'feeling weak, tired and rundown as a result of working as a therapist' was added to the equation. The addition of this third variable accounted for another 4% of the variance. Each of the best predictors were therapist variables, specifically those related to emotional health. A number of other variables were entered into the equation and were significant at the $p \leq .0001$ level, however, these therapist client and practice setting variables (e.g., collegial support, gender, hours of clinical service provided to rapists and stability of program funding) only accounted for a small percentage of the variance.

The overall model for the Compassion Fatigue sub-scale of the Compassion Fatigue Self-Test for Psychotherapists was significant and accounted for 33% of the variance. Clinicians 'feeling sad and downhearted in the last six months' was entered into the first equation, accounting for 28% of the variance. On the second step, the number of hours of clinical services provided to sex offenders per week was added to the equation, accounting for an additional 5% of the variance. On the third step, 'feeling depressed as a result of working as a therapist' was added to the equation. The addition of this third variable accounted for an additional 4% of the variance. Other variables such as the level of supervision, adequacy of salary and level of training prior to beginning to provide sex offender treatment were found to be significant, but accounted for only a small percentage of the variance.

The overall model for the Emotional Exhaustion sub-scale of the MBI was significant and accounted for 38% of the variance. Clinicians 'feeling sad and downhearted in the last six months' was entered into the first equation accounting for 29% of the variance. On the second step, feeling depressed as a result of working as a therapist was added to the equation, accounting for an additional 9% of the variance. The stress associated with providing clinical services to 'other' types of sex offenders, 'feeling weak, tired, and rundown as a result of working as a therapist' and caseload manageability were also found to be significant, however, the percentage of the variance these variables accounted for was minimal.

The overall model for the Depersonalization sub-scale of the MBI was significant and accounted for 21% of the variance. 'Feeling depressed as a result of working as a therapist' was

Table 18
Summary of Stepwise Regression Analysis for
Therapist, Practice Setting and Client Variables Predicting
Burnout and Compassion Fatigue
(Compassion Fatigue Self-Test for Psychotherapists)

Burnout (Overall Model)				
$F = 122.28, df = 242, p \leq .0001, \text{Total Adjusted } R^2 = .60$				
Variable	<i>B</i>	<i>T</i>	<i>p</i>	<i>R</i>²
Step 1				
Depressed as a therapist	.67	14.13	.0000	.45
Step 2				
Having felt downhearted, last 6 months	-.38	-7.80	.0000	.11
Depressed as therapist	.48	9.72	.0000	-
Step 3				
Having felt downhearted, last 6 months	-.33	-6.84	.0000	-
Feeling weak tired and rundown as therapist	.27	5.08	.0000	.04
Depressed as therapist	.33	6.05	.0000	-
Compassion Fatigue (Overall Model)				
$F = 62.89, df = 244, p \leq .0001, \text{Total Adjusted } R^2 = .33$				
Step 1				
Having felt downhearted, last 6 months	-.53	-9.87	.0000	.28
Step 2				
Having felt downhearted, last 6 months	-.49	-9.39	.0000	-
Hours per week of Sex Offender Treatment	.24	4.54	.0000	.05

Table 19
Summary of Stepwise Regression Analysis for
Therapist, Practice Setting and Client Variables Predicting
Emotional Exhaustion, Depersonalization and Personal Accomplishment
(MBI)

Emotional Exhaustion (Overall Model)				
$F = 63.09, df = 200, p \leq .0001, \text{Total Adjusted } R^2 = .38$				
Variable	<i>B</i>	<i>T</i>	<i>p</i>	<i>R</i>²
Step 1 Having felt downhearted, last 6 months	-.54	-9.20	.0000	.29
Step 2 Having felt downhearted, last 6 months	-.36	-5.53	.0000	-
Depressed as therapist	.35	5.43	.0000	.09
Depersonalization (Overall Model)				
$F = 27.62, df = 200, p \leq .0001, \text{Total Adjusted } R^2 = .21$				
Step 1 Depressed as therapist	.38	5.77	.0000	.14
Step 2 Percent of caseload sex offenders	.27	4.36	.0000	.07
Depressed as therapist	.36	5.79	.0000	-
Personal Accomplishment (Overall Model)				
$F = 22.50, df = 200, p \leq .0001, \text{Total Adjusted } R^2 = .18$				
Step 1 Collegial support	.33	4.95	.0000	.10
Step 2 Collegial support	.28	4.38	.0000	-
Depressed as therapist	-.28	-4.29	.0000	.08

entered into the first equation and accounted for 14% of the variance. On the second step, the percentage of sex offender clients on the clinicians caseload was added to the equation, accounting for an additional 7% of the variance. On the third step, the stress associated with providing clinical services to the category of 'other' sex offenders, was added to the equation. The addition of this third variable accounted for an additional 5% of the variance.

Other variables including profession, feeling sad and downhearted in the last six months and level of training prior to providing sex offender treatment were also added to the equation and found to be significant, but accounted for a minimal percentage of the variance.

The overall model for the Personal Accomplishment sub-scale of the MBI was significant and accounted for 18% of the variance. Collegial support was entered into the first equation accounting for 10% of the variance. On the second step, feeling depressed as a result of working as a therapist was added to the equation and accounted for an additional 7% of the variance. Hours of clinical service delivery to the category of 'other' sex offenders, profession and practice setting were also significant, but accounted for only a small percentage of the variance.

Focus Group Data

The questions posed to participants of the two focus groups were related to the stressors and difficulties associated with their clinical practice with sex offenders, the ways in which clinicians cope with the stress of their practice and the satisfactions associated with a clinical practice with sex offenders.

An ethnographic analysis of the focus groups was conducted in an effort to supplement the quantitative data collected through the survey. Data captured through the transcripts of the two

Focus Groups was categorized into key themes through a “process of discovery” (Morgan, 1988). Primary theme areas were identified with sub-categories for each of these major areas. Sets of quotations illustrating the dynamics of the research questions were identified.

The major theme areas are identified below along with the sub-categories. Quotations from the Focus Groups are provided to illustrate these themes.

Difficulties and Stressors: Therapist Issues

Overall, there was little discussion in either focus group about stressors that were related to clinicians’ own backgrounds or that were related to therapist variables. Comments were restricted to issues of gender and family.

Gender Issues

- P6** “talking about sex offending behaviors openly and being a woman, you know, it scared me to be around these people”.
- P9** “my biggest challenge, ... it was fighting that uphill battle of being a female or woman in a correctional institution and having some sort of, uh, respect for being there. That was really hard”.
- P9** “total disrespect for women ... They [male correctional officers] totally perpetuate the whole thing, that you’re in there trying to change ... the cognitive distortions of inmates, and the people who are supervising them on a 24 hour basis are perpetuating it, and right in front of them and with us right beside them”.

P3 “I’m almost ashamed to be a man because it seems like there are always crimes against females. Even those that were perpetrated against a boy, that is more a function of availability. The choice is female, whether an adult rapist or a child molester ... it would be nice to have a third choice not male, not female but be that third choice so you don’t feel like somebody goes ... ‘there’s one we just haven’t caught yet’”.

Having Children

P4 “the next part of that [stress associated with sex offender treatment] is if you have children or grandchildren, which I have, then if someone is a child offender or they are telling you about things they have done brutally to a child, and if the age matches up and you see your own family in what you’re hearing”.

Difficulties and Stressors: Practice Setting Issues

Practice setting was an area of much discussion in Focus Group 1 and less so in Focus Group 2. For the most part discussion identified community based programming as most stressful for clinicians, however, some stress factors related to institutional programming were identified. The stress of private practice work was also highlighted by one group member.

Stress of Community Practice

P2 “I like to have a job that I can go to at 8:00 in the morning and I can leave at 4:00, 4:30 or 5:00 p.m. and it’s done. I need that to function. I need to have time where I can go home and relax and totally forget about work. If I were working in the community, I couldn’t do that.

P2 “you can all leave it at work, or its easier because you know there’s bars, there’s some walls”.

Stress of Institutional Practice

P8 “We’ve had a major riot recently and, uh, my Unit was virtually broken out, moved around. People were tortured by other prisoners. So, my job has been a mess and I’ve been trying to piece it together again. Because of this little hiatus, uh, all the old rejections have resurfaced from new management, old management and guards and, uh, the guards now have a perception of a lot more power than they did, so they are reasserting themselves”.

Stress of Private Practice

P4 “My life is 24 hours a day, 7 days a week involvement. I have no, umm, there’s nothing in my life that’s not sex offender related. Ah, my husband works for me, all of my friends are in the field. This is my world. So, I don’t ever actually leave it. When I walk out of the office, I may have, you know four reports to work on and I may be at the computer until 2:00 a.m., doing it, so my involvement is probably a little different, I guess, than the others in here because I am, I’m where the buck stops, ... I have to be at it all the time”.

Difficulties and Stressors: Client Issues

While client issues were a major focus of discussion and identified as a significant source of stress, it was interesting to note that for the most part this discussion focused less on client characteristics (e.g., type of sex offender client, client’s presentation in therapy, client symptomatology) and more so on issues related to the therapeutic process with sex offenders, the stigma associated with delivering services to this client group and on recidivism.

Prevalence of Sexual Offending

P5 “When you pick up the newspaper or you turn on the TV and you hear another crime has been committed, and it’s not necessarily some work I could have done to prevent it, cause it’s in another place ... but it’s there, it’s in your face”.

Difficulty of Population and Concerns about Treatment Gains

P5 “Once we’re in the room, everything is going all over. It’s two, uh, independent, simultaneous therapy sessions going on because we just can’t agree on how to deal with the situation, because the client is so difficult”.

P1 “ with the high risk population that you work with, some of the guys, even if they are getting something out of it, the progress is very slow and it can be very frustrating at a personal level and at a therapeutic level. You know, you’ll be working hard with these guys and you feel you’re not getting anywhere and you can intellectualize it, you can rationalize it and you can say, you know, they are making progress in what you consider to be important areas and, then, all these ‘but’s’ come in”.

P9 “I had a few worries that I was teaching a few guys to go out and do it better”.

Partners of Offenders

P7 “sometimes the spouses gets in the way of treatment, while they really support, in some cases, they actually initiate the denial .. so that makes it really hard for us to work with them”.

Social Stigma Associated with Sex Offender Treatment

i) General Response

- P1** “There’s a big social factor to the whole thing. It’s difficult to discuss what you do and have other people relate to you”.
- P9** “I always feel I’m burnout out purely for external [reasons], I think it’s maybe, though what I’m having to show them, you know, that we’re not, we’re not wired because we want to do this and these people [sex offenders] aren’t, some are sick, some are truly psychotic, but some of them, you got to get down and then you can see they’re still human beings”.
- P5** “People neglect to see the benefit that’s coming out of it. ... it’s like society saying ‘control their behaviors, lock the person up, execute the person, do something that’s completely horrendous because of what they are ... but they don’t want any sort of help cause then you’re coddling the offender, feeling sorry for them”.
- P9** “ I’m 27 and the church we go to seems to be a real elderly, you know, real small and they’re trying to increase the younger population and so I was invited to the women’s group and they’re like, how do I say this without freaking out a roomful of church women. ... I was like, you know, well, I’m a psychologist and, oh you know, ‘who are you working with?’ ... I work in the prison system. ‘Oh, really, you know, what type of prisoners do you work with?’, and I’m like, quit asking me questions. You’re not going to like my answers. ... I finally just said, ‘I work with rapists and child molesters’, and ... they quit asking me questions after that ... That’s not true. They went on to ask me what I thought about the Chemical Castration Law”.

P3 “It’s not the kind of thing that you can sit around in a coffee shop and talk about openly”.

ii) Response from Colleagues

P4 “ the victim treatment providers come after you and say ‘what’s wrong with you?, how can you do this?, you should be working with us’.”

P6 “the view from our classmates who don’t work with us on our project, ... ask ‘well, do you actually think they’re treatable?, do you actually think there’s something you can do for them?, and it’s the same with family and friends.

iii) Response from Family Members

P2 “It’s difficult to discuss what you do and have other people relate to you. Family members look at you as though ‘so why did you choose this?’ ... I mean, if anybody studies schizophrenia, ... people don’t make the assumption, okay so you have schizophrenia ... as soon as you’re studying paraphilia, ... it’s ‘so what’s wrong with you, what’s the skeleton that’s in your closet?’”

P3 “hell, my father-in-law, and I’ve been married for 30 years plus, he can’t tell you what I do for a living. He refuses to talk about what I do. He knows about all his other son-in-laws and sons and daughters and daughter-in-laws, but refuses to acknowledge what I do. My own mother can’t even say the word ... she said ‘where did I do wrong?, Why do you want to deal with those people?’”.

Recidivism**i) Public's Expectations and Therapists Expectations**

P6 "you're expected to have a relapse rate of zero".

P2 "people always compare like sex offending to drug and alcohol or cigarette smoking when people go through a program to try to quite smoking 80% of them relapse in the first month ... when you think about that, like, sex offender treatment is much more successful than that".

P1 "the other issue is that when you look at some of the, at least the Canadian follow up data, I mean, you know we have follow up data 7, 10, 12 years. Look at, you know a weight loss group or any of these other groups. What's the follow up period? If you're lucky, you get 12 months".

P1 "the credibility of the program runs along with the clientele".

ii) Ongoing Worry About Client Recidivism

P3 "We look at the newspaper and see or hear on television a report about a sex offender, and we think, is it one of ours?"

Difficulties and Stressors: System Issues

There was discussion, particularly in Focus Group 2, about how system issues create stress for clinicians. System issues, and responding to system issues, such as a lack of understanding and appreciation for the area of sex offender treatment, shortfalls in the criminal justice system and poor interagency cooperation were highlighted as problem areas and areas of stress.

Educating Criminal Justice Systems

P7 “I think one of my biggest challenges has been trying to get the judiciary system to recognize what our needs are, what we need from them in order to do the very best job that we can”.

P7 “the biggest thing is trying to educate probation, judges A.D.A.’s and the D.A.”.

Inadequacies of Criminal Justice System

P5 “The sentencing is the whole part of the equation, ... one of the clients I had, ... as soon as his probation is up in four to five years ... he’s going to be incredibly high risk and there’s nothing I can do about it”.

Interagency Communication and Cooperation

P8 “another external thing that effects us is cooperation and communication between agencies ... that can be quite frustrating ... sometimes it can be demoralizing and more than difficult”.

Administrative Support and Understanding of Sex Offender Treatment Programming

P8 “it’s been a long, slow process to convince fellow workers, uh, administrators that I’m working with people and they’re to be afforded good treatment. Uh, the methodology we use, the techniques we use take longer than a week”.

The Impact on the Clinician

Focus group participants discussed the ways in which they have been affected by the various stressors associated with their sex offender treatment practice. Clinicians focused their comments on the emotional strain of psychotherapy with sex offenders, the impact of being exposed to trauma material, how they have been affected by client recidivism and how their work has impacted on their personal life and family relationships.

Emotional Impact

P4 “the intensity of what you must do with this population in guarding yourself and in not being sucked into, the manipulations suck your energy thoroughly. So by the time you may leave the office, ten o’clock at night, you’ve pretty much run the gambit of every emotion that you have and you’re going to come back and do it the next day.”

Impact of Client Trauma Material

P4 “you’re talking to people that are so horrendously damaged that if you have empathy yourself ... you actually resonate with their pain”.

P10 “We see a lot of people who have zero in most areas of their lives, uh from livelihood to economics ... they don’t have a hell of a lot ... every once and awhile, you feel a kind of despair over it”.

P9 “the first thing I had to do was read every crime story of every sex offender in our area and that was almost 300, 290 some. And you can imagine, it took me a long time. That was really hard. ... real uncomfortable ... I dreamt a lot at night about it ... I was having really bad dreams, you know, prisoners chasing me”.

Personal Impact of Client Recidivism

P4 “when you have a monumental success and it goes out there and fails, then you feel like you’re a failure”.

P3 “[you think] what could I have done differently?”

P4 “that [recidivism] can really take the starch out of you”

- P3** “the son of a gun that you’ve worked with for five years that says the right things, he talks the talk and when he gets out there, the first thing he does is re-offend. ... it’s like he’s learned how to do a different type of offence. If he were an exposer, he’s escalated. If he was a rapist, now he’s also a murderer or damn near murders the victim. So it’s like God, what did I do to cause him to escalate”.
- P4** “I get the feeling that it’s [recidivism] a retaliation for all that we put them through in terms of the pressure we put on them to change and that, when they do decide that they’re going to do their own thing they do it even more so, to make a statement”.
- P4** “We worked ... all those years doing all these minute steps and, you know, you do take it personally, in that you missed signals, possibly that might have clued you in and it does effect your belief in what you can really see. ... Now, taking it personally doesn’t mean going out and slashing your own wrists. ... But, it does say, it points out your own mortality, your own fallibility ... You’re not perfect and I’d like to be able to be perfect”.
- P4** “the rational part says he elected to throw away three or four years of therapy, so he gets what he deserves. But the other case of that is that the victim had to suffer too”

Impact on Practitioners Family

- P9** “my husband hated the fact that I worked with the prison system”.
- P9** “it [work] effected my marriage for just a little while, but just a short amount of time cause I realized what was going on”

- P8** “I don’t talk about my work a great deal at home, although I do talk about it in very general terms, but, you know you’re not going to get into details throughout the family dinner table. You know, I think my kids were ten before they really understood what I did”.
- P3** “it would be nice if you could also talk to the spouses because I’m sure what I do is really tough on my wife, ‘cause I get to unload on her and I’m not real sure who she gets to unload on”.

Coping with the Stressors of a Sex Offender Treatment Practice

Therapists described a variety of coping strategies that they used to help them cope with the stress of their clinical practice including: talking with colleagues, dark humor, framing recidivism, cognitive restructuring, separating work from personal life, avoiding media about abuse at home, exercise, holidays, personal therapy and having diversification in their practice.

Debriefing and Clinical Supervision

- P6** “we have weekly supervision with our supervisors and the other staff members ... [we] support each other and it’s helpful”.
- P8** “I really rely on co-workers to get rid of a lot of that stress”.
- P7** “it’s just nice to share similar experiences and go wow, I went through that too and I handled that in that way too, and I’m not crazy. I think it’s really good to have debriefing”.
- P9** it’s nice to have somebody, when you say what you do, that nods their heads and goes ‘yeah, I know, ‘I understand’ that laughs along with you or vents along with you, and doesn’t just stand there and goes ‘oh, okay’“.

- P3** “in terms of talking to people, you know, that’s really important, whether just going to somebody’s office to gripe or, you know, actually talking about, well, you know, ‘Do you think that I did okay with this client?’ ... ‘What should I have done differently?’ I think having that kind of feedback is really important to stress management”.

Pacing Oneself

- P8** “I don’t know whether it’s I’m getting old or older, but I find myself very consciously pacing ... it’s like double group day and it’s been horrendous ... I don’t kill myself the next morning. I try and set my schedule up with some fillers or light appointments”.
- P7** “if I have things that need to be done, I will do them on Saturday so that I’m ready by Monday morning and then I feel more relaxed when I go in”.

Black Humor

- P3** “when we joke, it’s real dark humor. I mean, you know you can look at a photograph of a child that’s dead and there’s parts missing and go, ‘well, that’s going to be a closed casket funeral’. God, that’s cold. ... I mean, you don’t even validate the fact that, that was a human being at one time. That the parents are really concerned. It’s, well, that’s going to be cheaper. They don’t have to spend that much money on the funeral. Just close the casket’. But, if you don’t protect yourself in those sorts of ways, you end up crying the whole time”.

Not Personalizing Recidivism

- P2** “The people that we’re dealing with are really fucked up when they come to us, and if they’re only slightly less fucked up when they leave, we’ve done something. And, you know, odds

are that most of the people we deal with are going to come back into prison for something, sooner or later”.

P2 “You know, we treat 50 guys a year. If 45 of them don’t re-offend, I’m happy. If 45 of them re-offend, 5 of them don’t. Like, I’m not looking for a really high success rate from the guys that we deal with”.

P2 “if a guy screws up, ... hopefully the way I’m going to deal with it, I’m not going to take it personally. It’s his decision, you know, I worked with him for, you know the six months or year or whatever. ... I helped him however I could, and what happens with him from that point on is his decision and if he chooses to, you know, go out and do something that hurt someone else, I hope that I don’t see that as my responsibility”.

Cognitive Restructuring

P8 “I have a little cognitive trick that I play on myself which seems to work cause I’m about one-half hour out of town and the halfway mark is the perimeter highway around the city and, after about 15 minutes in my car, the first 15 minutes I allow myself to worry, agonize, beat myself up, feel bad about what happened at work today, if there’s anything left after debriefing, and then I try to restructure it, roughly around the perimeter highway ... just like we teach our clients ... by the time I’m driving that last half of it, I’m thinking about what’s for dinner, better still, what am I cooking, what am I doing tonight, uh, where are the kids going, uh, and what [my wife] has accomplished at work today. That kind of stuff. And, uh, I’m pretty normal by the time I get home”.

Diversification of Practice

P3 “I counsel with, what I call, normal thugs. They’re pipe bomb manufacturers. They’re counterfeiters. They’re Colombian drug lords. And I talk to them, depression groups, chronic pain, I mean, just nice friendly stuff. Yeah, it keeps me grounded”.

Separating Clinical Practice from Personal Life

P1 “Sex offending crimes are big news in almost every place, so, distancing yourself in the sense of keeping occupied with things unrelated to the field and, portioning out times knowing that the demands of the field require you to stay up on top of what’s going on and require you to stay in focus, but you pretty much have to make that time to do other things, to forget about it, to get on with your life and to live that life”.

P8 “I de-brief and I do something nice that evening, or I relax or watch mindless TV, read a book, get a little exercise. ... It’s important to make sure there’s something else in your life besides the job”.

P9 “I make certain that I have a whole total life that does not involve sex offender treatment. I try to ... go to the opera at least once a year, twice if I can make it and, uh I take guitar lessons, things like that”.

P8 “I wouldn’t be caught dead watching something on TV that’s about abuse. I wouldn’t, sorry ... I’ve given at the office”.

P10 “it’s important to make sure there’s something else in your life besides the job because the job can take up too many hours in a day and a week and doing something that, uh you like and

it's just for yourself and staying away from [work]. I don't think I could watch a program on child abuse or sexual abuse if my life depended on it".

P4 "I think that where my disengagement comes is in the times that I allow myself to not let the thoughts of the sex offending world impinge on the moment that I'm interacting with my grandchild, or my dogs or whatever".

P6 "Having a diversity of interests is important ... I try and do non-psychology things ... to be in contact with people who are not in your field".

P4 "I have to actually leave the city, and if I can get on a plane, I leave it there. That's the only way that I will not live this world".

Exercise

P1 "I go back and work out with weights".

P1 "riding a bike".

P2 "I use running as a gauge, you know, I sometimes am not aware of how stressed I am and yet, I'll be running and I'll do, like five kilometers more than I'm used to doing or something like that, and it's sort of, I use it almost as a scale. 'Oh, shit. There's something I have to process' cause I have all this extra energy in me and it's stress related and, and, like, it'll get me thinking, 'Okay, what's going on?', and then something will click in my head like, 'Oh yea, I had this horrible session with this guy that I, you know was trying to forget about, but obviously it's there.

Personal Therapy

P4 “I did a lot of long-term therapeutic work in how to compartmentalize my life so that I wouldn’t let what I do 24 hours a day burn me up, so that I would be ineffective. And that, to me was extremely valuable because it helped me gain a perspective that I did learn, that I was not infallible, that I did learn that they make their own choices. And, not that I didn’t know it .. but you have to internalize those concepts and going to therapy the way I did for so long helped to sort of completely solidify that process”.

The Satisfactions and Rewards Associated with Sex Offender Treatment

Clinicians in both Focus Groups offered a range of satisfactions and rewards associated with providing clinical services to a sex offender population. The rewards identified included the interesting, challenging and exciting nature of the work, satisfying personal needs, the satisfaction associated with client change, altruistic motivation and clinician’s own personal growth.

Feeling the Work is the Area of Clinical Practice for them

P2 “there’s nothing else I’d ever want to do. .. I’ve had a few variety of jobs like working in a grocery store, I’ve worked on a survey crew and I work with sex offenders and I think like, working with sex offenders is about the only thing that ... I actually look forward to going to work”.

Finding the Work Interesting, Challenging and Exciting

P1 “I think sex is fascinating. I mean, the concept of sex gone wrong, what are you talking about, sexual dysfunctions, or are you talking about the sexual paraphilia or whatever, figuring out what’s going on. Like in the case of the guy sitting there with you who really doesn’t know

what's going on, what is related to his behavior ... it's fascinating! Just the process of figuring it out".

P2 "that fascinating sex topic thing ... I find the whole idea ... really fascinating ... like the whole cognitive distortions, all that stuff ... I just get off on it, to use a phrase".

P8 "It's interesting work with interesting people. It brings a lot of challenges. The job has never, ever been remotely dull".

P6 "I see it as a challenge ... I figure, if I can work with this population, I can work with many other populations".

P8 "I find the actual clinical work exciting".

Satisfying Emotional Needs through Clinical Practice

P4 "my selfish part [of the rewards of clinical practice] is that I need that sense of power and control of bad people and it works for me".

P2 "I actually look forward to going to work ... I was craving excitement and I find the job I do very exciting".

P3 "I also have a tremendous need for excitement. I, uh, spent two tours in Vietnam as a kid, uh, if you can figure somebody 20 and 21 as a kid and, uh, after you have worked 'Point' on alert detail for 19 straight months and you don't know what's around the next curve, there is nothing as high as coming out alive. I had to find something in civilian life that would do the same thing. And the power is part of it and then the fact that, even with a failure, my side is I can get the confession to put the guy away so he can't do any more damage. So, if I can't

do it on one side, I've got the chance to do it on the other. So, I, you, do feel like you're helping people, even though you'll never meet 'em".

Practicing in an Area that has Some Mystique

P10 "sometimes people talk about ... all the negative media and the negative ... attention ... you know, the sort of room-quieter. But there's also part of me, I think that likes that".

Relationship with Colleagues

P8 "The kind of work relationships you get. I find it absolutely satisfactory".

Participating in the Process of Change with Sex Offender Clients

P2 "one of the advantages to our population is with some of the guys we see, particularly the child molesters, it's there, they're not hiding from you anymore. Because .. the recidivist offenders, they're saying, 'okay, I've got to work on this now and some are actually quite motivated and they talk very openly about it and it's just fascinating".

P10 "it never ceases to amaze me and I think it's meant to make me, keep me humble. Uh, that these people who have had like mostly nothing, you know, and they can change ... it feels really good to see somebody [change]".

Altruism in Practice, Sense of Doing Good

P1 "working with this population, you know, you're saving victims out there. And that's important".

P7 "when you think about it, that we're really affecting the lives of children that haven't been born yet".

P4 "The altruistic [reward] is that I'm providing safety for many, many people".

- P5** “For all the negative publicity that I hear out in the world, there are people who actually think we do a good thing”.
- P7** “When I first started, I think I told myself I did it for the children and then ... I recognized that women were staying with these men who had committed these crimes, even against their own children, and if not, against their own children, then against the children of their wives. And then I say, well, I do it for the women and then, when I notice that men are really changing ... and hearing men talk about the quality of their lives, after they’d been through treatment ..then I say, I do it for the men, so, I think, I think really, I do it for the children, I do it for the spouses and I do it for the men, so, I think, ultimately, I do it for humanity and that’s a good feeling”.

Professional and Personal Growth

- P8** “I think this, the kind of work we’re doing demands your self-improvement, re-educating yourself constantly”.
- P9** “it’s definitely not a stagnating process ... Whenever I’m doing something with these people, whether individual or group, they’re not the only one that’s learning ... I’m not the only one teaching ... I’ve grown”.

DISCUSSION

This study has sought to enhance the knowledge base about the experience of providing clinical services to sex offender clients.

The findings are reviewed and discussed in seven sections. The first five sections outline the characteristics of the respondents, the experience of burnout and compassion fatigue, the moderating variables and the best predictors of distress, coping skills and strategies, and the satisfactions associated with sex offender treatment. In each section the primary results of the study are reported, integrating both the quantitative and qualitative findings. As well, the results are compared and contrasted with the existing literature and hypotheses to account for the findings that are put forward. In the last two sections the implications of the findings and future directions are discussed.

Respondent Characteristics

Overall, the majority of survey respondents were American males between the ages of 41-50, who were married or in a common-law relationship, educated at a Master of Arts level, and who described their profession as a 'therapist'. This profile was very similar to the subject population described by Bird Edmunds (1997) and Jackson et al., (1997). While it may be the case that this description represents the overall average characteristics of sex offender treatment providers, it is likely that the similarities are due to sampling of similar populations. Bird Edmunds (1997) described her sample as consisting of 276 clinicians obtained at the thirteenth annual national treatment and research conference of ATSA, while Jackson et al., (1997) describe a sample of 98 American sex offender therapists drawn from the twelfth annual national treatment and research conference of ATSA.

Most respondents (57%) described the majority of their clinical practice (over 60% of their caseload) as providing services to sex offender clients, and, on average, clinicians provided 16-25 hours of direct clinical service per week to these clients. Therapists who provide sex offender treatment appear to do so quite extensively. Bird Edmunds (1997) reported that 89% of the sex offender therapists in her sample identified that between 91-100% of their caseload was made up of sex offender clients, and 66% reported working an average of 41 hours or more a week, with 36% of the respondents indicating that 11-20 hours per week constituted direct client time.

Most clinicians had a vast amount of experience providing treatment to sex offender clients with almost half (42%) reporting over 10 years experience, and an average reporting between 7-9 years experience. This group of practitioners appears to be quite experienced as other studies point to similar time frames of providing services to sex offenders. Bird Edmunds (1997) related that just over a third (38%) of her sample had nine or more years of sex offender treatment experience, while Jackson et al., (1997) described their largest group of respondents (41%) as reporting 6-10 years of sex offender treatment experience.

Over one half (59%) of the respondents were employed in an agency, with three quarters of the respondents (76%) describing themselves as practising within a specialized sex offender treatment program. The majority of respondents in this study (56%) provided community based sex offender treatment programming. This was also found to be the primary treatment setting by Bird Edmunds (1997) and Jackson et al., (1997).

The majority of the sex offender therapists in this study did not receive specialized training prior to commencing their clinical practice with sex offenders (61%). This was consistent with an

earlier study in which Ellerby et al. (1993) reported that most therapists (66%) described themselves as poorly or not at all prepared to work with sex offenders. While clinicians received little in the way of training prior to beginning their sex offender practice, most (67%) reported having considerable opportunities for continuing education once they were in the field.

There appears to be some variability in clinicians' perception of the adequacy of their training. Jackson et al., (1997) state that the majority of the therapists in their sample (84%) reported having received adequate training for their work with sex offenders, while Bird Edmunds (1997) reports that only 45% of her sample reported feeling adequately trained. The training experiences described by Jackson et al., (1997) included participation in: workshops and seminars (83%), research/literature (65%), supervision (50%), internship (44%) and on-the-job training (30%). It may be, as appeared to be the case among the treatment providers sampled for this study, that there is a difference between receiving training opportunities prior to providing sex offender treatment and once in the field. Clinicians seemed dissatisfied with the level of prerequisite training but satisfied with the opportunities they later receive for ongoing training and continuing education.

The majority of clinicians described receiving a good deal of support from administrators (56%) and colleagues (60%). However, even though these positive work supports were in place, clinicians still reported experiencing high levels of stress associated with organizational politics and about the stability of funding for their sex offender treatment programs.

As a final note about the respondents, it appears that sex offender treatment providers have a keen interest in understanding more about how they, as a group, are affected by their sex offender practice. This level of interest was reflected by the excellent response rate (74%) for this study. It

is also worth noting, that in addition to responding to a relatively lengthy survey, 35% of the respondents took the time upon completing the questionnaire to provide additional, often lengthy and well thought out written comments on the back comment sheet of the survey. A number of these comments further illustrated the interest treatment providers have in this area: "Finally, someone is asking these questions", " I believe that this attempt at assessing treatment provider stress, burnout, depression etc. is a long overdue one", "Glad to see this topic being researched as I have often felt misunderstood by others in the community regarding the type of work I do", "This type of research may help me learn to better take care of myself" and "I am thankful that someone is looking at the difficulties and rewards of working with sex offenders as most clinical organizations do not possess a clear understanding, or for many even a clue, of what it is like to work with this population ... I believe that many therapists are not honest about how working with sex offenders has an impact on their personal lives".

Jackson et al., (1997) also suggest that sex offender treatment providers have a strong interest in how they may be affected by their work, and point to their high response rate (32%) and the thoughtful and detailed responses they received to difficult open-ended questions.

The Experience of Burnout and Compassion Fatigue

While much of the literature discussing the impact of providing sex offender treatment suggests that this type of practice exposes clinicians to many stressors which may place them at greater risk for burnout, this level of distress was not found in the survey data. On the other hand, the focus group disclosures revealed a greater level of work related concerns.

Overall, the sex offender treatment providers sampled, as a group, did not experience marked levels of burnout. Compared to a normative sample of mental health service providers (Maslach & Jackson, 1981), the sex offender therapists experienced similar levels of emotional exhaustion, slightly higher levels of depersonalization and a much greater sense of personal accomplishment, which is inversely related to burnout.

Additionally, responses on the Compassion Fatigue Self-Test for Psychotherapists indicated that the sex offender treatment providers sampled were not at high risk for burnout. In fact, 81% of the respondents presented as being at extremely low risk for the experience of burnout, while only 2% of the respondents were found to be at high or extremely high risk for burnout. The remaining 17% of the respondents were at moderate risk for burnout.

In considering the experience of burnout among sex offender treatment providers, Bird Edmunds (1997) did not use a standardized measure to assess the experience of, or risk for burnout, but did explore whether clinicians reported an increase among a number of emotional, physical and psychological symptoms associated with burnout. Overall, clinicians did not evidence a marked escalation in these symptoms. Over half (56%), reported no change at all in the experience of symptoms associated with burnout, while another 15% cited a decrease in these symptoms. However, 29% of the sex offender treatment providers did report an overall increase in the experience of these symptoms. While it can be inferred from this study, that the majority of sex offender treatment providers were not experiencing burnout, the experience of distress can not be ignored, as over a quarter of the sample did identify an increase in burnout symptoms.

The same is true of the present study. While therapist distress was not prominent in the overall sample, it is important to note that about one third of the sex offender treatment providers (31%) did experience a high level of emotional exhaustion, and about 45% experienced high levels of depersonalization. Therefore, while as a whole sex offender treatment providers did not demonstrate high levels of burnout, certainly a number of these clinicians did evidence elevations in symptoms associated with burnout which would likely affect their personal and professional functioning.

The experience of compassion fatigue, although similar to burnout, appeared more prominent among sex offender treatment providers. Twenty one percent of the service providers were seen to be at high to extremely high risk for compassion fatigue, while 29% were seen to be at moderate risk for compassion fatigue. The hallmark of compassion fatigue is the experience of personal depletion, or fatigue. This higher level of compassion fatigue among sex offender therapists is consistent with the previously reported experience of emotional exhaustion by a number of practitioners.

While Bird Edmunds (1997) did not assess for the experience of compassion fatigue, one of the burnout symptoms she investigated was the experience of fatigue among sex offender treatment providers. She noted that 60% of all respondents described experiencing an increase in fatigue over the course of the last year while providing clinical services to sex offender clients.

In considering the differential experience of symptoms related to burnout and compassion fatigue, it appears to be the case that although similar, these concepts are distinct. The difference between clinicians' experience of, and risk for burnout and for compassion fatigue support Figley's (1995) differentiation between these two conceptualizations of therapist impact.

As well, it may also be the case that the differential experience of burnout and compassion fatigue may be in part a function of the coping skills clinicians possess to address stress, and more specifically, stress related to trauma material.

Sex offender treatment providers may be better equipped to manage and reduce the experience of burnout, as a result of their evidenced strong coping skills and the high level of personal accomplishment they obtain from their work. While clinicians may be in a position to manage the generalized experience of distress associated with burnout, they may be less equipped and adept at coping with the more specific experience of empathic engagement with trauma material. This hypothesis will be further developed in the section on coping and coping skills.

The Moderating Variables and Best Predictors of Distress

To further understand what factors may contribute to sex offender treatment providers being more vulnerable, or more resilient, to burnout and compassion fatigue, the associations between these components of stress and therapist, practice setting and client variables were examined. The identification of moderating and predictor variables of distress is viewed as an important component of the research, as these findings more specifically detail which clinicians may be at greater risk for distress; identify factors that clinicians, clinical supervisors, program directors and administrators can be aware of and monitor; and may provide direction for developing strategies to support therapists who take on the challenge of providing clinical services to a sex offender population.

Therapist Variables

In considering therapist variables, while some demographic variables were found to be significant, issues of therapist training/support and emotional health figured prominently.

Younger sex offender therapists were found to be at greater risk for emotional exhaustion, depersonalization and compassion fatigue than their older, more experienced colleagues. This finding was consistent with previous research which has identified younger therapists as experiencing higher levels of personal depletion and distress (Boice & Myers, 1987; Farber & Heifetz, 1981). A similar finding has been reported specifically related to trauma therapists, indicating that younger therapists providing clinical services to trauma clients were found to be at greater risk for trauma related symptoms and depersonalization (Arvay & Uhlemann, 1996).

Younger clinicians may be more susceptible to experience distress as they are less clinically experienced, and, in the case of sex offender treatment providers, may have less background of being exposed to, and addressing trauma material. This could result in young therapists being at risk to become overwhelmed and depleted by the trauma material, while not having developed adequate skills to identify and process the affects of this exposure. It may be the case that younger therapists attempt to cope by distancing themselves from their clients and the trauma material, which would account for the heightened experience of depersonalization. Consistent with this hypothesis, Bengis (1997) notes that with longevity in this field comes the development of skills to cope with the stressors particular to sex offender treatment.

Clinicians' academic background and profession were also variables that moderated distress. Clinicians who had obtained higher levels of education (M.A. or Ph.D.) reported higher levels of personal accomplishment. However, in contrast to findings by Pearlman and MacIain (1994) and Arvay and Uhlemann (1996), education level was not found to be associated with other characteristics of burnout. The greater level of personal accomplishment identified by clinicians with

higher educations may be a result of increased financial compensation in their employment and/or due to them enjoying a higher level of professional status as a result of their academic background.

Profession was also associated with distress in that individuals providing sex offender treatment, whose primary profession was not related to providing mental health services, experienced higher levels of emotional exhaustion and depersonalization, were at higher risk for burnout and compassion fatigue, and had a lower sense of personal accomplishment, than clinicians who identified themselves as mental health professionals. In this regard, respondents who identified themselves as therapists (master and doctoral level) demonstrated a significantly greater sense of personal accomplishment than did probation and parole officers providing sex offender treatment.

There are a number of reasons that may account for these differences. Firstly, it is likely that the treatment providers who are mental health professionals have had the opportunity to be involved in training that provides them with a theoretical framework with which to approach their clinical practice and with training specific to counselling skills. This may not be true, or true to the same extent, of criminal justice personnel providing sex offender treatment services. As well, it may be the case that mental health professionals choose to provide services to a sex offender population, while criminal justice professionals may be assigned this task in an effort to provide programming in an area of need, in an attempt to maximize limited resources. In these instances this would be a shift in roles for which these individuals may be ill prepared. Finally, professional status has been identified as being associated with stress, specifically with lower status professionals experiencing higher levels of stress and burnout (Avery & Uhlemann, 1996; Farber & Heifetz, 1981; Pearlman & MacLan, 1994). It may be the case that criminal justice professionals view themselves as lower status

professionals in the area of providing clinical services, compared to therapists, psychologists and psychiatrists.

Other demographic variables such as gender, and being a parent or grandparent were not found to be significantly associated with distress in the quantitative data, but were highlighted within the two focus groups.

Female sex offender treatment providers discussed the difficulties, challenges and stressors related to being a female and providing clinical services to sex offenders, and being female and working in a correctional environment. Some focus group participants revealed experiencing fear and disrespect. Among samples of general therapists, female clinicians have been found to experience a greater level of distress (Boice & Myers, 1987; Deutsch, 1984). Bachynisk (1995) noted some tendencies for female sex offender treatment providers to demonstrate elevations in their experience of emotional depletion and depersonalization, and a lower sense of personal accomplishment compared to males, however, not at a level that was statistically significant.

One focus group participant discussed the emotional difficulty of hearing stories of sexual abuse against children, and connecting these images with one's own children or grandchildren. This phenomena has also been described by Pearlman and Saakvitne (1995b).

The level of supervision and support received by clinicians was conceptualized as another therapist variable that may moderate distress. While a smaller number of the sex offender treatment providers sampled described having frequent clinical supervision opportunities (27%), a greater number (67%) reported being able to frequently consult with more experienced sex offender treatment providers.

Supervision and consultation were found to be important moderating variables as therapists who reported limited opportunity to participate in clinical supervision and consultation experienced greater distress, particularly related to personal depletion (exhaustion and compassion fatigue) and burnout. As well, the greater the ability to consult, the higher the level of personal accomplishment reported. These findings are consistent with what has previously been identified as the importance of supervision and consultation in diminishing the negative impact of providing clinical services, particularly among therapists dealing with trauma issues (Cerney, 1995; Figley, 1995, Pearlman & Saakvitne, 1995 a, b).

The importance of supervision and consultation was also identified by respondents on the comment section of the survey and highlighted by participants of the focus groups. The benefits of these supports was described as: providing opportunities to vent, a forum to receive clinical guidance and direction, and a means of confirmation. Clinicians offered comments such as: "it's just nice to share similar experiences and go wow, I went through that too and I handled that in that way too, and I'm not crazy", "in terms of talking to people, you know, that's really important, whether just going to somebody's office to gripe or, you know, actually talking about, well, you know, 'Do you think that I did okay with this client?' ... 'What should I have done differently?' I think having that kind of feedback is really important to stress management". These findings were consistent with those reported by Jackson et al., (1997) who reported that the majority (88%) of their sex offender therapist respondents identified supervision as helpful and cited the primary benefits as: validation of the therapist's perceptions and/or others perceptions (48%), case management (27%) and the release of feelings (15%).

As one might expect, training also proved to be a variable that mitigated the experience of stress/distress. Those clinicians who reported receiving training specific to sex offender treatment prior to practising with this client group experienced lower levels of depersonalization. Therapists with knowledge about the client group and about the therapeutic interventions utilized in treating this population may feel more prepared, more comfortable and more confident in their ability to engage in therapy with sex offender clients. As a result, the therapists may be less likely to cope through distancing or disengaging from the client. Although training prior to providing sex offender treatment was found to be helpful in moderating the experience of distress, as noted previously, the majority of clinicians in this sample (61%) did not have extensive training/preparation prior to providing sex offender treatment.

The majority of sex offender treatment providers (70%) reported opportunities for continuing education once they were involved in the field. This is very positive as clinicians who reported not having the opportunity to participate in continuing education to further develop their professional skills were found to experience higher levels of emotional exhaustion, were at greater risk for burnout and compassion fatigue, and had a lower sense of personal accomplishment.

It appears that professional development is an important source of professional coping. It may be the case that contact with other professionals in the area, obtaining new information, receiving confirmation about the way in which one conducts their practice, and a break, even a short one, from clinical practice to reflect on one's work, helps to reduce stress. Continuing education may provide for something similar to what Farrenkopf (1992) describes as an 'adaptation phase' in a clinical practice with sex offenders. The opportunity for continuing education may facilitate clinicians to re-

gain their motivation for their work, to emotionally re-group, to re-focus their perceptions about their practice and method of practice, and to regain their sense of therapeutic compassion.

While previous literature has identified clinical supervision and ongoing consultation as sources of professional coping that moderates the experience of stress, the importance of having the opportunity to participate in training prior to practicing with trauma clients and the importance of continuing education once in the field have not been noted.

A stressor related to training, that was not anticipated, was the stress some respondents identified on the comment section of the survey as being associated with encountering untrained therapists providing sex offender treatment. Respondents related "I fail to understand therapists who say they know how to work with this population when they actually do not. I currently have a patient who was working with another therapist for over two years and during that time he reoffended on several occasions. When he finally reached my office he was weeks away from sentencing. I began to ask him about his sexual history, fantasies, triggers etc. This was all alien to him", "My main problem is that the agencies are referring sex offenders to treatment with psychologists and therapists that have no formal training in specific sex offender issues. They are not aware of the responsibility these caseloads represent and they do not work with authorities for follow up", and "Most of the frustration is dealing with systems and others who proclaim expertise in this field but do not have a clue".

The final therapist variable, and the most significant therapist variable that was observed to be associated with clinicians being either more resilient or more susceptible to distress was emotional health. While only a small percentage of respondents reported frequently feeling depressed (8%),

these clinicians (who reported having felt sad and downhearted a 'good bit of the time' or 'almost all the time', within the last six months), were at risk for distress and demonstrated significant elevations on all of the measures evaluating burnout and compassion fatigue. In fact, frequent depressed feelings within the last six months was the best overall predictor across all therapist, practice setting and client variables for the experience of personal depletion (emotional exhaustion and compassion fatigue). Recent depressed symptoms was the second best overall predictor of distress (burnout) and of a low level of personal accomplishment.

In a cross sectional study such as this, one is faced with a bit of a 'chicken and egg' problem, determining whether a pre-existing or general depression is the primary factor contributing to distress, or whether it is the emotional impact of a clinical practice, in the case of this study, a clinical practice with sex offenders, which contributes to a general malaise. The problem then becomes attempting to determine whether the observed experiences of distress are related to a general depression or are more specifically related to feelings of depression associated with one's clinical practice. A longitudinal study with multiple measures over time for depression and burnout would be needed to clarify this issues.

A high rate of depression among therapists is reported in the literature (Deutsch, 1985; Sussman, 1995). Sussman (1995) cites several studies suggesting that the demands and stressors of a psychotherapeutic practice are factors which greatly affect the emotional adjustment of clinicians and that can contribute to depression (Bermak, 1977; Deutsch, 1984; Hellman, Morrison & Abramowitz, 1986; Pearlman & Saakvitne, 1995). The experience of depression has also been identified as a significant factor for trauma therapists, and is viewed as one of the effects of engaging

in a therapeutic process with trauma clients (Cerney, 1995; Figley, 1995; Pearlman & Saakvitne, 1995).

The results of this study lend some support to the argument that the provision of clinical services to trauma clients (sex offenders) may take its toll on the emotional adjustment of therapists and place them at risk for distress (e.g., depression, fatigue, burnout), in large part due to the nature of their clinical practice.

Items embedded in the Compassion Fatigue Self Test for Psychotherapists, asked clinicians to what extent they experienced depression and personal depletion (e.g., feeling weak, tired, run down) which they attribute to being specifically associated with their sex offender treatment practice. Consistent with the general depression question, only a small number of clinicians reported feeling depressed (2%) or depleted (7%) as a result of their work with sex offenders. However, the experience of depression associated with practising as a sex offender therapist was the strongest therapist variable predictor for distress (burnout, compassion fatigue) and the second best predictor of depersonalization. In addition, the feeling of depression associated with being a sex offender treatment provider was the best overall predictor, across all therapist, practice setting and client variables, for the experiences of burnout and depersonalization, and the second best overall predictor for the experiences of emotional exhaustion and a low sense of personal accomplishment.

The experience of personal depletion associated with providing sex offender treatment was found to be the strongest therapist variable predicting emotional exhaustion and a low sense of personal accomplishment.

While only small numbers of sex offender treatment providers reported feeling depressed, either generally or in response to their contact with sex offender clients, it is evident that emotional fragility greatly escalates ones vulnerability for distress and that further attention to this area is warranted.

Practice Setting Variables

Practice setting variables were also found to moderate the experience of distress among sex offender treatment providers, in both the survey and focus group data.

Sex offender therapists who practised in an agency setting were found to experience greater levels of personal depletion (emotional exhaustion and compassion fatigue) and depersonalization than their colleagues in private practice. This finding is consistent with the literature on stressors identified for both general and trauma therapists (Arvey & Ulhemann, 1996; Deutsch, 1984; Pearlman & MacIan, 1994).

It may be the case that providing treatment services within the context of an agency practice is more stressful for clinicians because of the greater imposed structure. While private practice was identified in one focus group to be stressful because of the clinician having to assume 100% responsibility for their practice (e.g., both clinically and financially), private practice may offer a greater level of independence, autonomy, flexibility and an absence of the organizational stressors inherent in an agency practice. Clinicians working in an agency setting may have issues related to treatment programming imposed on them (e.g., duration of treatment, number of clients in groups, format of treatment), may have their work schedule structured for them, may have expectations and

pressure placed on them related to billing hours and may have to contend with organizational issues within the agency setting.

Differences were also found between clinicians who provided sex offender treatment in a correctional institutional setting versus a community setting. Sex offender treatment providers practising within correctional institutions experienced higher levels of depersonalization, while sex offender treatment providers practising in community based programs experienced a significantly greater sense of personal accomplishment. Farber and Heifetz (1981) reported a parallel finding within the mental health system, finding that clinicians who practice in an institutional or in-patient setting (non-correctional) experience greater levels of distress than those in a community setting.

There are various hypotheses that might account for these findings. Within correctional institutions the level of exposure to sex offender clients may be greater as treatment providers typically have daily contact with inmates in treatment. As well, inmates tend to be quite needy and demanding of attention, so clinicians may attempt to distance themselves from their inmate clients as a means of coping. Sex offender treatment providers working within correctional institutions may also be dealing with clients who have a greater degree of psychopathology, which again may impact on both the level of stress experienced by the clinician and how they cope with this stress. Furthermore, correctional institutions are typically punitive environments that, by their very nature, depersonalize inmates. This could also contribute to therapists' tendency to depersonalize. In this regard, Freeman-Long (1997) relates "What do I do with my sense of rage and helplessness at witnessing the horrors of our criminal justice system? How can we cope when our prisoner clients

are raped, beaten and assaulted, when they commit suicide, or as happened to one of my clients, when they are murdered?" (p. 7).

The greater level of personal accomplishment observed among the community treatment providers may be related to their ability to work with the clients in a 'real life' setting, away from the difficult institutional environment. As well, typically community treatment providers are able to see a client through to the completion of the treatment process, something that may result in personal and professional satisfaction. As one community treatment provider noted, "The thing I like best about my work with the sex offenders is that I get to see them complete treatment".

Although survey results found institutional treatment providers to experience more distress, focus group participants varied in their perceptions as to which setting was more stressful, with the majority identifying the community as a more difficult setting. While some therapists practising in correctional institutions identified their work as more stressful because of the atmosphere, rigidity and volatility of the environment they worked in, other correctional institution treatment providers believed that a community practice was more stressful. These participants indicated that they, unlike community treatment providers, were able to leave their work at home at the end of the day as they knew that their offender clients were incarcerated and not out in the community where they could be at risk to offend. Overall, community treatment providers identified a community based practice as more stressful, primarily for the same reason.

Other important practice setting variables that both moderated, and were predictors for the experience of distress were organizational issues related to internal politics, administrative and

collegial support and program funding. Each of these variables were associated with the dependent variables.

A number of the respondents (42%) described experiencing a high level of stress due to the organizational politics within their place of employment. The level of stress experienced as a result of organization politics was the best practice setting predictor of personal depletion (emotional exhaustion and compassion fatigue) and depersonalization, and was the second best predictor of burnout.

Survey and focus group participants highlighted and identified organizational issues as a source of stress. Comments included: "My work problems are not related to inmates/offenders but to organizational issues", "Most of the stress I experience is more related to administrative and political policies than to treatment itself" and "It is important to note that job frustration mainly comes from organizational politics rather than the actual work". This identification of organizational politics as an area of stress is consistent with a larger literature identifying organizational politics as associated with therapist stress and distress (Bermak, 1977; Chessick, 1978; Farber, 1979; Kottler, 1993; Norcross & Prochaska, 1986; Pearlman & Saakvitne, 1995).

The stress associated with organizational issues may be related to the fact that while clinicians expect to encounter difficulties and obstacles in their therapeutic work with clients, they do not anticipate experiencing such obstacles within their workplace. Often times organizational stressors are perceived as needles, 'add on stressors', which clinicians have little control over. Organizational issues also tend to be viewed as impeding, or making more difficult, the clinicians' primary goal and focus which is clinical service delivery.

The level of support clinicians received within their practice setting was another significant moderating variable for distress. The majority of respondents described receiving a good deal of support both from their administrators (56%) and colleagues (60%). These supports were found to be meaningful as those clinicians who identified receiving little administrative or collegial support experienced higher levels of distress. Collegial support was found to be a particularly important moderating variable. Limited collegial support was the best practice setting variable predicting the experience of distress (burnout, depersonalization, a low level of personal accomplishment), and the second best practice setting variable predicting personal depletion (emotional exhaustion and compassion fatigue). As well, strong collegial support was the best overall predictor, across all therapist, practice setting and client variables, for the experience of a high level of personal accomplishment. It is apparent that having the support of ones' colleagues is strongly connected to job satisfaction. Collegial support has previously been identified as an important factor which can reduce the experience of distress amongst both general and trauma therapists (Farber, 1983; Pearlman & Saakvitne, 1995a,b).

The necessity and value of having strong collegial support was further identified by focus group participants and survey respondents. Clinicians offered: "I don't know how anybody could do this work in isolation without a supportive team", "I am very fortunate to have had the support of my co-facilitator and members of my therapy team from the outset of my practice", and "I have had some difficult experiences with sex offenders. The worst time I had was when a sex offender I was seeing killed two children. I almost quit working at the time. However, I had a lot of support from the

others on the team. If I have learned anything about sex offender [treatment], it is to always be part of a treatment team".

The significance of collegial support, as evidenced in both the survey and focus group data, was further supported by Jackson et al., (1997) who reported that by far, the most frequently reported form of coping among sex offender treatment providers identified by their study (88%) was receiving support from other sex offender therapists.

Concern over the funding available to maintain sex offender treatment programming was a specific organizational concern that was identified as being associated with stress for a number of clinicians (48%). Clinicians experiencing a great deal of stress in relation to funding stability experienced significantly higher levels of personal depletion (emotional exhaustion and compassion fatigue) and distress (burnout, depersonalization). The lack of stability of program funding has been previously identified as a source of stress for therapists (Norcross & Prochaska, 1986; Pearlman & Saakvitne, 1995a,b).

Again, comments by sex offender treatment providers further supported these observations. Clinicians stated: "The majority of the stress and dissatisfaction I experience is related to the inadequacy of programs due to the lack of available funding", "In 1997 our budget was cut 1/3. I get letters every month from incarcerated offenders who need treatment to achieve parole. I can't tell them we have an ongoing program. It is frustrating" and "My biggest frustration is that the politicians who control funding are only willing to use our tax money to build more jails and bootcamps rather than for treatment. For example, I work/consult at a youth Detention Centre which houses about 30-40 adolescent sex offenders. I provide group treatment. Unfortunately, due to the lack of funding

I am only able to provide one, two hour group per week. I realize that this is inadequate. Does that mean I should quit? I don't have an answer. At this point I'm either depressed or pissed off'.

Concern and stress around funding issues may be similar to the concerns and stressors related to other organizational issues, in that clinicians appear to feel a sense of helplessness in addressing these external issues, and perceive these external factors as impeding their ability to practice and to provide service in areas that they view to be extremely important.

Although not directly related to practice setting, concerns about the criminal justice system and working both with, and within, this system were described as a major source of stress by the sex offender therapists who participated in the focus groups and provided comments on the survey. Clinicians expressed experiencing stress and frustration as a result of the lack of information within the criminal justice system about sex offenders and sex offender treatment, inadequacies within the criminal justice system that result in a failure to consistently manage these cases appropriately, the lack of interagency cooperation and communication in dealing with sex offender cases, and the systems' limited response in providing resources for effective sex offender programming. Similar concerns among sex offender treatment providers have been noted by other authors (Farrenkopf, 1992; Freeman-Longo, 1997; Jackson et al., 1997; Marshall & Barrett, 1990; Ryan & Lane, 1991).

Client Variables

Client variables, particularly those related to the concentration of sex offender clients in ones' practice and the frequency of exposure to these clients, were found to be both moderating and predictor variables for distress.

As previously noted, a number of clinicians sampled (56%) reported that over 60% of their case load consisted of sex offender clients, and that on average they spent considerable time (16-25 hours per week) providing direct clinical services to sex offenders. Over one third of the respondents (39%) reported providing over 25 hours of direct clinical service to sex offender clients per week.

This concentration of sex offender clients and the frequency of clinical hours with these clients is significant, as sex offender treatment providers whose caseload consisted primarily of sex offender clients and who provided a high number of clinical hours per week to these clients were found to experience higher levels of distress.

Clinicians whose caseloads were primarily made up of sex offender clients were at significantly greater risk for burnout than those clinicians who did not have a heavy concentration of sex offender clients. As well, a high percentage of sex offender clients was the second best client variable predictor for the experience of depersonalization and the second best overall predictor for the experience of depersonalization.

Clinicians who spent a great deal of time providing direct clinical service to sex offender clients each week were significantly more likely to experience emotional exhaustion, depersonalization and were at greater risk for compassion fatigue than were clinicians who provided fewer hours of sex offender treatment. The number of hours per week that clinicians provide to sex offender clients was found to be the best client variable predicting compassion fatigue and was the second best overall predictor for the experience of compassion fatigue across all therapist, practice setting and client variables.

These findings are consistent with the literature on trauma therapists which purports that higher caseloads of trauma clients and more frequent and intense contacts with trauma clients are related to therapist distress (Avery & Uhlemann, 1996; Cerney, 1995).

There are various explanations that could account for the increased level of distress associated with more intense contacts with sex offender clients. It has been well established that treating difficult clients is a source of significant therapist stress (Hellman, Morrison & Abramowitz, 1987; Chessick, 1978; Farber, 1979). Sex offender clients embody a number of the attributes that have been described in the literature as being characteristic of difficult clients, and stressful for clinicians. Focus group participants and respondents who provided comments on the survey identified stressful client characteristics. Treatment providers related: "The hardest thing is overcoming their resistance and developing the empathy needed to succeed", "The level of offender self-report and/or denial is a source of stress in my work with sex offenders", "One of the most challenging and frustrating parts of my work is the client's lack of empathy for their victims" and "Much of my stress comes from the relationship in therapy with the offender".

Clinicians who have more extensive contacts with sex offender clients are also exposed to a greater level of trauma material. This exposure may be another factor contributing to distress. The impact of trauma material, and specifically disclosures of sexual offending behavior, have been noted and identified as a potential source of therapist distress (Abel, 1983; Figley, 1995; Freeman-Longo, 1997; Jackson et al, 1997; Kearns, 1995; Pearlman & Saakvitne, 1995b; Peaslee, 1995, Ryan & Lane, 1991). The effect of exposure to trauma material was well described in the focus groups and on the survey. Clinicians offered: "you're talking to people that are so horrendously damaged that if you

have empathy yourself ... you actually resonate with their pain" and, "For two years I worked entirely with sex offenders, adults and juveniles, as well as thier families. I will never do that again. Working with sexual offenders introduced me to crap I wish I would never heard of. If I would have known how it was going to affect me personally I wouldn't have entered the field. You lose your innocence about life".

In contrast to the findings of this study, Bird Edmunds (1997) reported that although she assumed that clinicians spending the greatest amount of time with sex offender clients would experience the greatest degree of burnout symptoms, this hypothesis was not supported by her findings. Her data revealed that clinicians who provided an average of 11-20 direct client contact hours (in a range of client hours from 0 to over 41) reported the greatest increase in burnout symptoms, which included an increase in the experience of fatigue (67%), frustration (62%) and cynicism (43%). This will be an area that will require further exploration. It may be the case that within Bird Edmunds' sample, the therapists who provided the greatest number of treatment hours to sex offender clients (over 20 hours per week), were also the most experienced clinicians. The experience factor may moderate the effects of a high level of client contact/exposure and account for this finding.

Other areas identified as moderating client variables that are also associated with client contact included clinicians' perceptions about the manageability of their sex offender caseload and years of experience providing clinical services to sex offenders.

While the majority of treatment providers described their sex offender caseload to be manageable (86%), clinicians who saw themselves as having too many sex offenders on their caseload

experienced higher levels of distress. These therapists experienced significantly higher levels of emotional exhaustion and depersonalization and were at greater risk for burnout and compassion fatigue than clinicians who perceived their sex offender caseload as manageable or too low. This is consistent with the findings of Arvay and Uhlemann (1996) who report that trauma therapists who perceive their caseloads as being unmanageable experience higher levels of distress. This outcome seems quite straightforward as therapists who see themselves as overworked or feel overwhelmed would likely experience greater levels of stress and distress. In addition, distress for these clinicians might be compounded by their increased exposure to trauma material.

As previously noted, when looking at the role of age as a moderating therapist variable, the number of years clinicians have provided clinical services to sex offender clients appeared to play a role in the level of stress/distress experienced. It appears that clinicians may become more resilient over time and with greater experience and knowledge are better able to cope with the effects of their sex offender practice. This has also been noted by Bengis (1997).

Sex offender treatment providers with more years experience, experienced lower levels of emotional exhaustion and reported a significantly greater sense of personal accomplishment associated with their practice. Years experience was the best client variable for predicting a high level of personal accomplishment.

The role of experience with the client group was well illustrated by one clinician who offered: "After 13 years I no longer experience the anxiety that was present when I began to deal with sexual offenders. I feel much more seasoned as an experienced therapist generally, and particularly with sex offenders, having developed a good theoretical foundation for evaluation and treatment at

work". Experience is likely associated with having developed a solid understanding of sex offender treatment, a sense of confidence in one's therapeutic abilities and experience coping with the difficulties and stressors associated with sex offender treatment.

As one might expect, offenders that present as the most dangerous were identified as the most stressful to provide clinical services to. In reviewing which categories of offenders were identified as most stressful to work with, clinicians reported treating sadistic sex offenders as very stressful (46%), followed by rapist/pedophiles (30%), rapists (26%), pedophiles (16%), offenders in the 'other' category (7%) and incest offenders (4%).

Interestingly, the client variables that were the best predictors of distress (burnout, depersonalization) and depletion (emotional exhaustion, compassion fatigue) were providing treatment services to incest offenders and to offenders in the 'other' category. This finding was unexpected as one might predict that the more violent or predatory offender categories would have resulted in a greater impact, particularly as clinicians' identified sadistic rapists, rapist/pedophiles, rapists and pedophiles as respectively being the most stressful clients to work with.

In considering this finding, there may be some noteworthy characteristics associated with these particular client groups that may help to explain why they were associated with therapist distress. Without attempting to generalize across this particular client group, incest type offenders often present with a marked level of denial that is typically entrenched and may be very difficult to move. As well, incest offenders tend to be fairly controlling, often maintain a sense of entitlement related to their offending and tend to take on a victim stance, focussing on what they have lost as a result of their offending (e.g., family relationships, status, material possessions, finances) rather than on the

trauma they have inflicted. As well, in providing clinical services to incest offenders, clinicians may be more likely to also see the offender's partner and family as part of the treatment process. This could potentially add stress in a variety of ways. Some sex offender treatment providers may not have training in couple or family therapy, therefore, taking on this role may lead to additional stress. In cases where the incest offender is reconciling with his family, the therapist may experience a range of concerns about reunification, particularly related to the safety of the children and accurately assessing the offender's risk and suitability to return home safely. In doing family reconciliation work, therapists may also be confronted with meeting and perhaps doing some work with both the offender and his victim/survivor(s). This experience of putting a face to the victim may add an emotional strain and further enhance the impact of the trauma material. Another stressful scenario can occur when incest offenders who are in denial reconcile with a partner, and the couple are in treatment. In these instances, it is typical for the partner to also be in denial and quite resistant to the therapeutic process. The difficulties associated with resistant partners was also noted in the focus group discussion.

Offenders in the 'other' category were most often identified as exhibitionists, voyeurs, obscene telephone callers, and frotteurs. The characteristics that might account for the impact associated with the stress of providing clinical services to these particular type of offenders may be the very high rates of recidivism associated with these behaviors and its entrenched and repetitive nature (Marshall & Barbaree, 1990) Another stressor related to this group of clients is that they often have difficulty appreciating that anyone is harmed as a result of their inappropriate sexual behavior, and often see their actions as victimless, trivial and harmless (Kaplan & Krueger, 1997; Maletzky, 1997). A further stressor in working with this client group is that the criminal justice system often maintains beliefs

similar to the offenders in that the system tends to view and respond to these behaviors as primarily nuisance crimes.

Two other client related stressors that were identified by clinicians in the focus groups and on the survey included the social stigma attached to sex offenders and client recidivism.

The stigma associated with providing clinical services to sex offender clients was identified as a source of clinician stress. Participants in the focus group and survey respondents both described the stress associated with this stigma, including: feeling uncomfortable acknowledging that ones' practice is with sex offender clients; feeling a need to explain to people what you do and why you do it; dealing with society's negative perception of sex offenders, treatment for sex offenders; and in some cases the clinicians who provide this treatment; and feeling as if one can not openly talk about their work. In discussing client stigma clinicians related: "Possibly the most difficult part about working with this population is that this population is so unpopular.", "Social attitudes towards sex offenders have changed over the last few years. It is harder for clients to get jobs, places to live, etc. This adds some stress to my work" and "I am concerned with how others react to the general public's non-approval of therapists working with sex offenders. In Texas the attitude is jail and throw away the key. When a person learns what I do the usual response is "oh shit, how can you do that?" followed by them stepping backward a step or two. I feel they are afraid I am contaminated and it might rub off on them". These responses were consistent with other comments and findings that identified the stress associated with providing services to a stigmatized population; in particular to sex offender clients (Ellerby, et al., 1993; Freeman-Longo, 1997; Farrenkopf, 1992; Ryan & Lane, 1991).

Not surprisingly, issues related to client recidivism were also identified as a source of therapist stress during the focus groups and in the survey responses. The concerns ranged from stress related to perceptions about recidivism (e.g., the public's, the clinicians), worry about potential recidivism and the impact of client recidivism. Five main themes related to client recidivism emerged from the focus group data. These included: the stress and distress associated with the public's expectations for treatment to 'cure' offenders; clinician's own expectations about their level of personal responsibility to manage risk and prevent recidivism; uncertainty about the efficacy of sex offender treatment; the ongoing worry about client recidivism; and the impact of client recidivism. In describing these stressors, clinicians related: "I feel I have been successful in treating my clients but this can't be verified until my clients have died and never re-offended", "I'm constantly hearing in the media about how treatment of sexual offenders isn't effective", "My highest stress is always fears of a re-offense", "Stress for me is primarily related to the risk of reoffending" and "I do struggle with a sense of frustration and failure when one of our clients re-offends"

Ellerby et al., (1993) reported sex offender therapists as describing feeling angry (84%), disillusioned and depressed (79%), doubtful about their competence (74%), inadequate (58%) and guilty (42%). As well, it has been noted that personalizing client relapse can potentially traumatize the sex offender therapist and contribute to burnout, impede their ability to provide clinical services to this population, or may lead to ending one's practice in this field (Ellerby, 1997; Freeman-Long, 1997).

Coping Skills and Strategies

Efforts were made to review the coping skills and strategies of sex offender treatment providers and to consider how these coping skills were associated with the measures of distress.

Sex offender therapists demonstrated coping skills that were comparable to the level of coping skills found among a normed group of working adults (Osipow & Spokane, 1983). As well, there appeared to be little difference between the coping skills of male and female sex offender therapists, across the various coping skill sets measured. The vast majority of sex offender treatment providers (90%) evidenced average to strong coping skills in the areas of recreation, self-care, social support and rational-cognitive coping. Over one quarter of the clinicians (27%) demonstrated superior coping skills in these areas.

As one would expect, the presence of good coping skills was negatively associated with the measures of distress. Strengths in each of the coping skill areas were found to be associated with reductions in the experience of burnout, compassion fatigue, emotional exhaustion and depersonalization. As well, skill in each of the measured areas of coping was associated with a greater level of personal accomplishment. The strongest associations found were between clinicians having a high level of social support and good recreational outlets and the reduction of risk for burnout. The importance of the social supports is consistent with the significant role collegial support was found to have as a moderating variable.

It may be the case that the strong coping skills evidenced by clinicians account for the overall low level of therapist distress observed among sex offender treatment providers.

The focus group participants and respondents' comments on the survey helped to identify and describe the type of coping strategies sex offender treatment providers employ to assist them in managing the stressors connected to their clinical practice. A range of diverse professional and personal coping strategies were identified by sex offender treatment providers. These included: debriefing, support from co-workers, clinical supervision, being selective in choosing the types of clients served, monitoring ones' perception of their clients and clinical practice, pacing oneself, the use of humour, not personalizing recidivism, using cognitive restructuring, diversification of practice, separating ones' clinical practice from their private life, support from family, exercise and personal therapy. Typically a combination of coping strategies are used. The use of a range of coping strategies was well illustrated by one clinician who related:

"What helps me deal with stress and to survive and to do a good job working with sex offenders is exercise, prayer, a supportive family, friendships, colleagues, regular time off, other interests, respect in the community, reasonable income and a realistic belief about what I can do and remembering who has the problem (e.g., the sex offender), if he doesn't progress".

The importance of healthy coping for sex offender therapists, and strategies to cope effectively have been recently discussed by a number of authors (Bengis, 1997; Bird Edmunds, 1997; Freeman-Long, 1997; Jackson et al., 1997). For the most part this literature identifies coping strategies similar to the ones described in this study. The positive coping strategies described include: participation in supervision and consultation, the importance of balance, having good boundaries related to responsibility (e.g., the clients' versus the therapists) and between home and work, recognizing

progress in clients' lives, attending personal therapy, taking time away from work, exercise and involvement in sports, having a healthy diet, developing non-work related interests (e.g., recreational activities and hobbies) and, spending time with and having the support of friends and family (Bengis, 1997; Bird Edmunds, 1997; Freeman-Long, 1997; Jackson et al., 1997).

Bengis (1997) offers that while these traditional forms of self-care are important, positive coping for sex offender therapists must also include confronting and addressing issues specific to working with sex offender clients. In this regard, he stresses the need to explore issues related to images, feelings, fantasies, impulses and urges that represent the hidden sources of stress in providing clinical services to sex offenders. Bengis also encourages answering the question "why choose to work with sex offenders?" as a means of self-exploration, personal and professional development and self-care.

Satisfactions

This study sought not only to attend to stress and distress, but to also begin to investigate the satisfactions associated with providing sex offender treatment. Attending to satisfactions was thought to be important as job satisfaction has been identified as a moderating variable of distress. Exploring the satisfactions of psychotherapy has been described as often being overlooked, and literature on sex offender treatment has tended to focus on the negative (Farber & Heifetz, 1991; Maslach & Jackson, 1981; Sussman, 1995).

One of the striking findings of this study was the extremely high level of personal accomplishment reported by sex offender treatment providers. The vast majority of clinicians (90%) demonstrated strong feelings of personal accomplishment associated with their sex offender practice.

In addition, the mean rating for personal accomplishment among sex offender therapists ($M = 40.38$, $SD = 5.38$) was higher than the average score for personal accomplishment found among the normative sample of mental health providers ($M = 30.87$, $SD = 6.37$) as reported by Maslach and Jackson (1981). Consistent with this, Bird Edmunds (1997) reported that the vast majority of sex offender therapists (97%) perceived themselves to be effective in their practice.

Only a small number of sex offender therapists (3%) evidenced scores on the personal accomplishment scale that were indicative of being at moderate or high risk for burnout. The responses of sex offender treatment providers are indicative of engagement in ones' work (Maslach, Jackson & Leiter, 1996). As the risk for burnout has been identified as being reduced by job satisfaction, the high level of personal accomplishment experienced by sex offender therapists may be another important variable moderating the experience of burnout and fatigue. In addition to the strong coping skills evidenced by sex offender therapists, the high level of personal accomplishment may also account for the overall low levels of burnout and compassion fatigue found among these clinicians.

Consistent with this finding, the sex offender therapists who participated in the focus groups and who provided comments on the survey identified a high degree of personal satisfaction and a sense of personal accomplishment from their practice.

Treatment providers described a range of satisfactions including: finding the work challenging, fascinating and exciting; participating in the process of client growth and change; a sense of altruism (a feeling of doing good for society); finding that the work met emotional needs (e.g., power, control, excitement); a desire to be unconventional and work in a non-traditional area

of psychotherapy, the positive relationships with colleagues, and achieving both professional and personal growth.

Clinicians' comments which illustrate the satisfactions of their clinical practice include: "I really enjoy this work. It is challenging and worlds away from traditional therapies", "I find this population provides work that is challenging, interesting, rewarding and yes, even fun", "I think professionally the work I do with offenders is extremely gratifying when they choose to 'become' someone new, when they struggle and then own their deviance and control it", "I really like my work. I find it brings helpfulness (some men really do transform their lives in positive ways, and it is a variable reinforcement schedule) and helps me fulfill God's call to social action and better my community by lowering the potential for new victims" and "I really enjoy my work, I feel we are highly successful in facilitating clients' recovery and protecting the community, and don't really want to work with any other populations".

The satisfactions of a clinical practice with sex offender clients were similar to the satisfactions that have previously been identified as associated with a therapeutic practice (Farber, 1983; Farber & Heifetz, 1981; Rogow, 1970; Sussman, 1995b). As well, the identified satisfactions were consistent with what has been described in the literature as the benefits/satisfactions of providing clinical services to sex offender clients. In describing the benefits of a sex offender practice, Bird Edmunds (1997) related that the majority of the sex offender therapists identified their job as benefiting others (95%) and as offering diversity (86%). Other identified satisfactions have included: the perception of helping victims by working with offenders, being a part of the process of positive

change and growth in clients, the challenging nature of the work, a sense of purpose and the relationships with colleagues (Bird Edmunds, 1997; Freeman-Longo, 1997; Jackson et al., 1997).

Jackson et al., (1997) identify practitioners as having a sense of mission. One focus group participant described the need to have a "passion" in order to be involved in the treatment of sex offenders. The comments of the participants, both in the focus groups and on the survey certainly suggested the presence of passion. Clinicians presented as professionals who were committed and invested in their clinical practice, and who viewed their involvement with sex offender clients as making a real and significant difference.

Implications of the Research

The findings of this study offer valuable information to individuals considering a career as a sex offender therapist, for individuals currently practising in the field, for clinicians responsible for the supervision of sex offender treatment providers and for program supervisors and administrators who are responsible for developing, implementing and managing sex offender treatment programs.

While it is heartening that overall, clinicians appear to have adequate personal and professional coping resources to manage distress, there are still a number of treatment providers at risk to experience emotional exhaustion, depersonalisation and compassion fatigue. The findings of this study point to some areas that could potentially minimize the risk for these elements of burnout and fatigue.

Clearly there is a need for sex offender treatment programs to invest in the clinicians who provide the direct client service delivery. Attending to the needs of the clinicians has the long range

benefits of supporting the clinicians' emotional wellness, their effectiveness as therapists and their longevity in the field.

The first step in investing in clinicians is to provide them with training prior to involving them in direct service delivery with this difficult population. While an initial training program should focus on providing clinicians with information about sex offenders, sex offender assessment protocols, specialized treatment programming and system issues, it is also important that an introduction to the field include providing potential therapists with information about the possible personal impacts of providing clinical services to sex offenders.

The research also makes clear the point that training must be an ongoing process and include clinical supervision, the opportunity to consult with experts in the field and continuing education.

Administrators and program managers often do not appreciate the need for, or importance of, clinical supervision, and tend to see it as an added expense, both in terms of paying for consultation and the time taken away from programming. When clinicians are involved in supervision however, the benefits associated with this type of consultation are significant. Clinical supervision and opportunities to consult with experts in the field were found to moderate the experience of distress. Sex offender therapists reported the importance of these types of supports both for personal (e.g., venting anxiety, frustration and stress) and professional coping (e.g., receiving direction, guidance, support). In addition, the findings suggest that supervision/consultation should not be restricted to discussing program and client issues, but that there is also a pressing need for this time to be in part dedicated to therapist issues, particularly as they relate to job related depression and fatigue. Ongoing supervision and consultation may be the best forum for addressing the emotional

health issues that are so strongly linked to the experience of distress. Given the importance of supervision/consultation, the addition of this type of consultation process should be seriously considered as an integral part of any sex offender treatment program, rather than viewed as an expensive luxury.

As is the case with clinical supervision, often times sex offender treatment programs do not recognize the need for clinicians to interact with each other and to take time away from clinical service delivery to support one another. The support of ones colleagues within their sex offender practice was identified as a significant moderating variable for stress. Recognising the need for colleagues to spend time interacting and supporting this type of interaction is another way in which program supervisors and administrators can attend to and support therapist self-care issues. This could be done both in work related areas (e.g., having therapists attend seminars, workshops and conferences together; having a retreat for the treatment providers) and non-work related areas (e.g., organizing, encouraging and supporting activities such as pot luck meals, meals at a restaurant, horseback riding, baseball games etc.). Facilitating comradery and collegial support should be viewed as an important part of program development and management.

In attending to supervision issues, it would also be important for clinical supervisors and program managers to pay particular attention to the needs of younger, less experienced clinicians, and to individuals who are providing treatment to sex offenders, but whose primary profession is not as a mental health service provider.

As practising out of an agency and organizational issues were areas identified as sources of stress, it would be ideal for sex offender treatment programs to develop a process where-by clinicians

have a forum for discussing concerns about organizational issues and the structure of their positions within the workplace. Often times there is a separation between program administrators and program deliverers. It appears important to bridge this gap and facilitate open dialogue and problem solving related to agency/organizational issues, with program directors and administrators remaining mindful of the impact these kinds of issues can have on clinicians.

Within a sex offender treatment practice, there is a need to monitor the type of offenders accepted into the treatment program, client assignment, the number of hours of clinical service delivery therapists are providing to sex offender clients, clinicians' perception of their caseload and the potential impact of treating certain categories of offenders. Programs starting out may wish to be very selective about the type of clients accepted into the program so as not to overwhelm and jeopardize new therapists and a new program. The assignment of clients should be an ongoing area of attention with consideration being given to matching the skill level and experiences of clinicians with the difficulty of the client. Supervision, be it clinical or administrative, should also monitor and address clinicians' perceptions of their client load. Attending to stressors associated with specific client types should also be a focus of both clinical supervision and program management. Job design should ideally place a limit on the number of clinical hours therapists are permitted to provide direct service delivery to sex offender clients.

In considering the responsibilities/duties of sex offender treatment providers, it may also be advantageous to build in, or encourage diversification within their job. This may include providing services to other offender groups besides sex offenders, providing training or consultation, participating in research or publishing articles related to their practice. Encouraging clinicians to

become involved in public education about sex offender treatment may also be helpful, both as a means of creating some diversity in their practice, and as a productive means of challenging the social stigma attached to their profession.

Results of the study also suggest that it would be appropriate for sex offender treatment programs to establish a protocol for debriefing and supporting clinicians who have experienced a client's re-offence. In this regard it would be important to attend to the treatment provider's cognitive and emotional response to the re-offence, to conduct an autopsy on the case, and to process the re-offence so it can become a means of learning rather than a personally devastating or self-blaming experience, or an event that does not receive any specific attention.

The literature on the impact of psychotherapy, psychotherapy with trauma clients and psychotherapy with sex offenders, all provide information that supports the notion that sex offender treatment can be a difficult and stressful form of clinical practice. This research project further defines the stressors and the moderating variables associated with sex offender treatment. While this form of clinical practice can be stressful, there are strategies that individual clinicians, supervisors, program directors and administrators can implement to diminish the impact of this work. The primary message from this research is that sex offender therapists must be aware of the factors that contribute to distress and access the supports that will assist them to manage effectively. In addition, administrators, program directors and supervisors must make an investment in the treatment providers practising in their programs. Despite the ongoing high demand to provide treatment programming for sex offenders, we can not lose sight of the fact that the clinicians who deliver these programs are important agents of change, and if they are not supported to function in a healthy manner, the viability

of sustaining themselves in the field, the effectiveness of treatment programs and the efforts toward client change and community safety will be compromised.

Future Directions

While this research has identified a number of factors related to the difficulties and stressors associated with sex offender treatment, the impact of these stressors on clinicians, the variables that moderate and predict distress, coping skills and coping strategies that sex offender therapists employ to manage stress and the satisfaction associated with a sex offender treatment practice, there is much more that needs to be done to further the knowledge base in this area.

Firstly, because of the limited research in the area, this study was largely exploratory, descriptive and cross sectional in nature. It would be important to attempt to replicate these findings in a longitudinal research project where the data analysis was driven by a theoretical position rather than an exploratory one, and where changes could be tracked over time.

In much of the previous literature on the impact of sex offender treatment providers, the focus has been more on emotional, cognitive and behavioral changes that have occurred as a result of providing clinical services to sex offenders (e.g., becoming more suspicious/untrusting, disruptions in feelings of safety, changes in parenting, changes in sexual functioning). While these 'symptoms' have been described, there has been little empirical investigation into the prevalence of these changes. Another step forward in the research into therapist impact would be to do a large scale survey on clinicians who have left the field. Exploring specific ways in which these clinicians perceived their clinical practice as affecting them, to investigate how these changes may be related to the experience of their burnout and compassion fatigue, and to explore if these changes were moderated by various

therapist, practice setting and client variables. Such an approach would need to identify who left the field and why.

It may also be of interest and of value to further explore some of the variables that were discovered to be moderating variables of stress. For example, to further investigate the role, content and optimal timing of training and continuing education in moderating stress and developing a better understanding of the ways in which these factors are seen to moderate trauma over time.

As the emotional health issues were seen to be the most significant factors related to burnout and compassion fatigue, it would be worthwhile to further explore the role of emotional health and vulnerability to distress. In doing this it will be important to attempt to further clarify if personal issues are impacting on professional stress or if it is the professional stress that is affecting personal emotional stability. Again, a longitudinal design is needed to evaluate this question.

Finally, it would be interesting to compare and contrast the experience of sex offender treatment providers, with the experiences of survivor therapists and with clinicians who do not provide clinical services in the area of sexual abuse. This would help to clarify if the impact described is unique to sex offender treatment providers, or common to clinicians working in the area of sexual abuse or clinicians in general.

While it is important to further our understanding of the etiology of sexual abuse, characteristics of offenders, protocols for assessing offender risk and need, and evaluating treatment approaches for offenders, research in this field cannot neglect focussing on issues specific to the therapists who provide sex offender treatment. Therapists who take on the challenge of sex offender treatment do so with a sense of purpose and passion, in an effort to assist in the protection of society

and to facilitate personal growth and healing of offenders. It is imperative that these individuals be supported in this endeavour. As a field, sexual offender therapists must take on this responsibility by further investigating therapist impact issues and by formalizing supports for individuals committed to practicing in this area.

REFERENCES

- Abel, G. (1983). Preventing men from becoming rapists. In Albee Gordon S., and Leltenberg, H. (Eds.), Promoting sexual responsibility and preventing sexual problems. Hanover, NH: University Press of New England.
- Ackerley, G. Burnell, J., Holder, D., & Kurdek, L. (1988). Burnout among licensed psychologists Professional Psychology: Research and Practice, 19, 624-631
- Akerstrom, M. (1986). Outcasts in prison: The cases of informers and sex offenders. Deviant Behavior, 7, 1-20.
- Antonovsky, A. (1990). Pathways leading to successful coping and health. In M. Rosenbaum (Ed.), Learned resourcefulness: On coping skills, self-control, and adaptive behaviour. New York: Spinger.
- Arvy, M.J, & Uhlemann, M.R. (1996). Counsellor stress in the field of trauma: A preliminary study. Canadian Journal of Counselling, 30, 193-209.
- Backynski, L.A. (1995). Impact of sex offender treatment on female therapists: A preliminary investigation. Unpublished paper.
- Barbaree, H.E. & Marshall, W.L. (1989). Erectile response among heterosexual child molesters, father daughter incest offenders, and matched nonoffenders: Five distinct age preference profiles. Canadian Journal of Behavioral Sciences, 21, 70-82.
- Bengis, S. M. (1997). Personal and interpersonal issues for staff working with sexually abusive youth. In S. Bird Edmunds (Ed.), Impact: Working with Sexual Abusers. Vermont, Safer Society Press
- Bennett, P., Evans, R. & Tattersall, A. (1993). Stress and coping in social workers: A preliminary investigation. British Journal of Social Work, 23, 31-44.
- Berkowitz, C.D. (1995). Dealing with victims and perpetrators: Role confusion. Journal of Child Sexual Abuse, 4, 95-97.
- Berkowitz, M. (1987). Therapist survival: Maximizing generativity and minimizing burnout. Psychotherapy in Private Practice, 5, 85-89.
- Bermak, G. (1977). Do psychiatrists have special emotional problems? American Journal of Psychoanalysis, 37, 141-146.

- Bird Edmund, S. (1997). The personal impact of working with sex offenders. In S. Bird Edmunds (Ed.), Impact: Working with Sexual Abusers. Vermont, Safer Society Press
- Boice, R. & Myers, P.E. (1987). Which setting is healthier and happier, academe or private practice? Professional Psychology: Research and Practice, 18, 526-529.
- Boylin, W.M. & Briggie, C.R. (1987). The healthy therapist: The contribution of symbolic-experiential family therapy. Family Therapy, 14, 247-256.
- Bridges, N.A. (1995). Psychotherapy with therapists: Countertransference dilemmas. In M.B. Sussman (ed). A perilous calling: The hazards of psychotherapeutic practice (pp. 175-187) New York: John Wiley.
- Brown, G.T., & Pranger, T. (1992). Predictors of burnout for psychiatric occupational therapy personnel. Canadian Journal of Occupational Therapy, 59, 258-267.
- Carney, J., Donovan, R., Yurdin, M., Starr, R., Pernell-Arnold, A., Bromberg, M. (1993). Incidence of Burnout among New York City intensive case managers: Summary of findings. Psychosocial Rehabilitation Journal, 16, 25-38.
- Cerney, M.S. (1995) Treating the "heroic treaters". In C.R. Figley (ed.) Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (pp. 131-149). New York: Brunner/Mazel.
- Cherniss, C. (1993). Long-term consequences of burnout: An exploratory study. Journal of Organizational Behavior, 13, 1-11.
- Cherniss, C. (1980a). Staff Burnout, London, Sage.
- Cherniss, C. (1980b). Professional burnout in human service organizations. New York: Praeger.
- Chessick, R.D. (1978). The sad soul of the psychiatrist. Bulletin of the Menninger Clinic, 42, 1-9.
- Colson, D.B., Allen, J.G., Coyne, L., Dexter, N., Jehl, N., Mayer, M., Spohn, H. (1986). An anatomy of countertransference: Staff reactions to difficult psychiatric hospital patients. Hospital and Community Psychiatry, 37, 923-928.
- Corey, G., Corey, M.S., & Callanan, P. (1993). Issues and ethics in the helping professions. (4th ed.). Pacific Grove, CA: Brooks Cole.
- Cray, C. & Cray, M. (1977). Stresses and rewards within the psychiatrist's family. American Journal of Psychoanalysis, 37, 337-341.

- Denieli, Y. (1982). Therapists' difficulties in treating survivors of the Nazi Holocaust and their children (Doctoral dissertation, New York University, 1981). Dissertation Abstracts International, 42, 4947-4948.
- Daniels, A.K. (1974). What troubles trouble shooters. In P. M. Roman & H.M. Trice (Eds.), The Sociology of Psychotherapy, New York: Aronson.
- Deutsch, C.J. (1984). Self-reported sources of stress among psychotherapists. Professional Psychology: Research and Practice, 15, 833-845.
- Deutsch, C.J. (1985). A survey of therapists' personal problems and treatment. Professional Psychology: Research and Practice, 16, 305-315.
- Dignam, J.T., Barrera, M. & West, S.G. (1986). Occupational stress, social support, and burnout among correctional officers. American Journal of Community Psychology, 14, 177-193.
- Dillman, D.A. (1978). Mail and telephone surveys: The total design method. New York: Wiley.
- Dutton, M.A., Rubinstein, F.L. (1995). Working with people with PTSD: Research implications. In C.R. Figley (ed.) Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (pp. 82-100). New York: Brunner/Mazel.
- Egan, M. (1993). Resilience at the front lines: Hospital social work with AIDS patients and burnout. Social Work in Health Care, 18, 109-123.
- Eldwich, J. (1980). Burn-out: Stages of disillusionment in the helping professions. New York: Human Sciences Press.
- Ellerby, L. (1997). Impact on clinicians: Stressors and providers of sex-offender treatment. In S. Bird Edmunds (Ed.), Impact: Working with Sexual Abusers. Vermont, Safer Society Press
- Ellerby, L., Gutkin, B., Smith, T., & Atkinson, R. (1993). Treating sex offenders: The impact on clinicians. Unpublished paper.
- English, O.S. (1976). The emotional stress of psychotherapeutic practice. Journal of the American Academy of Psychoanalysis, 4, 191-201.
- Evans, B.K. & Fischer, D.G. (1993). The nature of burnout: A study of the three-factor model of burnout in human service and non-human service samples. Journal of Occupational and Organizational Psychology, 66, 29-38.

- Farber, B. (1979). The effects of psychotherapeutic practice upon psychotherapists: a phenomenological investigation. Dissertation Abstracts International, 40, 447B.
- Farber, B. (1983a). The effects of psychotherapeutic practice upon psychotherapists. Psychotherapy: Theory, research and practice, 20, 174-182.
- Farber, B. (1983b). Stress and burnout in the human service professions. New York: Pergamon.
- Farber, B. (1985). Clinical psychologists' perceptions of psychotherapeutic work. Clinical Psychologist, 38, 10-13.
- Farber, B. & Heifetz (1981). The satisfactions and stresses of psychotherapeutic work: A factor analytic study. Professional Psychology, 12, 621-629
- Farber, B. & Heifetz (1982). The process and dimension of burnout in psychotherapists. Professional Psychology, 13, 293-301.
- Farrenkopf, T. (1992). What happens to therapists who work with sex offenders? Journal of Offender Rehabilitation, 16, 217-223.
- Figley, C.R. (1983). Compassion stress and the family therapist. Family Therapy News, pp. 1-8.
- Figley, C.R. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York: Brunner/Mazel.
- Figley, C.R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C.R. Figley (ed.) Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (pp. 1-20). New York: Brunner/Mazel.
- Fimian, M.J. & Blanton, L.P. (1987). Stress, burnout, and role problems among teacher trainees and first year teachers. Journal of Occupational Behaviour, 8, 157-165.
- Fine, H. (1980). Despair and depletion in the therapist. Psychotherapy: The Theory, Research and Practice, 17, 392-395.
- Forney, D. Wallace-Schutzman, F., & Wiggers, T. (1982). Burnout among career development professionals: Preliminary findings and implications. Professional Psychology, 13, 293-301.
- Frank, J.D. (1973). Persuasion and healing. Baltimore, Md: John Hopkins University Press.

- Freeman-Longo, R. E. (1997). Introduction: A personal and professional Perspective on Burnout. In S. Bird Edmunds (Ed.), Impact: Working with Sexual Abusers. Vermont, Safer Society Press.
- Freud, S. (1964). Analysis terminable and interminable. Standard Edition, 23, London: Hogarth.
- Freudenberger, H. J. (1975). The staff burn-out syndrome in alternative institutions. Psychotherapy: Theory, research and practice, 21, 73-82.
- Freudenberger, H. J. & Robbins, A. (1979). The hazards of being a psychoanalyst. The Psychoanalytic Review, 66, 275-295.
- Freudenberger, H. J. (1990). The hazards of psychotherapeutic practice. Psychotherapy in Private Practice, 8, 31-35.
- Garrison, K. (1992). Working with sex offenders: a practice guide. Norwich: Social Work Monographs, University of East Anglia.
- Giovannoni, J. (1997). Increasing efficacy and eliminating burnout in sex offender treatment, In S. Bird Edmunds (Ed.), Impact: Working with Sexual Abusers. Vermont, Safer Society Press.
- Gordon, A., Holden, R., & Leis, T. (1991). Managing and treating sex offenders: Matching risk and needs with programming. Forum on Corrections Research, 3, 7-11.
- Greben, S.E. (1975). Some difficulties and satisfactions inherent in the practice of psychoanalysis. International Journal of Psychoanalysis, 56, 427-434.
- Green, TF (1968). Work, leisure and the American schools. New York: Random House.
- Greenbone, R. (1966). That "impossible" profession. Journal of American Psychoanalytic Association, 14, 9-27.
- Grosch, W.N. & Olsen, D.C. (1994). When helping starts to hurt: A new look at burnout among psychotherapists. New York, W.W. Norton and Company.
- Gutkin, B., Ellerby, L., Foss, H. (November 1994). Therapeutic alliance: The Importance of the Therapeutic relationship with sex offenders. Association For The Treatment of Sex Offenders. San Francisco, California USA.
- Guy, J.D., Poelstra, P.E. & Stark, M.J. (1989). Personal distress and therapeutic effectiveness: National Survey of Psychologists practising psychotherapy. Professional Psychology: Research and Practice, 20, 48-50.

- Guy, J.D. (1987). The personal life of the psychotherapist. New York: John Wiley.
- Harris, L.A. (1995). The importance of risk management in a managed care environment. In M.B. Sussman (ed). A perilous calling: The hazards of psychotherapeutic practice (pp. 247-258). New York: John Wiley.
- Hellman, I.D., Morison, T.L., & Abramowitz, S.I. (1987). Therapist flexibility/rigidity and work stress. Professional Psychology: Research and Practice, 18, 21-27.
- Henry, W.E. (1966). Some observations on the lives of healers. Human Development, 9, 47-56.
- Herman, J.L. (1992). Trauma and recovery: The aftermath of violence. Toronto: John Wiley.
- Horner, A. (1993). Occupational hazards and characterological vulnerability: The problem of burnout. American Journal of Psychoanalysis, 53, 137-141.
- Huebner, E.S. (1993). Burnout among school psychologists in the USA: Further data related to its prevalence and correlates. School Eased International, 14, 99-109.
- Jacobs, T.J. (1991). The use of the self: Countertransference and communication in the analytic situation. Madison, CT: International Universities Press.
- Jackson, K.E, Holzman C., Barnard, T. & Paradis, C. (1997). Working with sex offenders: The impact on practitioners. In S. Bird Edmunds (Ed.), Impact: Working with Sexual Abusers. Vermont, Safer Society Press
- Jayarante, S., Tripodi, T. & Chess, W.A. (1983). Perceptions of emotional support on burnout work stress and mental health among Norwegian and American social workers. Social Work Research and Abstracts, 19, 19-27.
- Johansen, K.H. (1993). Countertransference and divorce of the therapist. In J.H. Gold & J. C. Nemiah (eds.), Beyond transference: When the therapist's real life intrudes (pp. 87-108). Washington, D.C.: American Psychiatric Press.
- Joinson, C. (1992). Coping with compassion fatigue. Nursing, 22, 116-122.
- Kahill, S. (1986). Relationship of burnout among professional psychologists to professional expectations and social support. Psychological Reports, 59, 1043-51.
- Kahill, S. (1988) Interventions for burnout in the helping professions: A review of the empirical evidence. Canadian Journal of Counselling Review, 22, 116-122.

- Kandolin, I. (1993). Burnout of female and male nurses in shift work. Special issue: Night and shiftwork. Institute of Occupational Health, 36, 141-147.
- Kaplan, M.S., & Krueger, R.B. (1997). Voyeurism: Psychopathology and theory. In D.R. Laws, & W.O'Donohue (Eds.), Sexual Deviance: Theory, assessment, and treatment (pp. 297-331). New York, Guilford Press.
- Kearns, B. (1995). Self-reflection in work with sex offenders: A process not just for therapists. Journal of Child Sexual Abuse, 4, 107-110.
- Kline, F. (1972). Dynamics of a leaderless group. International Journal of Group Psychotherapy, 22, 234-242.
- Koeske, G.F. & Koeske, R.D. (1993). A preliminary test of a stress-strain outcome model for reconceptualizing the burnout phenomenon. Journal of Social Service Research, 17, 107-135.
- Kottler, J.A. (1993). On Being a Therapist. San Francisco: Jossey-Bass.
- Kottler, J.A. (1992). Compassion Therapy: Working with Difficult Clients. San Francisco: Jossey-Bass.
- Lalotis, D. & Grayson, J.H. (1985). Psychologist heal thyself: What's available for the impaired psychologist? American Psychologist, 40, 84-96.
- Laws, D.R., & O'Donohue, W. (1997). Sexual Deviance: Theory, assessment, and treatment. New York, Guilford Press.
- Little, (1957). 'R' - The analyst's total response to his patient's needs. International Journal of Psychoanalysis, 38, 240-254.
- London, R. (1977). The lonely profession: A study of the psychological rewards and negative aspects of the practice of psychotherapy. Dissertation Abstracts International, 37, No. 9B, 4691.
- Maeder, T. (1989). Children of psychiatrists and other psychotherapists. New York: John Wiley.
- Maletsky, B.M. (1997). Exhibitionism: Assessment and treatment. In D.R. Laws, & W.O'Donohue (Eds.), Sexual Deviance: Theory, assessment, and treatment (pp. 40-74). New York, Guilford Press.

- Marshall, W.L., & Barbaree, H. E. (1990). Outcome of comprehensive cognitive-behavioral treatment programs. In W.L. Marshall, D.R. Laws, & H.E. Barbaree (Eds.), Handbook of sexual assault: Issues, theories, and treatment of the offender (pp. 363-385). New York: Plenum Press.
- Marshall, W.L., & Barrett, S. (1990). Criminal Neglect: Why sex offenders go free. Toronto, Doubleday.
- Maslach, C. (1978). Job burnout: How people cope. Public Welfare, 36, 56-58.
- Maslach, C. (1982). Understanding burnout: Definitional issues in analysing a complex phenomenon. In W.S. Paine (Ed.), Job Stress and Burnout. Beverly Hills, CA: Sage.
- Maslach, C. & Jackson, S.E. (1981). The measurement of experienced burnout. Journal of Occupational Behavior, 2, 99-113.
- Maslach, C., Jackson, S.E. & Leiter, M.P. (1996). Maslach Burnout Inventory Manual (3rd ed.). Palo Alto, CA: Consulting Psychologists Press.
- McCann, I.L. & Pearlman, L.A. (1990). Vicarious traumatization: A contextual model for understanding the effects of trauma on helpers. Journal of Traumatic Stress, 3, 131-149.
- Meiselman, K.C. (1990). Resolving the trauma of incest: Reintegration therapy with survivors. San Francisco, CA: Jossey-Bass.
- Menninger, W.W. (1990). Anxiety in the psychotherapist. Bulletin of the Menninger Clinic, 54, 232-246.
- Mitchell, C. & Melikian, K (1995). The treatment of male sexual offenders: Countertransference reactions. Journal of Child Sexual Abuse, 4, 87-93.
- Miller, R. & Bor, R. (1988). AIDS: A Guide to Clinical Counselling. London: Science Press Ltd.
- Moore, E., Ball, R.A., & Kuipers, L. (1992). Expressed emotion in staff working with the long-term adult mentally ill. British Journal of Psychiatry, 161, 802-808.
- Morgan, D.L. (1988). Focus groups as qualitative research. Newbury Park CA: Sage.
- Morgan, D.L. (1993). Successful focus groups: Advancing the state of the art. Newbury Park CA: Sage.

- Mosteller, F. & Tukey, J.W. (1977). Data analysis and regression. Addison-Wesley: Reading, Mass.
- Neuman, D.A. & Gamble, S.J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. Psychotherapy, 32, 341-347.
- Norcross, J.C. & Guy, J.D. (1989). Ten therapists: The process of becoming and being. In W. Dryden & L. Spurling (Eds.), On Becoming a Psychotherapist. London: Tavistock/Routledge.
- Norcross, J.C., & Prochaska, J.O. (1986). Psychotherapist heal thyself: The psychological distress and self change of psychologists, counsellors and laypersons. Psychotherapy, 23, 102-114.
- O'Connell, M.A., Leberg, E. & Donaldson, C.R. (1990). Working with sex offenders: guidelines for therapist selection. Newbery Park, CA: Sage Publications.
- Osipow, S.H. & Spokane, A.R. (1981). Occupational stress inventory: manual research version. Psychological Assessment Resources Inc.
- Oktay, J. (1992). Burnout in hospital social workers who work with AIDS patients. Social Work, 37, 432-439.
- Paulhus, D.L. (1984). Two-component models of socially desirable responding. Journal of Personality and Social Psychology, 46, 598-609.
- Peaslee, D.M. (1995). Countertransference with specific client populations: A comment on "the treatment of male sexual offenders." Journal of Child Sexual Abuse, 4, 111-115.
- Pearlman L.A. & Saakvitne, K.W. (1995a). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C.R. Figley (ed.) Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (pp. 150-208). New York: Brunner/Mazel.
- Pearlman L.A. & Saakvitne, K.W. (1995b). Trauma and the therapist: Countertransference and Vicarious traumatization in psychotherapy with incest survivors. New York: W.W. Norton.
- Pearlman L. A., Mac Ian, P.S. (1995). Vicarious traumatization: An empirical study of the effect of trauma work on trauma therapists. Professional Psychology: Research & Practice, 26, 558-565.

- Pence, D. (1995). To hurt is human: To ventilate is divine. Journal of Child Sexual Abuse, 4, 103-106.
- Pines, A. Aronson, E., and Kafrey, D. (1981). Burnout: From tedium to personal growth, New York: Free Press.
- Pines, A., Maslach, C. (1978). Characteristics of staff burnout in mental health settings. Hospital and Community Psychiatry, 29, 233-237.
- Pithers, W.D., Marques, J.K., Gibat, C.C., & Marlatt, G.A. (1983). Relapse prevention with sexual aggressives: A self-control model of treatment and the maintenance of change. In J.G. Greer & I.R. Stuart (Eds.), The sexual aggressor: Current perspectives on treatment (pp. 292-310). New York: Guilford Press.
- Plyer, A., Woolley, C.S., & Anderson, T.K. (1990). Current treatment providers. In: A.L. Horton, B.L. Johnson, L.M. Roundy, & D. Williams, The incest perpetrator: A family member no once wants to treat, (pp. 198-218) Newbury Park, CA: Sage Publications.
- Pope, K.S. & Bouhoutsos, J.C. (1986). Sexual intimacy between therapists and patients. New York: Praeger.
- Poulin, J.E., & Walter, C.A. (1993). Burnout in gerontological social work. Social Work, 38, 305-310.
- Raquepaw, J.W. & Miller, R.S. (1989). Psychotherapist burnout: A componential analysis. Professional Psychology: Research and Practice, 20, 32-36.
- Rich, K.D. (1997). Vicarious Traumatization: A preliminary Study. In S. Bird Edmunds (Ed.), Impact: Working with Sexual Abusers. Vermont, Safer Society Press
- Rich, K.D. (1994), Outpatient group therapy with adult male sex offenders: Clinical Issues and concerns. Special Issue: Counselling men. Journal for Specialists in Group Work, 19, 120-128.
- Richter, J.M., Bottenberg, D.J., & Roberto, K.A. (1991). Focus group: Implications for program evaluation of mental health services. Journal of Mental Health Administration, 18, 148-153.
- Robbins, J.M., Beck, P.R., Mueller, D.P., & Mizener, D.A. (1988). Therapists' perceptions of difficult psychiatric patients. Journal of Nervous and Mental Diseases, 176, 490-496.

- Rodolfa, E.R., Kraft, W.A., & Reilley, R.R. (1988). Stressors of professionals and trainees at APA approved counselling and VA medical centre internship sites. Professional Psychology: Research and Practice, 19, 43-49.
- Rogow, A. (1970). The Psychiatrists. New York: Putnam.
- Ryan, C.C. (1990). The training and support of health care professionals dealing with the psychiatric aspects of AIDS. In Ostrow, D.G., (Ed.) Behavioural Aspects of AIDS. (pp. 355-369) New York: Plenum Publishing Corp.
- Ryan, G., & Lane, S. (1991). The impact of sexual abuse on the interventionist. In G.D. Ryan & S.L. Lane (Eds.), Juvenile sexual offending: causes, consequences and corrections, 411-428. Toronto: Lexington Books.
- Salant, P. & Dillman, D.A. (1994). How to conduct your own survey. New York: John Wiley.
- Savicki, V. & Cooley, E.J. (1987). The relationship of work environment and client contact in burnout in mental health professionals. Journal of Counselling and Development, 63, 249-252.
- Scott, E. (1987). Is there a criminal mind? International Journal of Offender Therapy and Comparative Criminology, 33, 215-226.
- Sheroff, M. (1995). AIDS: The therapist's journey. In M.B. Sussman (ed). A perilous calling: The hazards of psychotherapeutic practice (pp. 139-147). New York: John Wiley Stamm, B.H. & Varra, M.E. (Eds.). Instrumentation in the field of traumatic stress Chicago: Research and Methodology Interest Group, International Society for Traumatic Stress Studies.
- Stenson, N. (1987). A Comparison of the Stresses Generated for Mental Health Practitioners Working with Mandated and Voluntary Clients in Agency Setting and in Private Practice. Doctoral dissertation. Forest Grove, Oregon: Pacific University.
- Steinberg, M. & Salamon, M.J. (1995) Geropsychology: How the venerable leave us vulnerable. In M.B. Sussman (ed). A perilous calling: The hazards of psychotherapeutic practice (pp. 45-54). New York: John Wiley.
- Stenson, N. (1987). A comparison of the stresses generated for mental health practitioners working with mandated and voluntary clients in agency settings and in private practice. Doctoral dissertation. Forest Grove, Oregon: Pacific University.

- Sussman, M.B. (1995a). A perilous calling: The hazards of psychotherapeutic practice. New York: John Wiley.
- Sussman, M.B. (1995b). Intimation of morality. In M.B. Sussman (ed). A perilous calling: The hazards of psychotherapeutic practice (pp. 15-25). New York: John Wiley.
- Tick, E. (1995). Therapist in the combat zone. In M.B. Sussman (ed). A perilous calling: The hazards of psychotherapeutic practice (26-36). New York: John Wiley.
- Thoreson, R.W., Miller, M., & Krauskopf, C.J. (1986). Perceptions of alcohol misuse and work behaviour among professionals: Identification and intervention. Professional Psychology: Research and Practice, 17, 210-216.
- Thoreson, R.W., Miller, M., & Krauskopf, C.J. (1989). The distressed psychologist: Prevalence and treatment considerations. Professional Psychology: Research and Practice, 20, 153-158.
- Valent, P. (1995). Survival strategies: A framework for understanding secondary traumatic stress and coping in helpers. In C.R. Figley (ed.) Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (pp. 21-50). New York: Brunner/Mazel.
- Weeks, J.R., Pelletier, G. & Beaudette (1992). What do correctional officers think of sex offenders. Forum on Corrections Research, 4, 12-13.
- Wheelis, A. (1959). The vocation hazards of psychoanalysis. International Journal of Psychoanalysis, 37, 45-48.
- Wormith, J.S., & Hanson, R.K. (1992). The treatment of Sexual Offenders in Canada: An update. Canadian Psychology, 33, 180-193.

Appendix A

October 28, 1996

Mr. T. Smith
Native Clan Organization
203-138 Portage Ave East
Winnipeg, Manitoba
R3C OA1

Dear Mr. Smith:

As the number of sex offender treatment practitioners grows, the need to better understand the impact of providing clinical services to this challenging client population becomes more compelling.

Enclosed, you will find the Sex Offender Treatment Provider Survey (SOTPS). This survey is being distributed to sex offender treatment providers in an effort to better understand the stressors, satisfactions, impact and moderating variables associated sex offender treatment. We would greatly appreciate you taking the time to complete this survey.

It is hoped that the data gathered through the support of treatment providers such as yourself will assist us in considering the training, supervision, support and self-care needs of sex offender treatment providers.

In completing this survey you may be assured of complete confidentiality. The survey has an identification number for mailing purposes only. This is so that we may check you name off the mailing list when your survey is returned. Your name will never be placed on the survey itself.

If you have any questions about this study, please feel free to contact me. You may write, call collect at (204) 943-7357 or reach me by Email at nativecl@mbnet.mb.ca.

Thank you very much for your anticipated cooperation.

Sincerely,

Lawrence A. Ellerby, M.A.
Clinical Director
Forensic Behavioral Management Clinic
Native Clan Organization

Appendix B

The Sex Offender Treatment Provider Survey

**An International Survey of Sex Offender Treatment Providers
Fall 1996**

*If you do not provide 3 or more hours of sex offender treatment per week, please
check here and return survey uncompleted _____*

Please return your completed questionnaire in the enclosed envelope to:

The Forensic Behavioural Management Clinic

203-138 Portage Avenue East, Winnipeg, Manitoba, Canada, R3C 0A1

MBI Human Services Survey

The following set of questions are to determine how individuals in the helping profession view their jobs and their clients. Please read each statement carefully and select the most appropriate response.

Everyday
 A few times a week
 Once a month
 A few times a month or less
 Once a year or less
 Never

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

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ID#:

23. Over the last 6 months I have felt sad and down-hearted:
 Almost All The Time Some Time Never
 A Good Bit of Time Rarely

Self Test for Psychotherapists

Consider each of the following characteristics about you and your current situation. Please read each statement carefully and circle the most appropriate response.

	<i>Never/Rarely</i>	<i>At times</i>	<i>Not sure</i>	<i>Often</i>	<i>Very often</i>
24. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.	1	2	3	4	5
25. I find myself avoiding certain activities or situations because they remind me of a frightening experience.	1	2	3	4	5
26. I have gaps in my memory about frightening events.	1	2	3	4	5
27. I feel estranged from others.	1	2	3	4	5
28. I have difficulty falling or staying asleep.	1	2	3	4	5
29. I have outbursts of anger or irritability with little provocation.	1	2	3	4	5
30. I startle easily.	1	2	3	4	5
31. While working with a sexual offender I have thought about violence against the offender.	1	2	3	4	5
32. I am a sensitive person.	1	2	3	4	5
33. I have had flashbacks connected to my sexual offender clients.	1	2	3	4	5
34. I have had first-hand experience with traumatic events in my adult life.	1	2	3	4	5
35. I have had first-hand experience with traumatic events in my childhood.	1	2	3	4	5
36. I have thought that I need to "work through" a traumatic experience in my life.	1	2	3	4	5
37. I have thought that I need more close friends.	1	2	3	4	5
38. I have thought that there is no one to talk with about highly stressful experiences.	1	2	3	4	5
39. I have concluded that I work too hard for my own good.	1	2	3	4	5
40. I am frightened of things a client has said or done to me.	1	2	3	4	5
41. I experience troubling dreams connected to my sex offender clients.	1	2	3	4	5
42. I have experienced intrusive thoughts of sessions with especially difficult sex offender clients.	1	2	3	4	5
43. I have suddenly and involuntarily recalled a frightening experience while working with a sex offender client.	1	2	3	4	5
44. I am preoccupied with more than one sex offender client.	1	2	3	4	5
45. I have lost sleep over a sex offender clients potential for relapse.	1	2	3	4	5

	Never/rarely	At times	Not sure	Often	Very often
46. I have thought that I might have been "infected" by traumatic stress of my clients.	1	2	3	4	5
47. I remind myself to be less concerned about the well-being of my clients.	1	2	3	4	5
48. I have felt trapped by my work as a therapist.	1	2	3	4	5
49. I have felt a sense of hopelessness associated with working with sex offender clients.	1	2	3	4	5
50. I have felt "on edge" about various things and I attribute this to working with sex offender clients.	1	2	3	4	5
51. I have wished that I could avoid working with some sex offender clients.	1	2	3	4	5
52. I have been in danger working with sex offender clients.	1	2	3	4	5
53. I have felt that my sex offender clients dislike me personally.	1	2	3	4	5
<i>Items about being a Psychotherapist and your work environment.</i>					
54. I have felt weak, tired and rundown as a result of my work as a therapist.	1	2	3	4	5
55. I have felt depressed as a result of my work as a therapist.	1	2	3	4	5
56. I am unsuccessful at separating work from personal life.	1	2	3	4	5
57. I feel little compassion toward most of my co-workers.	1	2	3	4	5
58. I feel I am working more for the money than for personal fulfillment.	1	2	3	4	5
59. I find it difficult separating my personal life from my work life.	1	2	3	4	5
60. I have a sense of worthlessness/disillusionment/resentment associated with my work.	1	2	3	4	5
61. I have thoughts that I am a failure as a psychotherapist for sex offender clients.	1	2	3	4	5
62. I have thoughts that I am not succeeding at achieving my life goals.	1	2	3	4	5
63. I have to deal with bureaucratic, unimportant tasks in my life.	1	2	3	4	5

Personal Resources Questionnaire

Please read each statement carefully and select the most appropriate response.

	<i>Almost None</i>	<i>Very Little</i>	<i>Quite A Bit</i>	<i>A Great Deal</i>
64. When I need a vacation I take one.	1	2	3	4 5
65. I am able to do what I want to do in my free time.	1	2	3	4 5
66. On weekends I spend time doing the things I enjoy most.	1	2	3	4 5
67. Lately, my main recreational activity is watching television.	1	2	3	4 5
68. A lot of my free time is spent attending performances (e.g., sporting events, theater, movies, concerts etc.).	1	2	3	4 5
69. I spend a lot of my time in participant activities (e.g., sports, music, painting, woodworking, sewing, etc.).	1	2	3	4 5
70. I spend a lot of my time in community activities (e.g., scouts, religious, school, local government, etc.).	1	2	3	4 5
71. I find engaging in recreational activities relaxing.	1	2	3	4 5
72. I spend enough time in recreational activities to meet my needs.	1	2	3	4 5
73. I spend a lot of my free time on hobbies (e.g., collections of various kinds, etc.).	1	2	3	4 5
74. I am careful about my diet (e.g., eating regularly, moderately, and with good nutrition in mind).	1	2	3	4 5
75. I get regular check ups.	1	2	3	4 5
76. I avoid excessive use of alcohol.	1	2	3	4 5
77. I exercise regularly (at least 20 minutes most days).	1	2	3	4 5
78. I practice "relaxation" techniques.	1	2	3	4 5
79. I get the sleep that I need.	1	2	3	4 5
80. I avoid eating or drinking things I know are unhealthy (e.g., coffee, tea, cigarettes, etc.).	1	2	3	4 5
81. I engage in meditation.	1	2	3	4 5
82. I practice deep breathing exercises a few minutes several times each day.	1	2	3	4 5
83. I set aside time to do the things I really enjoy.	1	2	3	4 5
84. There is at least one person important to me who values me.	1	2	3	4 5
85. I have help with tasks around the house.	1	2	3	4 5
86. I have help with the important things that have to be done.	1	2	3	4 5
87. There is at least one sympathetic person with whom I can discuss my concerns.	1	2	3	4 5
88. There is at least one sympathetic person with whom I can discuss my work problems.	1	2	3	4 5

	Almost Never	Very Little	Quite A Bit	A Great Deal
89. I feel I have at least one good friend I can count on.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
90. I feel loved.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
91. There is a person with whom I feel really close.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
92. I have a circle of friends who value me.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
93. I gain personal benefit from participation in formal social groups (e.g., religious, political, professional organizations, etc.).	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
94. I am able to put my job out of my mind when I go home.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
95. I feel that there are other jobs I could do besides my current one.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
96. I periodically re-examine or reorganize my work style and schedule.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
97. I can establish priorities for the use of my time.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
98. Once they are set, I am able to stick to my priorities.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
99. I have techniques to help avoid being distracted.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
100. I can identify important elements of problems I encounter.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
101. When faced with a problem I use a systematic approach.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
102. When faced with the need to make a decision I try to think through the consequences of choices I might make.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5
103. I try to keep aware of important ways I behave and things I do.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 5

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Therapist Background Information

104. What is your gender?

Male

Female

105. How old are you?

20-25

36-40

51-55

26-30

41-45

56-60

31-35

46-50

61+

106. Are you currently:

Single

Married/common-law

Divorced/separated

107. Do you have any dependents (e.g., children, step-children)?

Yes

No

108. Highest level of education completed?
- High School Diploma Master's Degree Other
- Community College Ph.D.
- Bachelor's Degree M.D.
109. What is your primary profession?
- Probation/parole officer Master's Level Therapist Other
- Nurse Psychologist
- Social Worker Psychiatrist

110. How much formal training specific to sex offenders did you receive when you first began to provide clinical services to this population?
111. How much opportunity do you receive for continuing education/training which deals specifically with sex offender assessment and treatment issues?
112. How much opportunity do you have to consult with other clinicians who have expertise in working with sex offenders?
113. What level of clinical supervision do you receive?

Almost None
Very Little
Some
Quite A Bit
A Great Deal

Practice Setting Information

114. Does your clinical practice with sex offenders primarily occur within:
 an independent practice an agency
115. In which setting do you primarily provide sex offender treatment?
 Community Hospital Community + Institution
 Residential Correctional Facility Other
116. In treating sex offenders, do you practice as part of a clinical team within a specialized sex offender program?
 Yes No

117. How much understanding is there at the administrative level for your work with sex offenders?
118. How much support/appreciation do you receive from other colleagues for your work with sex offenders?

Almost None
Very Little
Some
Quite A Bit
A Great Deal

Almost None
 Very Little
 Quite A Bit
 A Great Deal

119. How much concern do you experience about the ongoing funding available for your work with sex offenders?
120. To what extent do organizational politics contribute to the stress you experience in your clinical work with sex offenders?
121. Is your salary/wage adequate for the work you do?
 Yes No
122. In what country do you practice?
 United States Canada Other (Specify)

Client Contacts/Exposure

123. How many years have you provided direct clinical services to sex offenders?
 < 1 1-3 4-6 7-9 10-12 13+
124. Over the last year, what percentage of your clinical practice has consisted of sex offender clients?
 <10% 11-25% 26-45% 46-60% 61-75% 76-100%

<5
 6-15
 16-25
 25-35
 36+

Over the last year, approximately how man hours per week have you provided clinical services to each of the following client groups?

125. Sex offenders (In general)
126. Incest offenders
127. Pedophiles
128. Rapists
129. Rapist/pedophiles
130. Sadistic sex offenders
131. Other sex offenders, Specify
132. Do you believe your sex offender case load to be:
 Too low Manageable Too high
133. On average, what is the length of time that you see sex offender clients in treatment (in months)?
 <5 6-15 16-25 26-35 36+

Minimally
Somewhat
Moderately
Very
Usure

How stressful do you find it to work with each of the following client groups?

134. Incest offenders

135. Pedophiles

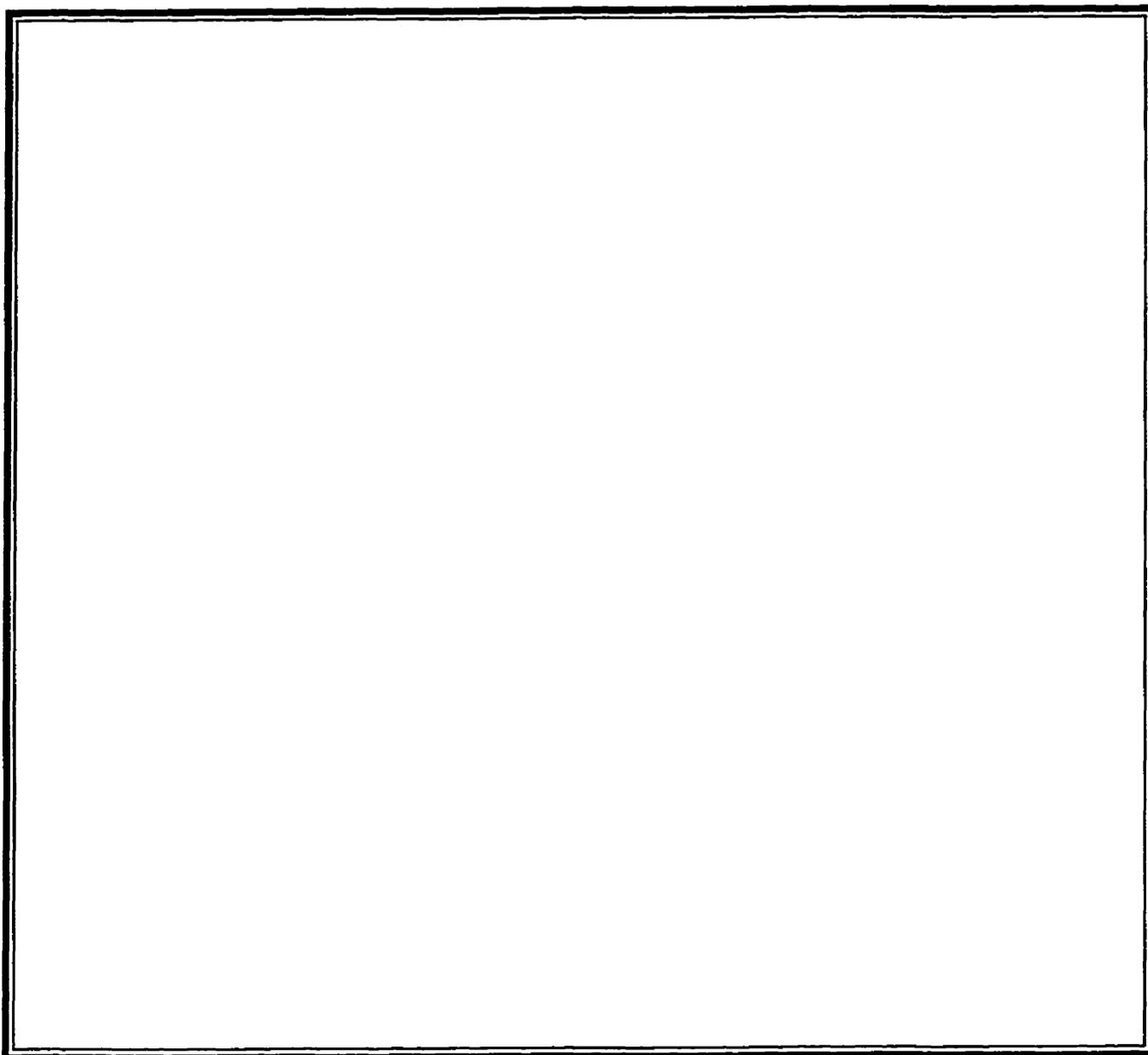
136. Rapists

137. Rapist/pedophiles

138. Sadistic sex offenders

139. Other sex offenders, Specify

Any comments you may wish to provide about this research project would be appreciated.



***** Please Indicate If You Would Like A Summary of the Results of this Study _____ *****

Thank you for your assistance.

Please return your completed questionnaire in the enclosed envelope to:

The Forensic Behavioural Management Clinic
203-138 Portage Avenue East, Winnipeg, Manitoba, Canada, R3C 0A1

Appendix C

Last week, a survey investigating the impact of providing treatment services to sex offenders was mailed to you.

If you have already completed and returned the survey to us, please accept our sincere thanks. If not, please do so today. We are especially grateful for your help because we believe that your response will be very useful in assisting us to develop a knowledge base about how providing treatment services to this difficult population impacts clinicians and what type of training, supervision and supports are helpful for sex offender treatment providers.

If you did not receive a survey, or if it was misplaced, please call us collect at (204) 943-7357 or contact me by Email at nativecl@mbnet.mb.ca and we will get another one in the mail to you today.

Sincerely,

Lawrence A. Ellerby, M.A.
Clinical Director
Forensic Behavioral Management Clinic
Native Clan Organization
203-138 Portage Ave. East
Winnipeg, Manitoba, Canada, R3C 0A1

Appendix D

November 29, 1996

Dear Research Participant:

Thank you very much for taking the time to complete the *Sex Offender Treatment Provider Survey*.

As a result of comments received about the survey from respondents, we were alerted to a significant error in the scale for one of the measures. Unfortunately, we did not discover this prior to the mailing. As this particular measure is a central component of the research I have enclosed a revised version. If you could please take a few minutes to complete this corrected version, we would be most appreciative.

My sincere apologies for the inconvenience our mistake has caused, and thank you for your anticipated understanding and cooperation.

Lawrence Ellerby, M.A.
Clinical Director
Forensic Behavioral Management Clinic

Appendix E

November 22, 1996

Mr. T. Smith
Native Clan Organization
203-138 Portage Ave East
Winnipeg, Manitoba
R3C 0A1

Dear Mr. Smith:

About three weeks ago, we wrote you to seek your opinions about the impact of providing treatment services to sex offenders on clinicians. As of today, we have not received your completed survey. We realize that you may not have had time to complete it however, we would genuinely appreciate hearing from you.

This study is being conducted so that we can better understand how providing treatment services to this difficult population impacts clinicians and what type of training, supervision and supports would be most helpful for sex offender treatment providers. We are writing to you again because the study's usefulness depends on our receiving a survey from each respondent.

In the event that your survey has been misplaced, a replacement is enclosed. We would be happy to answer any questions you have about the study. Please feel free to contact me by calling collect at (204) 943-7357 or by Email at nativecl@mbnet.mb.ca.

Thank you for your assistance.

Sincerely,

Lawrence A. Ellerby, M.A.
Clinical Director
Forensic Behavioral Management Clinic
Native Clan Organization

Appendix F

Sign Up Now For A

Focus Group

Come and Discuss Your Experiences as
a Sex Offender Treatment Provider

In addition to the *Sex Offender Treatment Provider Survey*, Focus Groups Investigating the stressors, satisfactions and moderating variables associated with providing sex offender programming will be held at the ATSA Conference in Chicago!

Focus Groups will be held at the conference hotel on:

~ November 14, 1996 (5:30 p.m.-6:30 p.m.)

~ November 15, 1996 (5:30 p.m.-6:30 p.m.)

To register to participate in one of the Focus Groups, please contact:

Lawrence A. Ellerby, M.A.

Clinical Director

Forensic Behavioral Management Clinic

Native Clan Organization

Email: nativecl@mbnet.mb.ca

Fax: (204) 943-4085

Tel.: (204) 943-7357

**** Your interest and participation in this project would be greatly appreciated ****

Appendix G

**FOCUS GROUP 1 TRANSCRIPT
(ATSA Conference, 1996)**

Legend:	FV	Female Voice
	MV	Male Voice
	V's	Voices
	**	Anonymous

MV: My name is **(M), and this is **(F) and **(M) from the Forensic Behavioral Management Clinic (FBMC) in Winnipeg, and as you may know, we are right now in the midst of doing some research looking at the impact and the experience for people who are working with sexual offenders, and are trying to do sort of two things in looking at this.

The first piece we are doing is a survey to get sort of more of the quantitative data about what is the experience and what are the moderating variables that, either make people more vulnerable to the stress, or that help people be more resilient, in terms of dealing with the work that they do.

The other piece that we wanted to do was have a more qualitative piece, where we ask people to be able to talk a little about 'what are their experiences'. I guess to give us a different kind of information than the quantitative information you give us and I guess, also, to help gear how we look at this question in future research. So those are the goals and we wanted to try to use The Association for the Treatment of Sexual Abusers (ATSA), as an opportunity to get new ideas of people other than those people who are in our home community.

So, looking, I mean, it's very casual and very informal. I mean, you can see that we are taping the Focus Group and the reason for that is that the audio tape will be transcribed and that transcript will really be our data, and we will be doing content analysis on that. The audio tapes will not be used by anyone other than the research team and will be destroyed after the transcript is made and the transcripts, of course, are anonymous and no names are attached.

So the questions that I wanted to put out over the next 45 minutes, or an hour to you for discussion are really looking at, in your experience of working with offenders, what has some of the difficulties been, some of the stresses that you perceive as associated with the work, how do you cope with your work, looking at how you feel and that your personal or your professional life has been affected, if you feel it has been in any way, as a direct result of your work and, lastly, what are the satisfactions of doing work, I mean, we focus a lot on the negatives but people stay in there doing the work, so what are the benefits, what are some of the things that are satisfying. And, again, keeping it quite unstructured.

So, maybe as a good place to start, if you don't mind, maybe we can just go around in a circle, do a round circle and maybe you could just introduce yourself, in terms of, I mean, if you want to give your first name, your full name, how long you have worked with offenders, where you work, maybe what your background is and then maybe we can just jump into the first question.

* * *

MV: I'm **. I work at the Regional Treatment Centre in Kingston, Ontario. It's a forensic psychiatric hospital on the grounds of Kingston Penitentiary. I'm a psychologist there. I've been there for about a year and a half, and my background is in sex therapy and working with offenders.

MV: How long have you worked with offenders, **?

MV: Ah, a year and a half at the Regional Treatment Centre and I did some research with them for my Masters Degree, as well.

MV: Okay.

MV: I'm **. I work at the Regional Treatment Centre. Right now, I'm acting as the Program Director for the program there. I've been working with sex offenders since, I guess, 1987. I started basically doing the phallometric stuff at the Regional Psychiatric Centre in Saskatoon, which is basically the same building, just a different province. I got involved in group work while I was there and then I went on to do my Masters at Queen's and I started working at the Treatment Centre, three and one-half years ago, I guess. I started as an intern.

MV: My name is **. I've spent 32 years in law enforcement, the last 25 has been as a Polygraph Examiner. Twelve years ago, I got involved in specialized and dealing with sex offenders and recognized that there was so much that I didn't know. I went back and got a Fourth Graduate Degree as a counselor and now I have added counseling, but on a very limited basis. There's a conflict of interest to do testing with your own clients, but it grounds me into what goes on, on the other side and has helped me, I think, be a better examiner because I understand that these people are truly humans. Now, it sounds funny, but as a police officer, the perpetrators are not human. We dehumanize them, as bad as they dehumanize their victims, and we have our own nasty little names for them. So, it helped seeing these people as vulnerable, as needy, as being helpless at times. It helped me recognize that they are human. I don't do therapy as a means of employment, but it's been profitable.

FV: Okay, now I want to make sure you're destroying the tape after you . . .

MV: Yes.

FV: Okay.

MV: Yeah.

FV: I don't ever talk about my own life, so I'm going to make sure that, that goes away after you're done, whatever you do with it.

MV: Absolutely, absolutely.

FV: Okay, I'm **. I'm Director of the Highland Institute for Behavioral Change in Atlanta, also Executive Director of the Highland Foundation, which is a non-profit, uhmm, children who are sex offenders program. I started four years ago, so I've been doing sex work nine, it will be ten years in 1997. I started out in social work. I have a Ph.D. in Criminal Psychology and that's . . .

MV: Thanks.

MV: My name is **. I'm a Doctoral student in the clinic of psychology. My Undergraduate in Masters (sessions ?) was in Clinical Psychology, so I have that background. My experience, as far as clients go and, as far as the actual research with sex offenders has been ongoing for the two years since I've been in the Ph.D.(?) program. The community that my colleague and I work with are mentally retarded sex offenders, so it's a different realm altogether because it's that added component.

MV: Sure, thanks.

FV: I'm also a second year student in the Doctorate program with **. My name is **, and I've also been working in this project which is called Project 'SOP'(sp). It's operated out of our Department of Clinical and Health Psychology. It's funded by the city of Philadelphia. Yeah, we treat intellectually disabled sex offenders.

MV: Okay. Well, I think, I mean, it's smaller(?) But it's a real diversity and that's nice and that's hopefully going to add to the discussion. Again, I want to try to keep my comments really limited because I think the purpose here of doing a Focus Group is really to learn from you about your experiences, and, I guess, the place where we can start is just 'What makes your work with sex offenders, what's your experience in terms of what makes that work difficult and what makes it challenging, or what are the things that are the most difficult or stressful about your work'. Not an easy thing to start with (laugh).

MV: For me, if I've spent three or four days on the road, straight, I'm almost ashamed to be a man because it seems like there are always crimes against females.

MV: Uh humm.

MV: Even those that were perpetrated against a boy, that's more of a function of availability. The choice is a female, whether an adult rapist or a child molester. But it's always against a female, and it would be nice to have a third choice, not male, not female, but be that third choice so you don't feel like 'somebody goes uh huh, there's one we just haven't caught yet'.

MV: Okay. What about other people?

FV: I find the stress multiple. It is, first off, you're talking to people that are so horrendously damaged that if you have empathy yourself, you feel what, that you actually resonate with their pain. The next part of that is that if you have children or grandchildren, which I have, then if someone is a child offender or they are telling you about things they have done brutally(?) to a child, and if the age matches up and you see your own family in what you're hearing, and I think that there is also another part of that, which is that the intensity of what you must do with this population in guarding yourself and in not being sucked into, the manipulations suck your energy, thoroughly. So by the time you may leave the office, ten o'clock at night, you've pretty much run the gambit of every emotion that you have and you're going to come back and do it the next day. So, I think the stress is certainly, multiplexed. It's not one stressor in this field at all.

MV: Um humm. Good.

- MV: There's a big social factor to the whole thing. It's difficult to discuss what you do and have other people relate to you.
- MV: Um humm.
- MV: Family members will look at you as though 'So why did you choose this?'
- FV: Yeah, we know about you . . . (laughter).
- MV: Right. There's an immediate correlation that's incredible. I mean, if anybody studies schizophrenia, the immediate, people don't make the assumption, okay, so you have schizophrenia. They just hammer(?) it. Anything besides sex offending behaviors, it's fine, but as soon as you're studying paraphilia, uh, you're studying, uh, sort of sexually abhorrent behaviors, 'So what's wrong with you, what's the skeleton that's in your closet?'
- MV: It's not the kind of thing that you can sit around in a coffee shop and talk about openly.
- V's: No.
- MV: I hope that ties into, uh . . .
- FV: Yeah. I agree.
- MV: Not fully in the field yet. Well, maybe that's what I'm saying, that's the difficulty, that's the challenge. I mean, to justify your own existence and having to justify why you do these things. People neglect to see the benefit that's coming out of it. Uh, I mean, even if the statistics are wrong, every one of these guys that we work with, somebody's got to be saved and, if that one person is a success, hey, that's great! I mean, that's fine with me. It's better than doing nothing for that person. So, it's like (the anonymity of - ?) society, saying 'Control their behaviors, lock the person up, execute the person, do something that's completely horrendous because what they are, are completely horrendous, uh, but they don't want any sort of help cause then you're coddling the offender, feeling sorry for them.
- FV: Well, the other piece of what you're saying and, I don't know if you've had to face this yet in the treatment community, the victim treatment providers come after you and say 'what's wrong with you?, how can you do this?, you should be working with us'. This is stupid. When the community, you know, is trying to do with these irreparable people. So, you're almost, a whole new community of treatment providers come after you, too.
- FV: The view from our classmates, who don't work with us on our project, they kind of, you know, they'll ask 'well, do you actually think they're treatable?, do you actually think there's something you can do for them?', and it's the same with family and friends. Since I never actually considered working with this population before I came to Grad School, it was kind of a spontaneous thing. Umm, I don't think that much about it and just getting used to it, talking about sex openly, talking about sex offending behaviors openly and being a woman, you know, it scared me to be around these people. I was scared of the guys at first and just getting used to the whole thing, getting used to things.

- MV: Well, that's important to hear because I think that there's different feelings and different experiences that go along with the different points, when we do the work so. I guess, what you're sharing is really invaluable.
- MV: Yeah, the context I think you're coming from is really important. I know for myself, my context is coming from sex therapy, where, you know, 80% of our guys with couples we see, get an erection, they're having sex, you know, it's a very behavioral measure of success in a lot of what you do in sex therapy, and the other people are benefitting from it, whereas, here, I mean, especially with the high risk population that you work with, some of the guys, even if they are getting something out of it, the progress is very slow and it can be very frustrating at a personal level and at a therapeutic level. You know, you'll be working hard with these guys and you feel you're not getting anywhere and you can intellectualize it, you can rationalize it and you can say, you know, they are making progress in what you consider to be important areas and, then, all these 'but's' come in.
- FV: And when you have a monumental success and it goes out there and fails, then you feel like you're a failure.
- MV: Um humm.
- MV: 'What could I have done differently?'
- FV: That can really take the starch out of you.
- MV: Um humm. Yeah, the son of a gun that you've worked with for five years that says the right things, he talks the 'talk' and when he gets out there, the first thing he does is re-offend.
- FV: Um humm.
- MV: But it's like he's learned how to do a different type of offence. If he were an exposé, he's escalated. If he was a rapist, now he's also a murderer or damn near murders the victim. So it's like, 'God. What did I do to cause him to escalate?'
- FV: I get the feeling that it's a retaliation for all that we put them through in terms of, . . .
- MV: Might be.
- FV: in terms of the pressure we put on them to change and that, when they do decide that they're going to do their own thing, they do it even more so, to make a statement.
- MV: But like you said, if they are with us for five years, they're not offending so, how many victims did they not offend against?
- MV: I'm (balancing ?) my head when I'm hear right now because I'm still in the most encouraging field to get into so this is something that I want to do, as far as, a career to have that, every now and then, more often than not that you're going to have your failures, it's the question of balancing the therapist. If, hey, if you've got the guy for five years, and we've got guys that are on Probation, they're court

adjudicated with us for about the next seven or eight years, uh, out-patient basis, uh, weekly monitoring. They have individual, they have group, uh, it's well supervised and my (catharsis ?) For the year, the way I measure it is, they don't do anything for a year. If I don't accomplish anything else, that's the gold. The gold is don't sexually offend.

FV: That's right.

MV: If I can work with this population, if I can work on daily living skills, increase hygiene, that's a plus. but that's not the big picture. The big picture is sex offending behaviors and everything else is underneath that because it's their own responsible (technique or testing?).

MV: Yeah. So far, as far as I know, none of the guys that I have worked with have sexually re-offended, like, you know, like, as far as I know. Umm, I've followed a few of the ones that I can remember and they haven't, but I've had a couple of guys who were revoked for drugs and a guy that just went out, Possession of Stolen Property, stuff like that. But the way I look at it, the way I try to look at it, is like, I don't see this, you know, when, if a guy screws up, hopefully, and I hear about it, hopefully, the way I'm going to deal with it, I'm not going to take it personally.

FV: (laughter)

MV: It's, it's his decision, you know, I worked with him for, you know, the six months or year or whatever. I worked with him, umm, I helped him however I could, and what happens with him from that point on is his decision and if he chooses to, you know, go out and do something that hurts someone else, I hope that I don't see that as my responsibility.

FV: It will be interesting if you can hold that perspective in the face of whatever happens.

MV: Actually, one of the guys I worked with did, I just remembered, he did, yeah, he (snaps fingers twice), **, that was his name. Yeah, he did sexually re-offend and I didn't take it personally.

V's: (laughter)

MV: Of course, I didn't expect him to make it, so that makes it easier.

V's: (louder laughter)

FV: I think the mixture is there that you take it personally, that there's something that you missed . . .

MV: Um humm.

FV: And the other part is the rational part that says (a lot of noise, unable to decipher -like machine being moved and books being put down hard on a surface) if possible to and that, you know, he elected to throw away three or four years of therapy, so he gets what he deserves. But the other case of that is that the victim had to suffer too.

MV: Um humm.

FV: And you know that, that, this was a re-offence against the same victim who was adamant that he come back out and what we went through in the way of mediation with his family. It took us four years to put this family together. I had the wife in Wives' Group, he was in my group, he was seen individually, the child was seen by someone. We collaborated in all aspects with other treatment providers, with Probation. I mean, we did not let up on a lot of things upon this case and yet, when we found out that he re-offended, umm, he started from the day he walked back into town, he took the cameras off the doors that we had had in there for three years of visitation, and visitation only began with, uh, you know, one hour of dinner on Sunday.

MV: Um humm.

FV: We worked on, all those years doing all these minute steps and, you know, you know, you do take it personally, in that you missed signals, possibly that might have clued you in, and it does effect your belief in what you can really see.

MV: Um humm.

FV: Now, taking it personally doesn't mean going out and slashing your own wrists.

MV: No.

FV: But, it does say, it points out your own mortality, your own fallibility.

MV: Um humm.

FV: You're not perfect and I'd like to be able to (end ?).

FV: Quiet laughter. Um humm.

MV: But, it sounds like he was scamming right from the beginning and . . .

FV: I have to make that assumption.

MV: It's probably not that you missed something. It's probably that he wasn't telling you everything, so .

FV: Well, I guess the hardest part to all of this (coughing in background) is that the victim wasn't telling either.

MV: Yeah.

FV: Because we found out so much that it was just astonishing. She didn't tell until six months after he'd been home, and her mother was participating, also.

MV: Humph!

FV: So, I mean, we got conned . . .

MV: Right from . . .

FV: Six ways from Sunday, so . . .

MV: Sure.

FV: But, it's only happened twice, in nine years, so . . .

FV: My supervisor of course points out that (undecipherable) when sex offender treatment program (undecipherable) especially during the recession (undecipherable) is really highlighted here because you're expected to have a relapse rate of zero.

FV: That's right.

MV: Yeah.

FV: Of course, then your credibility of the program runs along with the clientele, and then with depression, 80% of people get better and don't become depressed within the next few years and that's, you know

FV: Look at drug and alcohol programs, my God, they relapse all over the place.

MV: Well, actually, then, people always compare like sex offending to drug and alcohol or cigarette smoking, and I've very recently . . . When people go through a program to try to quit smoking, 80% of them relapse in the first month. That's people who get treated, so, like, when you think about that, like, sex offender treatment is much more successful than that.

V's: (laughter)

MV: Nobody says anything about that.

MV: And the other issue is that when you look at some of the, at least the Canadian follow-up data, I mean, you know, we have follow-up data 7, 10, 12 years. Look at, you know, a weight loss group or any of these other groups. What's the follow-up period? If you're lucky, you get 12 months.

MV: Yeah.

MV: You know, 24 at (?), you know wandered.

FV: Um humm.

MV: You know, who has survival curves on smoking groups, you know, that go 10 or 12 years?

FV: Um humm.

MV: And if you were to do that, I mean, you know, you, you, (laughter). I think we'd end up looking a lot better than we do. At least in the media and some other places.

MV: Compared to a lot of . . . , yeah, but then again, like smoking, you're hurting yourself.

FV: Well, I . . .

MV: Secondary, secondary smoke . . .

FV: What about drunks who . . . ?

MV: Yeah.

MV: Drive.

MV: Yeah.

FV: That's a whole heck of a lot . . .

MV: They're talking about Indeterminate Sentencing for those guys.

FV: Um humm. Yeah, more damage there than, than what we see.

MV: That's the other part. The sentencing is the whole part of the equation, also, because, uh, I am fairly confident to say that one of the clients that I had, they're suing, as soon as his probation is up in four to five years. He's going to be incredibly high risk and there's nothing I can do about it.

FV: Yeah.

MV: Yeah. And, the challenge is just to make sure again. Over the next four years, you're fine. But a week after that, you're out and you re-offend, I'm going to feel really bad about it, but I'm not going to take it personally.

FV: Yeah, well, not at first, you don't.

MV: I'm not going to take it personally because, I mean, it's battling the systems. You can't do anything with the way the system is set up.

MV: Yeah.

FV: We have those. We know absolutely too, when they re-offend.

MV: A lot of the people we deal with, like, we're in a maximum security federal prison. The guys that we're dealing with are basically the worst of the worst.

FV: Um humm.

MV: As far as sex offenders go, in our region anyway and I think that's one thing that makes it lot easier to not take it personally.

MV: Yes.

MV: The people that we're dealing with are really fucked up when they come to us, and if they're only slightly less fucked up when they leave, we've done something.

FV: Right.

MV: And, you know, odds are that most of the people we deal with are going to come back into prison for something, sooner or later.

FV: Um humm.

MV: And there's some of the them won't and those are the ones that I sort of look to towards, you know, to keep me going.

FV: Um humm.

MV: You know, we treat 50 guys a year. If 45 of them don't re-offend, I'm happy (nervous laughter). If 45 of them re-offend, 5 of them don't. Like, I'm not looking for a really high success rate from the guys that we deal with.

FV: Well, actually, that's a really good point about being in prison because I'm working with women in prison and I think that, at that perspective, with them.

MV: Yeah.

FV: Because I don't work with them every day, I'm not totally involved with their lives like I am with community based.

MV: Yeah, humm, I could never work in a community.

MV: It feels different.

FV: Yeah. It really does. When he said that it really . . .

MV: Um humm.

MV: Yeah, community work is something I would never do.

FV: Somebody's got to do it.

MV: Yeah.

V's: (laughter)

MV: Not me. (laughter)

MV: How come?

MV: (Laughter) How come?

MV: Yeah.

MV: How come?

MV: Yeah.

MV: Because, okay, for one thing, I like to have a job that I can go to at 8:00 in the morning and I can leave at 4:00, 4:30, or 5:00 pm and it's done. I need that to function. I need to have time where I can go home and relax and totally forget about work. If I were working in the community, I couldn't do that.

FV: No, you can't.

FV: No, you don't.

MV: And . . .

MV: You shop in the same stores they are.

MV: Yeah.

MV: They come down the grocery aisle and you see your client right down there.

V's: (laughter) Yeah.

MV: But, I live in a town of 8000 people.

MV: My God.

MV: And, in, so they're not my clients. They're my colleague's (?) clients. But I don't treat them. But I see them.

MV: Yeah.

MV: There's 12 of them that live in (Floogerville) and they come right down the aisle.

V's: (laughter)

MV: Um humm.

MV: And yet the mayor stands up, in part of his re-election speech, was talking about why people move to a small community, because we don't have those kind of people here.

V's: (louder laughter)

MV: They're in Austin, and I want to go, 'You stupid bastard! There are a dozen of them here. Do you want me to tell you where they are?!'

V's: (laughter)

MV: Of course, you can't.

MV: Yeah.

MV: You know, but they're everything and so that's tough.

V's: Yeah.

MV: So, you know, I understand how you feel.

MV: Yeah. Yeah.

MV: So, what do I do for fun? On Thursdays, I spend the day at the federal penitentiary in (Abbscott?).

V's: (laughter)

MV: And I counsel with, what I call, normal thugs.

V's: (laughter)

MV: They're pipe bomb manufacturers. They're counterfeiters.

FV: Yeah, (laughter)

MV: They're Columbian drug lords.

FV: The easy ones.

V's: (laughter)

MV: And I talk to them, depression groups, chronic pain (anti-detect?) disorder, I mean, just nice friendly stuff.

V's: (laughter)

MV: Yeah. it keeps me grounded.

V's: (laughter)

MV: So. on that. I mean. what do people do other than. so. what you do to keep yourself grounded is diversify.

MV: Um humm.

MV: What you do. umm. and I think people have touched on this as you've talked. umm. already that with some of the difficulties that you've raised, umm, yeah, how do you cope, how do you manage that?

MV: Oh. I go back and work out with weights.

MV: I run.

V's: (laughter)

MV: And I don't work in the community.

MV: Don't work in the community.

V's: (laughter)

MV: I leave work at work.

MV: Yeah.

MV: When I come home, well. unless I. except when I go the gym. because I work out with him.

V's: (laughter)

MV: When I go home, I don't talk about work, like. well, actually, there, you know. I come home. my wife's there, we talk about work for like 15 minutes and then, that's it.

MV: I use running as a gauge, umm, you know, I sometimes am not aware of how stressed I am and yet, I'll be running and I'll do, like, five kilometers more than I'm used to doing or something like that, and it's sort of, I use it almost as a scale. 'Oh, shit. There's something I have to process' cause I have all this extra energy in me and it's stress related and, and, like, it'll get me thinking, 'Okay. What's going on', and then something will click in my head like, 'Oh, yeah, I had this horrible session with this guy that I, you know, was trying to forget about, but obviously it's there. And I think about it for a little while, or either just work through it, in the job or whatever.

MV: Riding a bike, it does the same thing for me.

MV: Um humm.

FV: (undecipherable, noises, shuffling) the diversity of interests in play, I think that as a Grad Student. I try to do non-psychology things . . .

MV: Um humm.

FV: To be in contact with people who are not in your field.

MV: Um humm.

FV: Umm, and also support from your colleagues in (cults?). Our supervision, we have weekly supervision with our supervisors and the other (staff members?). Sometimes, it's like a gripe session. I mean, we all jump around in our, at work and support each other and it's helpful.

MV: Essentially, everybody probably does the same thing, regardless of what the field is because they can all feel that, it hits home a little more because it's a little more salient. When you pick up the newspaper or you turn on the TV and you hear another crime has been committed, and it's not necessarily some work I could have done to prevent it cause it's in another (county?). It's a long way, but it's there, it's in your face.

MV: Yeah.

MV: The impression is not in the news everyday . . . (?) It's nothing brand new. Sex offending crimes are big news in almost every place, so, distance yourself in the sense of keeping occupied with things unrelated to the field and, portioning out times knowing that the demands of the field require you to stay up on top of what's going on and require you to stay in focus, but you pretty much have to make that time to do other things, to forget about it, to get on with your life and to live that life.

MV: I think what you were saying before, in terms of talking to people, you know, that's really important, whether just going to somebody's office to gripe or, you know, actually talking about, well, you know, 'Do you think that I did okay with this client?', like, 'What should I have done differently?'. I think having that kind of feedback is really important to stress management.

MV: Yeah.

MV: And we have a really good team of people that we work with, that we spend a lot of time doing this with.

V's: (laughter)

MV: I think that ** and I have a different side that you all can leave it at work, or it's easier because you know there's bars, there's some walls.

MV: Um humm.

MV: We look at the newspaper and see or hear on television a report about a sex offender, and we think, is it one of ours?

FV: Yes. Oh, yeah.

MV: ... of our out-patients.

MV: Okay, so you have the same . . .

MV: In supermarkets. I'm thinking, it's not as real as that but I know where my clients live and they're only about a mile away from where I live, and I'm thinking about that.

MV: Um humm.

FV: Like, it's not out of the realm and I don't know if I necessarily feel very uncomfortable with the fact, going to the store, running into one of these guys on the street cause I'm pretty much comfortable with who they are, not who they were.

MV: Um humm. It doesn't bother me, but you sit there and you think I got to supervise them.

MV: Right.

MV: You don't. But you get that feeling.

MV: But you know about him, so it's your turn to watch him.

FV: My life is 24 hours a day, 7 days a week involvement. I have no, umm, there's nothing in my life that's not sex offender related. Ah, my husband works for me, all of my friends are in the field. This is my world. So, I don't ever actually leave it. When I walk out of the office, I may have, you know, four reports to work on and I may, I may be at the computer until 2:00 AM, doing it, so, my involvement is probably a little different, I guess, than the others in here because I am, I'm where the buck stops, you, and I travel a lot and do lots of speaking and write lots of stuff, and I have to be at it all the time. I think that where my disengagement comes is in the times that I allow myself to not let the thoughts of the sex offending world impinge on the moment that I'm interacting with my grandchild, or my dogs or whatever. I have to actually leave the city, and if I can get on a plane, I leave it there. That's the only way that I will not live this world and heck, I've been in, you know, a couple years of therapy to deal with all the issues of, well, a couple years. That's a misnomer. I did a lot of long-term, umm, therapeutic work in how to compartmentalize my life so that I wouldn't let what I do 24 hours a day burn me up, so that I would be ineffective.

MV: Um humm.

FV: And that, to me was extremely valuable because it helped me gain a perspective that I did learn, that I was not infallible, that I did learn that they make their own choices. And not that I didn't know it . . .

MV: Um humm.

FV: But you have to internalize those concepts and going to therapy the way I did for so long helped to sort of complete solidify that process. Umm. I was very, very, very good at disassociation and so, whenever it would get too intense, I would disassociate. But that doesn't work real good when you've got a business to run and you've got to keep all this stuff all lined up, and you've got this court case and you've got to remember to take these notes to do that and all that stuff. So, I learned a better way of coping and not happen to take that tactic and to stay focused. So, you know, it's just been over time.

FV: Are we locked in?

MV: No.

V's: (laughter)

FV: We are now.

V's: (laughter)

MV: There's a panic bar over there.

FV: Oh, good, good, good.

FV: So, you know, I don't know if that's helpful in looking at how people handle how they can get some distance.

MV: Um humm.

FV: My distance comes a little bit differently, I think, than other people handle it. I guess we all do a different thing.

MV: Um humm.

FV: Drugs help.

MV &

V's: (laughter)

FV: That was a joke . . .

V's: (laughter)

FV: I wish I could, but, I mean, I truly do. I mean, there are times that I'd like to flat out get loaded.

FV: (laughter)

FV: But that would lead to alcohol and I can't drink.

MV: So, there are other kinds of things to keep your strength up and your sort of ability to stay in the game that are . . .

FV: Just some of the stuff that people are talking about. If one was just listening to this, I mean, the question that comes to mind is 'Why are we doing this?'

FV: Because the rewards are tremendous.

MV: Yeah.

FV: Absolutely.

FV: But, what are some of the rewards?

FV: Umm. For me, there is, there is, there's two parts to the rewards that I feel. One, very altruistic and one, very selfish and the altruistic is that I'm providing safety for many, many people. Umm. That includes my own family, my own extended family and whatever they are in, what state they are in. Uh, my selfish part is that I need that sense of power and control of bad people and it works for me.

MV: Um humm.

FV: And I love it! So, it is a two-fold process. You know, I feel very strongly that it, it cannot be totally selfish-based, or you're going to destroy people. It cannot be totally altruistic based, or you're going to be destroyed.

MV: Um humm. Um humm.

FV: You have to have a balance of those two things and that's why I do it.

MV: Yeah. (clears throat) I also have a tremendous need for excitement. I, uh, spent two tours in Vietnam as a kid, uh, if you can figure somebody 20 and 21 as a kid and, uh, after you have worked 'Point' on alert detail for 19 straight months and you don't know what's around that next curve, there's nothing, as high as coming out alive. I had to find something in civilian life that would do the same thing. And the power is part of it and then the fact that, even with a failure, my side is I can get the confession to put the guy away so he can't do any more damage. So, if I can't do it on one side, I've got the chance to do it on the other. So, I, you do feel like you're helping people, even though you'll never meet 'em and no one knows. I mean, hell, my father-in-law, and I've been married 30 years plus, he can't tell you what I do for a living. He refuses to talk about what I do. He knows about all his other son-in-laws and sons and daughters and daughter-in-laws, but he refuses to acknowledge what I do. My own mother can't even say the word. She makes polygraph a four symbol word, a four syllable word. I mean, she just can't do it and she said 'Where did I do wrong?', 'Why do you want to deal with those people?'

FV: (light laughter)

MV: I, I, you can't explain it. If you ask the question, then they're not really going to listen to the answer.

FV: Um humm.

MV: I came here from another presentation that dealt with the same topic, and one of the guys that was doing the presentation said that he came from a group and that he had heard something terrible, and he comes to this restaurant, his wife is there, his friend is there and the friend says 'Gosh, you really look kind of rugged. What happened?', and he says, he starts to tell him and the wife is kicking him under the table and hitting him and, afterwards, she says 'Bill or whatever the friend's name, she says 'his eyes glazed over, he didn't hear three-quarters of what you said because he didn't want to'. So, I don't interact with a lot of people that are not in the field.

FV: Um humm.

MV: There are other police, there are other Polygraph Examiners, there are other therapists, there are other institutional workers. But, they all face the same things in various degrees and they understand. And, so, when we joke, it's real dark humor.

FV: Yeah. It is.

MV: I mean, you know, you can, uh, look at a photograph of a child that's dead and there's parts missing and go, 'Well, that's going to be a closed-casket funeral'. God, that's cold.

MV: Um humm.

MV: I mean, you don't even validate the fact that, that was a human being at one time. That the parents are really concerned. It's, 'Well, that's going to be cheaper. They don't have to spend that much money on the funeral. Just close the casket'. But, if you don't protect yourself in those sorts of ways, you end up crying the whole time. As she says . .

MV: Um humm.

MV: It's not the power the whole time, but there's that balance. But I wouldn't tell that to anybody else.

FV: Um humm. That's right. (laughter)

MV: (laughter)

MV: Um humm.

FV: I like what you said about being in Vietnam and having lived that kind of high voltage type of thing, because I've often considered that being really good at this, comes from living through hell and that, that's what makes those of us that are really good, really good. Umm, that's sort of why it works so well.

MV: So, we began to talk about and, again, with all these things right, I mean, it comes back to what Brenda had said, I mean, well, 'Why do this, what, you know, what keeps people in it, what keeps people going,

or why do you get into it or make a decision that, that's what you want to do?' Uh, 'What are the satisfactions, what are the benefits', other than some of the ones we've heard?

FV: I see it as a challenge, too, because I figure, if I can work with this population, I can work with many other populations. Umm, that's why. I mean, you're not so. I see it, I mean, you're not so. ultimately, you're working for the victim and working for the sex offender.

MV: Um humm.

MV: Second to the concept is the altruistic and there is the selfish part. I mean, in some ways, I actually do enjoy other people. I mean, you discuss some things, just to see what their reaction is going to be cause ...

FV: Um humm.

MV: It's expected. So, let's see what am I doing to do. Hey, it's a party, 'What do you do for a living?' This is what I do for a living.

V's: (laughter)

FV: There's that, I don't always get the reactions I'm expecting to get.

MV: My other life is computers. My two interests are in computers which keeps me busy 90% of the time that I'm not doing things related to clinical experience. Uh, my two interests are trying to merge sexual assessment with a computer device, ala able, ala other type of things. We're trying to come up with something I can sexualize as being a little bit more specific to target behaviors, but if I don't have the computers, basically, I'm in a lost world. I do jobs related to computer work and if I go out and I do a convention such as this, then, and I'm behind the curtains running the show and people ask me, 'So, what's my day job' and I tell them 'Sex offenders. Uh, I work with mentally retarded sex offenders'. I don't always get the reaction I'm expecting, which is emotion. I sometimes get people that tell me, 'That's terrible cause I had a family member that was molested and I found it to be really difficult to try and deal with it', and I started to get into these great conversations. For all the negative publicity that I hear out in the world, there are people who actually think we do a good thing.

V's: Um humm.

MV: And it's hard finding those people and I found it in the strangest places. I found it in technicians, I found it in people that I knew didn't have any contact whatsoever with the sort of population, and it just happened to come out because they asked the question, 'So, what do you do for a living?'

FV: It's a great opportunity to educate someone else.

MV's: Yeah.

FV: Wonderful!

MV: I think my reasons are a little bit, if you want philosophic, or, I mean, I think sex is fascinating. I mean, the concept of sex gone wrong, what are you talking about, sexual dysfunctions, or are you talking about the sexual paraphilia or whatever, figuring out what's going on. Like in the case of a guy sitting there with you who really doesn't know what's going on, what is related to his behavior, I mean, what are the factors that need to be addressed, I mean, it's fascinating! Just the process of figuring it out. I think of it as a puzzle.

MV &

FV: Um humm.

MV: And I don't have an answer to it, and I'll go wrong in many places and that's part of what makes it the art of therapy. I mean, and if, and if you're going to pick part of the art of therapy, I think the part that makes it most fascinating. Sex is the, probably the most interesting thing to talk about, in that area. And that's speaking personally. It's because it's such a difficult thing to talk about, there's so many taboos about talking about it, all these things about it. If you're going to do it, it seems to me, doing therapy, see if you're going to pick a subject, I can't think of a more interesting subject than sex and drugs.

V's: (laughter)

MV: And that's what we do.

V's: (laughter)

MV: No matter what, it'll just get you into arguments.

MV: (laughter)

MV: So, I think that's one of the things that I find very motivating about it and there, there is that element that me working with this population, you know, you're saving victims out there. And that's important.

MV: Yeah.

FV: It's never dull.

MV: For me, it's like I've worked, I've had a few variety of jobs like working in a grocery store, I've worked on a survey crew and I work with sex offenders and I think like, working with sex offenders is about the only thing that I'm all, I actually look forward to going to work a lot of the time, like, I took two months off to, to stay at home with the kid and uh, I was looking forward to going back to work and it wasn't because, part of it was because I was sick of being at home. I was bored at home. I was also, I was craving excitement and I find the job I do very exciting and umm, it's like, you know, for a lot of it is this sort of, that fascinating sex topic thing, like, well, sex offender, like, I find the whole idea. Like rapists, I'm not so much into, but child molesters, I find really fascinating, just the whole, like the whole cognitive distortion, all that stuff is, I just get off on it, to use . . .

V's: (laughter)

MV: a phrase.

MV: But one of the advantages to our population is with, some of the guys we see, particularly the child molesters, it's there, they're not hiding from you anymore.

MV: Yeah.

MV: Because they, you know, the recidivist offenders, they're saying, okay, I've got to work on this now and some of them are actually quite motivated.

MV: And they talk very openly about it and it's just fascinating.

MV: Yeah.

MV: There's no other word for it.

MV: Yeah, it really is.

MV: There's nothing else I'd ever want to do.

FV: That's not so encouraging.

FV: (laughter)

FV: I have colleagues, you know, that work for me that have been with me seven and eight years, and they feel exactly the way I do. Nothing else they would rather do.

MV: I think if anything, if you're not, there's got to be something. I don't know what it is, but there's got to be something that is consistent with everybody that works in this field. Something. The people that are good. The people that are well capable of actually addressing the problem, of actually providing therapy, of actually gaining some sort of insight into what the problem is, and the people that aren't effective, are the people that weren't meant for it.

FV: Yeah.

MV: They thought they might have been, but they really weren't. But the people that are, there's got to be that one little piece that, that's the reason why everybody, that's the one thing that we all have in common.

FV: And you know, and I think you can identify it as passion.

MV'S: Um humm.

FV: You have to have the passion or you can't do this work. It's very simple. I train Interns, and I get rid

of them because they haven't got it. You know, in six months, you know whether a person's got the passion or not. If they don't, they're gone.

FV: From my experience, our program happens to have a (Ward Culp?) program, uh, so we get some people from the (low program bits?). They want to do their practicum on our project and the problem is, they come in with the lawyer first.

V's: Um humm.

MV: . . . second and for me the difficulty is one of the therapists I work with is in this program, and the difficulty is we have a very common limited client that is incredibly, incredibly concrete. Our supervisors look at this guy and are amazed that this guy is so concrete.

V: (cough)

MV: Uh, we basically have to do everything three or four times in session. Not because he can't handle the task, but it's because he's not interested in handling the task and, if we don't abstract, he's gone.

MV: Um humm.

MV: But the lawyer and my (Culp?) therapist wants to interrogate him.

MV: Um humm.

END OF SIDE ONE - TAPE 1

* * *

MV: There's a side of me that needs to foster, or in some ways being pampered, uh, and what the client is pulling, I mean, that's the draining that you talk about, is that the plan is, that's what the client's pulling out of you. It's pulling out that discord. Uh, my (Culp?) therapist and I are great, as long as we're not in the room together.

FV: (laughter)

MV: Once we're in the room, everything is going all over. It's two, uh, independent, simultaneous therapy sessions going on because we just can't agree on how to deal with the situation, because the client is so difficult.

FV: Um humm.

MV: I might speak in to the fact that this population may not work well, uh, some people may not work well. You really have to tally things and know your population.

MV: Yeah.

MV: Ummm.

MV: (We're running out) of time and that it is late, after all. I want to do a conferencing. Umm, maybe we can just, again, do a quick round of, sort of thing in case anyone has any other comments that they want to make sure they get in, in terms of the stressors or, ah, how you cope or the satisfactions of job. Sort of a last word, if you need one. I don't know.

MV: I don't have really a last work, other than, that I think this sort of thing should be done more often.

MV: Yeah, I agree with that.

MV: Um humm.

MV: It would be nice if you could also talk to the spouses because I'm sure what I do is really tough on my wife, 'cause I get to unload on her and I'm not real sure who she gets to unload on.

MV: Um humm.

MV: So, it might be interesting.

MV: Yeah.

MV: And I know your husband (laughter) . . .

FV: Well, he's right in the middle of it, so . . .

MV: That's right.

FV: We unload on each other.

MV: Yeah.

FV: Well, I think that one of the things that is a problem for him is, he's not a therapist, so he doesn't get to work out any of this stuff. He's just, he's just there in it, you know, he does the 'plthysmig' and he does all the administrative stuff and, you know, and I'm the one saying this is what's going on and I know that he would like to, well, sit in on a session so he could (relate results?).

FV: (laughter)

V's: (laughter)

FV: So, yeah, it's, it's probably very difficult on him.

MV: Ummm. I'm new to the field. I'll have to stick with therapist. I think it's probably the most rewarding area, or else I wouldn't have been interested in it four or five years ago, just doing Undergraduate research.

FV: I think you're right.

MV: Uh, I was thinking in perspective on what you did and it's for improvement, umm, yeah, that's basically it.

MV: Okay. Well, this is sort of in conclusion. I want to thank you all very much. Umm, I think in putting this project together, one of the things that I was most excited about, even though it was probably the smaller part of the research, was doing this, sitting down with people and hearing what they have to say. Umm, not prompting them, not leading people, umm, I mean, just listening to what you've shared, you know, today and the experiences you've talked about and how candid and open you've been. Umm, uh, first of all, I appreciate it, in terms of the research, I appreciate personally, as well and think that, uh, I mean, it goes a long way to really increasing the value of this research project.

MV: I think someone wants us out of here.

V's: (laughter)

MV: So, so, thank you very much for your time.

FV: Yeah, it was great.

MV: And your thoughts and, umm, it is most appreciated.

FOCUS GROUP 2 TRANSCRIPT (ATSA Conference, 1996)

Legend: FV Female Voice
 MV Male Voice
 V's Voices
 ** Anonymous

- MV: Yesterday evening and again today we are conducting Focus Groups to, uh, help supplement a study that we're doing looking at the experience of providing sex offender treatment, on clinicians. This survey was sent out to The Association for the Treatment of Sexual Abusers (ATSA) members, and is looking at a range of measures of impact, gathering quantitative data. We also wanted to try and get some qualitative information, the flavor for, you know, what people's experiences are, where we're not directing with the questions or guiding them, in terms of what the areas that are important to look at might be. Umm, we're audio-taping the group and the reason that we do that is that, that the group information ends up being the data. And, so what we'll be doing is, we're going to be, ah, transcribing the audio tapes and look at these transcripts and from them, try and come up with different themes of what people have talked about. Umm, the audio tapes will be destroyed after they're transcribed and no one, besides the clinical team who is involved in the research project will have access to them, and the transcripts themselves will, umm, be anonymous. What we're looking at is doing a content analysis of the manuscripts, to be able to support or, or identify new areas that didn't get addressed, in terms, in the survey . . .
- MV: Okay, so the, umm, really there's just three main questions that I wanted to put out for discussion and, ah, and really try to play a pretty inactive role because the purpose a group like this is to learn from you and your experiences. And, I guess the first is just to get a sense of what the difficulties, what things make your work with sex offenders difficult, umm, then looking at 'what, what do you do to help you cope with the difficulties that are a part of that work' and, I guess, the final question is looking at, umm, 'what are the benefits of this work.' 'What are the things that make, you know, this kind of work worthwhile and keep people doing it'. So, I don't know if anyone, if you've got any questions about that.
- FV: I kind of assumed that that was what was going to be from the survey because I did get that, and went ahead and returned it.
- MV: Right, okay, good.
- MV: Well, I mean it's a small group. We had about six, umm, people yesterday, but the information they were able to provide us was quite incredible. So, I guess, maybe you can just start out with, just describe, 'what do you do, umm, where do you work, . . .' umm, 'how long have you worked with sex offenders, umm what's your position in handling sex offenders in your profession and, uh, just as way of introduction and then we can go into the questions.
- MV: Do you want to start?

MV: Okay. I'll start.

MV: Yeah.

MV: Umm, I'm a program specialist for a Justice Department and mostly, I work full-time. I work exclusively with sex offenders in a sex offender unit in, uh, in a medium security jail. Uh, we, uh, it's largely group, umm, intervention and, uh, (undecipherable, too much noise) a pretty predominant model. uh, supplemented by one-on-one, uh, to enhance the group but also, some, sometimes little skill building, if necessary. I've been doing that, uh, through both in the community and, uh, institutions for about ten years and that's largely the group I work with and, uh, this is, I rolled into this field after having worked with domestic violence as a special. Is that . . . ?

FV: Um humm.

MV: Yeah, yeah, no. That's good, yeah, that's great.

FV: Umm, well, I'm pretty new in the field. I worked for about 15 months. Umm, I'm a psychologist, so I worked for about 15 months with adult incarcerated sex offenders doing a purely instructional Relapse Prevention program. Umm, and then, I'm just, in the past two months taken a new position with a local (group ?) child abuse prevention centre and I'd be working with, umm, (sigh) the title is Abuse Reactive. but we're also looking at the ASO . . . population, the younger, you know, whole realm of youth, . . .

MV: Um humm.

FV: you know, 7 to 17, 4 to 17, whatever, but I've just done a few assessments, but it's a brand new program. It's just getting off its' feet, so . . .

MV: Okay, good.

FV: (Clears throat) I've worked with adult sex offenders at Exchange Scan in Winston, South and North Carolina, and that's a Non-For-Profit agency. I work as a therapist there and also, as the Case Manager, and I've been doing this for about six years and I come from a background of, uh, classroom teacher, Assistant Principal, Career Planner, kind of . . .

MV: Is there anyone else in your, in your agency that does work with sex offenders, or are you . . .

FV: No. I'm it.

FV: Well, ** has come to our agency, . . .

MV: Okay.

FV: Although we have, we have four groups of male sex offenders and we have one After Care Group. Really, we have five groups. Uh, the four groups that we have of the regular treatment sex offenders usually has from 10-12 members at any given time. And the After Care Group is usually, maybe 3-5. It's something like that, not really a great number of them. And we have a Companion Group for the

spouses and significant others of the men who are in treatment, and that is run by a person who is in private practice and who is under contract to us to do those groups for us . . .

MV: Right.

FV: every other week.

FV: And she's the one. she's the one who's going to be working with the. uh, uh. Abuse Reactive Group. but, before that time, I was the . . .

MV: Okay.

FV: sex offender program.

FV: And I work in a community program, uh, but we also do programming in, uh, two of the federal institutions, a minimum and maximum that are connected to each other, and I've been doing some form of sexual offending, I guess, treatment for 10 to 15 years. I started off in child abuse work with the. uh, non-offending parents and kids and then, moved on to the offenders.

Whisper: Okay. Good.

MV: Thanks. So, a range, in terms of experience, I mean, where you worked and so, that's good, but I guess the first question is, is really, uh, it'll be interesting because you have a different amount of time with these guys (laugh).

FV: Yes.

MV: Uh, What have you found, or what are you beginning to find that makes doing this work difficult for you, or, or a challenge, or things about the work that are stressful?

FV: Hummph.

FV: My biggest challenge, I think with, uh, experience of working with inmates was being a female in a correctional institution and it wasn't just the inmates because it's North Carolina (laughter), the real Southern mentality. I'm sure all, but then you get the good ole boy network and the Southern network and that was a real challenge. Umm, that was the biggest challenge and that was also probably the biggest, umm, catalyst for me looking for something else, out of the prison system. It was more of a challenge working with the administration as a woman, than it was working with rapists and child molesters.

FV: Not giving you credibility, or . . .

FV: Yeah, just, yeah, total disrespect for women.

FV: Um humm.

FV: They totally perpetuate the whole thing, that you're in there trying to change a lot, the cognitive distortions of inmates, and the people who are supervising them on a 24-hour basis are perpetuating it, and right in front of them and with you right beside them.

FV: Um humm.

FV: And, it was just not a good environment to work in as a female. That was my biggest challenge really, in the whole thing because I enjoyed what I did. I really felt like, you know, I was that nice ideal. I was making a difference.

FV: Um humm. Right.

FV: But, you know, I saw some good results and I saw some bad, you know, results. I had a few worries that I was teaching a few guys to go out and do it better and that, but that I was helping a few guys to really make a lasting behavior change. So, I felt real good about what I was doing, but it was just fighting that uphill battle of being a female or woman in a correctional institution and having some sort of, uh, respect for being there. That was really hard.

MV: Thanks.

FV: I think one of my biggest challenges has been trying to get the judiciary system to recognize what our needs are, what we need from them in order to do the very best job that we can. I guess, maybe in a sense, I've avoided some of the stereotypical kind of behavior that ** had to experience because of my boss, who is also a male. But, it's that as people want to approach him with things that were connected to our sex offence, sexual offender treatment program, he would say "You need to run that by Dorothy. You need to talk to Dorothy about that".

MV &

FV: Um humm.

FV: That's our area of expertise and he just sort of kept turning them in that direction, so, I think that helped me to get by a lot of this because they recognized this is, we have to go this . . .

MV: Um humm.

FV: way to get what we need to go and so that has been really helpful. But, the biggest thing is trying to educate Probation, judges, A.D.A.'s and the D.A. and, uh, we've made a lot of progress, really. I feel that as judiciary systems go, we probably have one of the better working ones across the nation in working with us, in working with what we're trying to do. Because, we've got A.D.A.'s who will call and say "Dorothy, we've got this guy, I know he's going to Plea Bargain. We need to work with you to come up with a plan for him. That's what we need".

MV: Um humm.

FV: And, so that makes it really, you know, that makes it a lot better.

MV: I'm not going to say a lot that's different. Umm, the easiest part of my work is working with my clients and that's probably the most satisfying part of my work, but, uh, other than my immediate co-workers is very satisfying too, but the externalities are always, have always been the problem and it's, umm, every brick in our program, uh, has been put there laboriously and fought for and, uh, coming into the jail environment is a relatively new program, uh, that we have to start over again. It's the same story, moving from one agency to another and building it all over again and, uh, you don't. I don't think there've been any breakthroughs, people's concerns off slowly and exorably at the, and that's the approach, and just round, we seem to have taken, and gradually people have begrudged resources and, uh, that sounds kind of negative, but I think that's fairly accurate.

FV: Um humm.

MV: It's been a long, slow process of convincing fellow workers, uh, administrators that I'm working with people and there to be afforded good treatment. Uh, that, uh, the methodology we use, the techniques we use, take longer than a week.

FV: Um humm.

MV: Which is quite shocking in the correctional system.

FV: Absolutely. (laughter)

MV: You can do Anger Management in four days.

V's: (laughter)

MV: What do these guys need. Well, they need something to carry on in life and, uh, so it's not over. We've had a major riot recently and, uh, my Unit was virtually broken out, moved around. People were tortured by other prisoners. So, my job has been (a mess?) And I've been trying to piece it together again and because there's been this little hiatus, uh, all the old rejections have resurfaced from new management, old management and guards and, uh, the guards now have a perception of a lot more power than they did, so they're reasserting themselves. And you talk about Southern good 'ole boys (laugh), uh . . .

FV: (laughter)

MV: I think there are Southern good 'ole boys everywhere.

FV: (laughter)

MV: Even where it snows a lot.

V's: (laughter)

FV: I believe it.

MV: It gets a lot colder than it does here, I'll tell you.

V's: (laughter)

MV: But, it's just, uh, I think that's, you put your head down and do it again because, and this, we're starting at a better level than we were before and, I guess that's the hope I see is that the plateau and fight from is, is a lot more advantageous than the other ones, than the previous levels of, but, again, I mean, it's the same story, it's not in the client problem or issue, that's the, . . . These are behaviors we are dealing with. These are, these are human beings that are good for other things.

MV: Um humm.

FV: I think I have less concern about sort of administrative kind of issues, in that, it seems to work out somewhat than what people are describing (shuffle, noise). I think, sort of the hardest, periodically, it's not consistently, but is every so often having the sense of 'Oh my God, look at the responsibility that we have, I think, sort of hits me and, uh, can sort of, uh, you know, be overwhelming at times, not to the point of wanting to change jobs or quit or anything like that, and I think sometimes, I just view that as a healthy kind of thing, as well. It's not a, you know . . .

FV: Um humm.

FV: It's not a bad thing to remember that, but, uh, unlike what you're saying, I think sometimes it's the just the clients and the number of problems that they, uh, present with, you know, aside from their sexual offending behavior. We see a lot of people who have zero in most areas of their lives, uh, from livelihood to economics, to, you know, I mean, the whole, they don't have a hell of a lot. I mean, it's every once in awhile, it's that kind of, sort of despair over it.

FV: Um humm.

MV: Any other challenges, any other things that make your work difficult?

FV: Sometimes the spouses get in the way of treatment, while they really support, in some cases, they actually initiate the denial . . .

FV: Um humm.

FV: of their spouses and so that makes it really hard for us to work with them, with that a lot of times and I can see though that the beginning of the Companion Group has really helped a lot because we present some of the same kinds of materials to them that we present to the men, so that's really helpful when we find the spouses or girlfriends or whoever, who are willing to come to that group because we don't feel that we can, uh, require them to come since they themselves are secondary victims, in many cases, so we don't do that, but that too does, uh, present its' own set of problems sometimes. They're not overwhelming necessarily, but they're there and they are of course, blocks to treatment.

MV: Anything else? That's it?

MV: Well, I guess another external thing that effects us is cooperation and communication between agencies and sometimes that can be. it's a lot better now (clears throat), than it ever was. but, and it's improving but, there're still are setbacks sometimes, particularly in Child Welfare is not as forthcoming or

cooperative as you would expect. You know, people are, uh, working with, ah, parallel cases, in many cases. That can be quite frustrating, even when there's a grievance between agencies to help or share or whatever the (?) is and that's, uh, I mean, that's been a struggle all along and it doesn't just pertain to our area.

MV: Um humm.

MV: But, sometimes it can be demoralizing and more than difficult. Sometimes you relay important information in safety issues to some people who aren't discrete as they could be, as it might be, and we're not sure where our information is going, whether it crops up into cyberspace or whether it's utilized, and there's no feedback or there isn't, so . . .

MV: Um humm.

MV: that's a frustration.

MV: So, so with these different challenges or difficulties, whether they're, in terms of working with the inmates or responsibilities of the job or system issues, umm, do you have certain things that are important for you, uh, to be doing to keep yourself strong and to keep yourself, uh, healthy. Is that something you pay attention to, think about?

FV: I make certain that I have a whole total life that does not involve sex offender treatment.

FV: Um humm.

FV: Umm. I do things. I try to see at least, go to the opera at least once year, twice if I can make it and, uh, I take guitar lessons, things like that.

FV: This is a quiet group.

MV: And you're a quiet person.

V's: (laughter)

MV: Yeah. You're a quiet person.

FV: Well, since we have to, have to compete with the . . .

MV: Contend with . . .

FV: contend with the . . .

MV: the party . . .

FV: cocktail party . . .

V's: (laughter)

FV: Yeah, and I agree with that, as well. I mean, it's important to make sure there's something else in your life besides the job because the job can take up, uh, too many hours in a day and a week, and doing something that, uh, you like and it's just for yourself and staying away from, I mean, I don't think I could watch a program on child abuse or sexual abuse if my life depended on it sometimes.

FV: (light laughter)

FV: Yeah, it's inundated too.

FV: Yeah, don't want those . . .

FV: Yeah, the media . . .

FV: Yeah, just to have some separateness.

FV: That's true. Before I'd worked as, I'm the type of person that loves true life stories and true . . .

MV &

FV: (light laughter)

FV: to life books and then, after doing this, if we're watching TV one night and something in, just say 'No', whatever that comes on. I'm like, give me a break!

MV &

FV: (light laughter)

FV: Click, click, click, find something else. I think my husband's really thankful too, not to have to deal with true life issues.

MV: (chuckle)

FV: But, I'm a young mother of young children. So, it's not hard for me to have a separate life from work. When I'm gone at 4:30, a nice hour in the afternoon, that's pretty much it. That's really nice because there the, having a family is overwhelming and I like it that way.

FV: Is it hard not to take it home though, when you've got young kids?

FV: Uh . . .

FV: I mean, I've got a daughter.

- FV: Well, when I was, when I just started, I have two boys and so, umm, I'm just getting into the, you know, working with kids, which is where I want to be. That's where my passions have always been anyway. To be honest, when I went into my Internship with the Department of Corrections, the first thing I had to do was read every crime story of every sex offender in our area and that was almost 300. 290 some.
- MV: Hummph.
- FV: And you can imagine, it took me a long time. That was really hard. I took, I dreamt a lot at night about it and when it was almost one of those, you know, gave at the office all day, I don't have anything to do with this once I get home, so . . .
- FV: Um humm.
- FV: it did effect, it effected my marriage for just a little while, but just a short amount of time 'cause I realized what was going on and that was like . . .
- FV: Um humm.
- FV: I just went to my Intern Supervisor and said "I think this is a ridiculous task that you asked me to perform and, and it's really effected me", so we changed it, but that was, that was a real, it was uncomfortable. I was having really bad dreams, you know, of prisoners chasing me at night.
- FV: Um humm. Um humm.
- FV: That was an experience, but with children, it hasn't really bothered me. I haven't, my mind hasn't switched to that focus. It's been more, more, I've dealt more with rapists than with child molesters in the prison system. Where we were so, uh, running into my Day Care though and having the Day Care Director, "I know what you do now", and showing me a folder full of graphic pornography that a seven year old brought to school. It's like, and where was my son . . .
- FV: (chuckle)
- FV: when this was being passed around? Forget what I do, (laughter). Where was my son when this was being passed around. So, but that hasn't really effected me yet and that's nice. I'm appreciative. I hope I will keep it that way, but . . . I like to read a lot and I'm in the middle of studying for my license or exams, so that's also taking up a lot of my time, to not take it home with me.
- MV: So, other things, in terms of how you keep healthy, how you cope with the stresses of work.
- FV: Talking to people that, uh, that I work with.
- FV: Yeah.
- FV: You know, if there's something that you're worried about, particularly around a client, uh, if you feel that, you know, that you're missing something, just having something validated.

- FV: Um humm.
- FV: You know, talking about that and making sure that, uh, that you're getting grounded, or your instincts are maybe correct, or . . .
- FV: Um humm.
- FV: you're really out to lunch (chuckle), or just complaining and bitching.
- FV: Yeah.
- MV: Hummph.
- FV: That is a good, that is a good stress reliever because where I was working, it was just me.
- FV: Yeah.
- FV: It was real isolating and then, since I've worked here, it's just nice to share similar experiences and go 'Wow, I went through that too and I handled that in that way too (chuckle), and I'm not crazy (chuckle).
- FV: (low voice) I think it's really good to have debriefing.
- MV: Um humm. That's a real important piece.
- FV: I think so. I think it is.
- FV: (low voice) Yes.
- V's: Not really in isolation.
- FV: Like everyone is bringing up around here, you know, if you say what you do, you're a real 'room-silencer'.
- MV & FV: (laughter)
- FV: And, and it's nice to have somebody when you say what you do that nods their head and goes 'Yeah, I know, I understand', that laughs along with you or vents along with you, and doesn't just stand there and goes 'Oh, okay'.
- FV: This is probably the only cocktail party in America right now . . .
- V's: (laughter)
- FV: where you can say what you do and people are interested.
- V's: (laughter)

FV: Where the 'S' word is floating around very freely and everybody's face isn't turning red, and somebody's not . . . (undecipherable).

MV &

FV: (laughter)

FV: That's right.

MV: (laughter)

FV: I'm, I'm 27 and the church we go to seems to be a real elderly, you know, real small and they're trying to increase the younger population and so I was invited to the women's group and they're like, how do I say this without freaking out a roomful of church women.

MV &

FV: (laughter)

FV: You know, 75 years and older.

MV: You mumble.

MV: (laughter)

FV: Yeah, I was like, you know, well, I'm, I'm, I'm a psychologist and 'Oh, you know, who are you working with?'

MV: Hummph.

FV: Umm, I work in the prison system. 'Oh, really, you know, what type of prisoners do you work with?'. and I'm like, quit asking me questions.

MV &

FV: (laughter)

FV: You're not going to like my answers (chuckle).

FV: So, did you end up telling them?

FV: Yeah, I finally just said, 'I work with rapists and child molesters', and that was, they quit asking me questions after that.

MV: (laughter)

FV: It was kinda like, okay, on to the program.

LE &

FV: (laughter)

FV: We'll have a prayer now.

MV &

FV: (laughter)

FV: No. That's not true. They went on to ask me what I thought about the Chemical Castration law.

MV: Ohhhh (like a sigh).

FV: Um humm.

FV: So, I got on my little soap box for a little while and then they got real quiet and I told my husband, 'I think I used the 'S' word one too many times . . .

MV &

FV: (laughter)

FV: in church tonight'. But, that's another thing. I joke about it, so,

MV: Yeah.

FV: and that helps.

V's: (light laughter)

FV: Yeah.

MV: I find that, uh, after a day's work, like I find during work, I de-brief a lot and it's, I re-group. I really rely on co-workers to get rid of a lot of that stress and by making it, validating it, or repudiating it, uh, whatever is necessary and I find that very, very helpful, and I guess, that's one of the strings and strains of the field, where the type of work that we do is that there is at least one other person who always knows exactly what you're doing, if not, probably, what you're doing and, uh, any of those people are good to talk to and, uh, it could be a specific case, or it could be group today, or . . .

FV: Um humm.

MV: You know, the latest political mash of nations in the legislative and you get a sympathy from somebody hearing for one thing, but you also get somebody who can give you fairly accurate feedback and, uh .

..

FV: Um humm.

MV: which is really helpful in . . .

FV: Um humm.

MV: The other thing, I have a little cognitive trick that I play on myself which seems to work cause I'm about one-half hour out of town and the halfway mark is the perimeter highway around the city and, after about 15 minutes in my car, the first 15 minutes I allow myself to worry, agonize, beat myself up, feel bad about what happened at work today, if there's anything left after de-briefing, and then I try to restructure it, roughly around the perimeter highway . . .

FV: Um humm.

MV: and just like we teach our clients,

FV: Um humm.

MV: and it's the same process, exactly.

FV: Um humm.

MV: And, if necessary, I'll say it out loud because I'm alone in the car and I don't look too weird . . .

V's: (laughter)

MV: with that much traffic passing along.

V's: (laughter)

MV: And by the time I'm driving that last half of it, I'm thinking about what's for dinner, better still, what am I cooking, uh, uh, what am I doing tonight, uh, where are the kids going, uh . . .

FV: Um humm.

MV: and what ** has accomplished at work today. That kind of stuff. And, uh, I'm pretty normal by the time I get home.

FV: Um humm.

MV: And I'm more worried about having to paint the second bedroom than I am, . . .

MV &

FV: (laughter)

MV: whether there's a new piece of legislation going through in Ottawa and, uh, so, I mean, uh, I'm taking my own advice, I suppose, in some ways.

FV: Um humm. Um humm.

MV: It seems to work and your discussion about a separate life and, I wouldn't be caught dead watching something on TV that's about abuse. I wouldn't. Sorry. I, I'd leave. It's not, it's not. I put, I put my, I've given at the office, I guess.

FV: (laughter)

MV: And, uh, I, I don't want it to be and I don't talk about my work a great deal at home, although I do talk about it in very general terms, but, you know, you're not going to get into details throughout the family dinner table. You know, I think my kids were ten before they really understood what I did.

FV: Uh huh.

MV: Because they would be asked at school and they go 'Dad goes . . .

FV: To prison (laughter).

V's: (laughter)

MV: in circles.

MV: (laughter)

FV: A two year old, 'My Mommie's in prison'.

V's: (laughter)

FV: (now I'm on the Day Plan ?)

MV: You got special treatment this time.

FV: Yeah.

V's: (laughter)

MV: That's good. Well, maybe, sort of, lastly, I think a lot of times when people talk about working with sex offenders, I mean, we talk about things that are stressful or difficult, umm, and after some conversations, I mean the question is, I mean, why does anyone do this work when you hear, you know, all the different thing that can contribute to the stress or difficulties and, I guess, that's the last question maybe for the group is, umm, what are the satisfactions of doing this kind of work, what are the benefits, umm, why hang in there through some of the things you talked about.

FV: When I first started, I think I told myself I did it for the children and then, as I noticed that men were changing, uh, well, I guess, maybe even before I noticed that men were changing, I recognized that women were staying with these men who had committed these crimes, even against their own children, and if not against their own children, then against the children of their wife's. And then I say, well, I

do it for the women and then, when I notice that men are really changing, that lives were really changing and working with Family Services and child protective services and things, and seeing families get back together and hearing men talk about the quality of their lives, after they'd been through treatment and things like that, and then I say, I do it for the men, so I think, I think, really, I do it for the children, I do it for the spouses and I do it for the men so, I think, ultimately, I do it for humanity and that's a good feeling. Which brings me to another point, I also work with Habitat For Humanity because that too .

..

MV &

FV: Um humm.

FV: adds to that too. that's one of my diversions, as well.

MV: So, why do this, what are the satisfying . . .

V's: (laughter)

FV: I'll go next. Oh well, I mean, I mean, like I said, I'm new in it but I'm, I got into psychology for a lot of typical reasons when I was an Undergraduate and started reading. I did that syndrome of 'Oh, I'm that, my family was that, yeah, I'm . . .'

FV: (chuckle)

FV: 'I think I can change now'.

MV &

FV: (laughter)

FV: And then, when I got my Undergrad, it's like, what are you going to do, you know. I didn't want to do anything else. So I went on to Graduate School and, umm, decided to be Clinical Psychologist because I have always worked with children, I was the town babysitter and this and that and I just love, children are my passion. And, I decided that there's so many screwed up people out there that, if I started early enough, maybe there wouldn't be so many screwed up people out there. So, that's, umm, where I came from, never in a million years imagine I would be working with sex offenders. That fell into my lap through my Internship because D.O.C. pays for Internships and we were a young family and we needed money, so we ended up taking Internship, and that's the reason I chose Department of Corrections, was purely monetary and this area happens to focus on sex offenders. So, there I was and I did, I got into, I agree with it. I say my children are little experiments in . . .

FV: (chuckle)

FV: behaviorism and then, as I got into cognitive behaviorism, there was more experiments and that, and seeing how that works with relapse prevention. That was just a real interest for me. So, I kept going with it and got a lot of satisfaction out of just seeing one person actually process it and go, 'Okay, okay', you know, and they would see and they would change what they were saying and not even in front of me. When they would come back the next week, because of my Internship, it was once a week, then,

in my job, I did it, was every day. Umm, even they'd come back and they would reaffirm each other, you know. I heard him yesterday correcting so & so when they were saying such & such. ('Look at that broad!'), you know, they're no longer talking about this one woman who hangs out on her porch on the way to prison school every morning, so, . . .

MV: (chuckle)

FV: you know, it's like they're redirecting their focus, so that was good. But, umm, as I mentioned earlier, just my, my quality of life at home was my husband hated the fact that I worked with the prison system, as well as everything else, so, and I kept saying 'I want to work with children. I want to work with children. I want to work with children'. There's an ad in the paper for a counselor. It doesn't say anything else about it. I called up and 'Bam', they want a therapist to work with children and it just happens to be with children who are sex offending. Like there's this 'calling' out there for me.

FV: Exactly.

MV: Um humm. (chuckle)

FV: So here I still am. I'm just still enjoying it. I haven't, I haven't, I don't feel I've been in it long enough to feel burned out because of the clients. I always feel I'm burned out purely for external, I think it's maybe, though what I'm hearing, what I heard yesterday morning, for the outside world, having to show them, you know, that we're not, we're not weird because we want to do this and these people aren't, some are sick, some are truly psychotic, but some of them, you got to get down and then you can see they're still human beings so, I don't, I'm not, I haven't been burned out by the clientele yet. I'm still real inspired and real excited to be working with them so, it's purely (undecipherable) right now.

FV: Well, and that's kind of like some of the same reasons, uh, why it can be really frustrating and challenging, are some of the same reasons why I really like it.

FV: Yeah.

FV: Uh, you know, when I, it never ceases to amaze me and I think it's meant to make me, keep me humble. Uh, that these people who have had like mostly nothing, you know, and they can change . . .

FV: Um humm.

FV: And it does, it feels really good to see somebody . . .

Whisper: It does.

FV: Because, well, speaking for myself, I can become very attached, you know, to people and to see what they're doing and to support them in their change and, and, yeah, it's worth it. I don't think so much anymore about doing it for the victims, or, I mean, it's not even there so much in my face but, umm, but, yeah, it's, it's just seeing people change and really want to change.

FV: Yeah.

- FV: You know, that's, it's not, it's not, uh, false. And It's exciting.
- FV: Um humm.
- FV: You know.
- FV: It is.
- FV: There's, ah, ah, sometimes people talk about just, you know, all the negative media and the negative sort of, uh, attention maybe, you know, the sort of room-quietener.
- FV: Um humm.
- FV: But, there's also part of me, I think, that likes, that, I mean, you know, it's sort of like, yes, I do.
- FV: Uh huh.
- FV: So, what do you think about that?
- V's: (chuckle)
- FV: You know, what do you think of it (chuckle) and that's (close?). That's me.
- FV: That's true.
- FV: I haven't given up my rebellious stage yet.
- MV: I find the actual clinical work exciting. It's interesting work with interesting people. Ah, it brings a lot of challenges. The job has never, ever been remotely dull. But when I was doing a huge caseload, generic work, it wasn't dull but it was uninteresting because I couldn't get as much depth with more than a few of my clients.
- FV: Um humm.
- MV: And you have that small residual tenure going crazy with, enjoying the work and maybe getting somewhere with it. The rest, 'You're still living at the same place? Good'. You know, 'I'll check, I'll check to see if you're still attending school'. That would drive me, I have (all of that) stuff with my work like that and I find the intensity is healthy for me. I find working with fewer clients at a deeper level, longer, or at least more often, following things up clearly from where we left off, . . .
- FV's: Um humm.
- MV: uh, communicating at a different level and you can with a large case load, umm.
- FV: Um humm.

MV: It sort of, all those things you learned in school, you're doing, or many of them you're, you always get idealized cases when you're in training and, umm . . .

FV: Um humm.

MV: most of my cases were somewhat idealized, at least as far as what I'm able to do, you know. how far they get is another question.

FV: Um humm.

MV: But, the other thing I see, I get (silence/no sound) uh, there are disappointments. but even the disappointments we run across aren't necessarily awfully surprising.

FV: Um humm.

MV: Basically, they tend to be marginal . . .

FV: Um humm.

MV: really (devouredly ?) marginal cases that leave your program . . .

FV: Um humm.

MV: that tend to fail. Now, I can be wrong on that, tomorrow I'll read the paper when I get home . . .

V's: (laughter)

MV: umm, but, I mean . . .

FV: (low voice) I already, I stopped it there . . . ?

MV: I think it's the style of work, where you're working, very, you have to work colaborately with other people.

FV: Absolutely.

MV: You're, you're under scrutiny, you're, you have to be honest in your work.

FV: Um humm.

MV: You can't pretend . . .

FV: No.

MV: to be a worker but you're not. Umm, sharing with people, adapting new ideas. It tends to come at a higher, faster pace and it's not, you can do this style of work with perverts or drug addicts.

FV: Um humm.

MV: But, for now, this is where I am and I think it's the style, as much as anything.

FV: Um humm.

MV: I mean, I got into it because I began to advocate for sex offenders but I only had one or two on a general case load because they were getting no services, but I think what's kept me there is, uh, a lot of this, the effectiveness, I can feel, or I do with this style of work.

FV: Um humm.

MV: Umm. The kind of work relationships you get. I find it absolutely satisfactory. The faces come and go of co-workers but what stays the same is that, that style, it seems to click.

FV: You know what's challenging too, when you think about it, that we're really effecting the lives of children that haven't been born yet.

FV: Um humm.

FV: That's really, that's a part of the challenge is just knowing that we are, by trying to change the behavior now.

MV: Yeah.

FV: We're not perpetuating if they're really, if they're really changing so that's really exciting in itself.

FV: Um humm. With so many clients, I mean, do you see it that way too, you know that they're stopping this generation?

FV: Yeah.

FV: Hopefully.

FV: Um humm.

FV: You know, so that future ones are better off.

FV: Right.

FV: Um humm.

MV: Well, mindful of the, the time and it's, as I said, Friday evening approaching, or here. Umm, any last comments before we close off for, anything you'd like to make about the experience of doing this work

and what it's been like for you, so there's no, a last opportunity to say what you want to say (chuckle), what feels important to say.

FV: I would just say that it's a continuing education process, you know. I'm not the only one who's learning.

FV: Um humm.

FV: Whenever I'm doing something with these people, whether individual or group, they're not the only one that's learning.

FV: Yes.

FV: I'm not the only one teaching. Ya'll know what I'm trying to say.

FV: I know.

FV: I'm learning. I do. I've grown, even in this 15 months that, you know, some of my, none of my, what I think as my, you know, just real solid values, some of the ways I think about things, some of the ways I process and, umm, at, which is good, especially of course the label my generation gets, it's definitely good if some of us can change for the more positive (chuckle). But, I just, I, I grow along with these people and I think that's a really important thing about this field is to realize, and I see that in everybody so far that I've encountered here, really enjoys it, that they learn and grow with us.

FV: Um humm. Yeah, that's something (valid?).

FV: You know, it's definitely not a stagnating process.

MV: Um humm.

FV: No. I agree with that and I think the one thing that I would share with the group that ** already said, heard me say, of all the jobs that there are to do in my office, I'm doing the one I would most want to do.

FV: Um humm.

MV: Yeah.

FV: And that's such a good thing to be able to say, isn't it?

FV: Um humm.

FV: Yep.

FV: ** tells?

V's: (laughter)

MV: I think I agree with her as a (gross ?), that we shouldn't (heal ?). I think. I mean. I've been working over 20 years in depressions and, umm, I feel I'm a hell of a lot better worker now. than I was 3 years ago.

FV: Um humm.

MV: And. as opposed to five years ago.

MV: Umm.

MV: And, I think this, the kind of work we're doing demands your self-improvement, re-educating yourself constantly. It's insulting when people who, who have better information than you do on certain things and, uh . . .

FV: Um humm. Organizational, yes.

MV: asking for feedback. . . .

FV: Right.

MV: and getting it.

MV: Whether you like it, or not.

FV: Yeah. Right. Right.

FV: You know, that's true **.

MV: I mean. these are all things that help you grow.

FV: Um humm. That's right.

MV: I mean, I see colleagues who streamed off into major backwaters and that are doing exactly the same work that they did . . .

FV: Yeah.

MV: when, when they both, we all came in and that's, that's rusting . . .

FV: Right.

MV: and they suffer for it.

FV: Um humm.

- MV: They're, they're not excited about their work. You know, Monday isn't the worst day . . .
- V's: Ohhhh . . . (chuckles)
- FV: I go to, I sometimes go to my office and work on Saturdays because I may have that time, but never mind the fact that I'm going to make sure that I have the time to look after myself. But if I have things that need to be done, I will do them on Saturday so that I'm ready by Monday morning and then I feel more relaxed when I go in to do it. So, I don't mind doing that. I don't feel that I'm cheating myself out of anything. I'm just doing something that's going to make me perform better on the other side and do a better job, knowing that I still have, I have, uh, the time to do it. I need to do for me.
- MV: But, you pace yourself. You . . .
- FV: Absolutely.
- MV: consciously, . . .
- MV: Um humm.
- MV: consciously pacing.
- FV: Absolutely. It's a choice I'm making to do that.
- V's: Yeah. Yeah.
- MV: I don't know whether it's I'm getting old or older or not, but I find myself very consciously pacing. I can't . . .
- FV: Absolutely.
- MV: You know, it's like double group day and it's been horrendous. I de-brief and I do something nice that evening, or I relax or watch mindless TV, read a book, uh, get a little exercise. It's, and I don't kill myself the next morning. I try and set my schedule up with some . . . (fillers or lights?).
- FV: Um humm.
- MV: And, ah, you know, for every calorie I burn badly, I make sure I consume one too, well . . .
- FV: You sound very parallel to the way I handle that situation.
- MV: And it's self-interest, for sure.
- FV: Absolutely.
- FV: Um humm, which is necessary.

MV: Um humm. Handling it, which is what this is all about.

FV: (laughter)

MV: So, I just . . .

FV: Did we pass the test?

MV: Yeah. How about that?

FV's: (chuckles)

MV: But, I would just really like to thank you again. I mean, ah . . .

FV: Sure.

MV: it was a small group but, you have had a. a tremendous amount of. I think, important information to share and I think it's gonna', ah, help considerably in, in developing, the research that, that we're doing. And, I think we want to look at a whole range of things, to be able to look at what does this mean, in terms of, training and developing training programs. We want to be able to talk about what does this mean, in terms of how supervisors, a program is supervised meet the needs of clinicians, ah, and, umm, what are the needs of people who work with sex offenders and what do clinicians need to be aware of, ah . . .

FV: Um humm.

MV: You're looking at how people in this job can take care of themselves and I think you can given just tremendous information, and I thank you for that.

V's: Your welcome!

MV: Yeah.

FV: Thank you for giving us this opportunity. It was good to share.

FV: Yeah. It was.

V's: Yeah. Yeah. Yeah.

MV: Yeah.

MV: It was nice meeting you.

MV: Me too.

FV: Yes. Thank you.

Appendix H

Qualitative Data Sotps

STRESSORS

Offender Related

As a sex offender treatment specialist I work with both adult and adolescent offenders. I have found that each age group population has its own pros and cons which it offers to the clinician. While adolescents are intrinsically a more "hopeful" population (i.e., offering the greatest opportunity for successful change) they are the more demanding and stressful cliental. Adult offender generally exhibit a greater level of maturity and motivation to change their offensive behaviours but are often faced with identifying and addressing patterns which have been ingrained for tens of years.

I have found that every so often I have a client who is dangerous and angry at me (e.g., for reporting him to CAS etc.) who has made me and my family feel threatened. this is very difficult to cope with when it occurs. These occasions are periodic buy very difficult to cope with. At these times the support of colleagues is good but does little to reduce this stress because one can not "talk away" or restructure the way one looks at a threat to ones children for example. Though rare, these events have me seriously considering a change in career either to a more administrative function or a different population entirely.

The hardest thing is overcoming their resistance and developing the empathy needed to succeed.

One of the most challenging and frustrating part of my work is the clients lack of empathy for their victims.

The population served is important. My caseload are adolescents who are low functioning, it makes a **d**ifference.

The level of offender self-report and/or denial is a source of stress in my work with sex offenders.

Much of my stress comes from the relationship in therapy with the offender.

I don't feel I have a system to treatment rapist-pedophiles or sadistic sex offenders.

I work alot with families which is a significant source of stress in my working with juvenile sex offenders. In fact dealing with resistant families is the most stressful part of my clinical practice.

Concern about offenders in the community is a source os stress.

At times my discomfort with the population creates a source of stress.

Working with an incarcerated client is more difficult than treatment on the streets

My practice also includes work with men who are survivors of childhood sexual abuse which contributes to job stress and vicarious trauma.

Recidivism/efficacy of treatment

I do struggle with a sense of frustration and failure when one of our clients re-offends

My highest stress is always rears of a re-offense.

I feel I have been successful in treatment my clients but this can't be verified until my clients have died and never re-offended. In constantly hearing in the media about how treatment of sexual offenders isn't effective.

Stress for me is primarily related to the risk of reoffending.

Organizational

Dealing with the administration and being overworked has been a very stressful part of my work.

The actual work with clients tends to energize me - the work with bureaucrats drains me.

Organizational politics are awful and have led to my decision to work at a different organization.

My work problems are not related to inmates/offender but to organizational issues.

Most of the stress I experience is more related to administrative and political policies than to treatment itself.

It is important to note that job frustration Mainly comes from organizational politics rather than the actual work.

Most of my stress comes form conflicts with some of my colleagues. You need to be very healthy mentally and alert to work with sex offenders. You need to work as a team and capable of humility. Problems include: competition, feelings of being threatened by knowledge of others, feelings of superiority.

State agencies are more concerned with bureaucratic processes and CYA rather then provide good quality treatment.

Last summer I was out on stress leave for 2 months related to the bureaucracy.

Paperwork

The burnout that I experience has little do to with my interactions with clients and everything to do with the overwhelming amount of paperwork that goes along with the job.

System Issues

Working with the authorities, probation officers, parole officers etc. has caused me to decide not to work with this population as a treatment provider. The community climate is hostile, civil liberties and human dignity have lost meaning and I can no longer and will no longer participate in a system which has come to demand that I violate personal and professional ethics. I have long supported sex offender rehabilitation and have been very active in bringing funding and legislative support for treatment I have grown tired of the battle and am ready to

turn my efforts more to writing research etc. The day to day battles with authorities to protect the right to provide treatment rather than act solely as a social control agent have been depleting.

Most frustrating are the political consultants and lack of knowledge by professionals outside of this field such as legislature, police, case managers, other agencies, physicians and inexperienced therapists, judges etc. A major impediment in dealing with inmates who are ready for parole but are not paroled because of political agendas

My biggest stresses are the occasional incompetent probation officer and uninformed directors of corrections departments.

Right now, the most stressful aspect of treating sex offenders are all the bureaucratic requirements associated with our new state (Colorado) standards and the lack of funding available for offender treatment. Also if your program is the least bit innovative and does not just fit into the standards, you are subject to extra scrutiny, even if you meet all the stated requirements. Being forced to do "cookie cutter" therapy seems bad for clients and clinicians.

Some of the most frustrating and destructive factors in the treatment of sex offenders are the defense attorneys. They often distort the truth and care little about truth or treatment

The stress I experience is not from the offenders (they are supposed to behave that way). Most stress comes from the "system" including but not limited to attorneys, probation and other providers of treatment who are untrained treating and assessing this population.

New law that mandate automatic remand to adult system for offender over 15 with lengthy minimum sentences has sent offender and their parents into hiding and fewer are getting into treatment services but rather sitting in limbo with adult system lawyers trying to get them off the hook (e.g., Measure 11 in Oregon)

Much of the problems I experience with sexual offenders arises from the perception of the society at large and prosecutors who use societal hysteria to achieve what seem to be political ends (e.g., higher conviction rates, longer sentences for those who admit what they've done and by virtue of their admission present as more positive candidates for treatment. Much More of the stress now is experienced through bureaucratic or political issues.

Most of my stress comes from the court and defense attorney misunderstanding treatment

Social Stigma/perception

I have felt misunderstood by others because of my choice to working in sex offenders.

Possibly the most difficult part about working with this population is that this population is so unpopular. Society in general does not understand what, or why, we do in treatment with offenders.

I am concerned with how others react to the general publics non-approval of therapists working with sex offenders. In texas the attitude is jail and throw away the key. When a person learns what I do the usual response is "oh shit, how can you do that?" followed by them stepping backward step or two. I feel they are afraid I am contaminated and it might rub off on them.

I experience stress from interaction with a very punitive justice system, public perception of the various of sex offender work. Punishment vs therapy sort of duel. Lock em all up vs coddling sex offenders, cure vs effective treatment.

The push by insurance companies and the public to practice short term brief therapy with offenders is constant.

Social attitudes towards sex offenders has changed over the last few years. It is harder for y clients to get jobs, places to live. etc.. This adds some stress to my work.

Practice Issues

My stress had improved. For 10 years I ran a weekly treatment groups encountering high stress. Now I supervise and consult around the group encountering much less stress The break from directs services is helpful.

I am much more stressed by administering Sex offender programs and working in a prison than by treatment sex offenders

Treatment Programming

One of the most frustrating experiences for me as a sex offender therapist is the lack of resources for aftercare for this population. This is particularly so for juvenile offenders who after lengthy treatment in a structured artificial environment have no where to go and many end up going back to families when it is recommended that these are not good places for them.

The follow up services are typically of deep concern to me. The continuum of care simply does not exist well enough or often enough to suit me. This ultimately places people at risk for sexual victimization.

I work with a group of sex offenders in an 8 month treatment program 16 members. At times this can be very stressful at times less so depending on the intensity demanded in the treatment programs content (i.e., empathy training and interpersonal confrontation).

Therapist Related

Waking up and worrying about clients who are of concern.

The high amount of turn over/burnout rate of staff working with sexual offenders

Qualifications

I fail to understand therapists who say they know how to work with this population when they actually do not. I currently have a patient who was working with another therapist for over two years and during that time he reoffended on several occasions. When he finally reached my office he was weeks away from sentencing. I began to ask him about his sexual history, fantasies, triggers etc. This was all alien to him.

There are "therapists" in the community who "treat" sex offender clients and have not training, do not believe treatment works and continue to waste clients time and money.

Most of the frustration is dealing with systems and others who proclaim expertise in this field but do not have a clue.

My main problem is that the agencies are referring sex offenders to treatment with psychologists and therapists that have no formal training in specific sex offender issues. They are not aware of the responsibility said case loads represent and they do not work with authorities for follow up.

Isolation

I believe that the greatest stress to me is the lack of cooperation/coordination with other helpers in the community involved with offenders.

I work in a very isolated, rural area and began all sex offender treatment here. I have no professional supervision/consultation except bi-monthly professional meetings.

I lack anyone to discuss cases with as i am in a very rural area and am the only sex offender therapist.

I don't know how anybody could do this work in isolation without a supportive team

I operate in a semi rural area and am the only provider with a structured program in the entire area. Sometimes this does create a since of isolation.

Training/Development

I just don't have enough time to read and ponder information.

I can't afford t come to the ATSA Convention and have a great desire to do so.

Privatization of treatment programs have made it impossible for therapists to be hones or speak up about real issues for fear of losing their jobs. Supervision the has become inadequate and meaningless. As result there is little onsite support or supervision.

Most of my stress from this work comes from supervising employees, not offender work.

Funding

We receive no outside funding for treatment, court ordered fee for service only, limits service.

Politics and money have made it difficult to provide adequate care as the mental health issues of sex offenders toes unaddressed

In 1997 our budget was cut 1/3 . I get letters every month from incarcerated offenders who need treatment to achieve parole. I can't tell them we have an ongoing program. It is frustrating.

No therapists I know are paid enough, though some administrators do pretty well.

My biggest frustration is that the politicians who control funding are only willing to use our tax money to build

more jails and bootcamps rather than for treatment. For example, I work/consult at a youth Detention Centre which houses about 30–40 adolescents sex offenders. I provide group treatment. Unfortunately due to the lack of funding I am only able to provide one 2 hour group per week. I realize that this is inadequate. Does that mean I should quit? I don't have an answer. At this point I'm either depressed or pissed off.

The majority of the stress and dissatisfaction I experience is related to the inadequacy of programs due to the lack of available funding.

The constant amount of bureaucratic paperwork required for funding, especially medicaid, is overwhelming.

Other/General

An issue that is extremely stressful is the litigation associated with working with this cliental.

I would find my job much more enjoyable had I more leeway for research or other career development activities.

My stress comes form reoffense risk in outpatient community based treatment program, feeling victim pain/impact day after day, constant anger from sex offender clients, threats of lawsuits, truing to make a living in private practice.

Biggest problems: dealing with non-offending spouses failure of agencies to recognize adequate from inadequate services and to understand that for every hour of direct contact there is another 3 to 4 hours of meetings, listening to tapes, grading homework etc., incompetent and untrained therapists treating sex offenders, failure of the legal / judicial system to look at cases objectively and apply sanctions when necessary, totally inadequate response of the juvenile justice system to juvenile offenders.

The lack of research and bad research that doe not seem to give direction to our practice is a major problem.

IMPACT

Sexual relationship

To do this level o f intensive work requires that the therapist become desensitized to explicit sexual material and can affect ones own sexuality and relationships after doing the work for many years.

This work can affect the therapists sex life and marriage in general.

I feel there is a companion risk in personal sexuality.

Sexual reaction/response to this work can relate to both burnout as well as other personal effects of this type of work.

Working with sex offenders takes its toll on my own sexual desires. Sometimes the deeds the men did will intrude at a moment of intimacy and I am unable to find pleasure and have to stop. Sometimes I find myself thinking about the pain they have caused and the pleasure I have and they get twisted together.

Emotional

For two years I worked entirely with sex offenders, adults and juveniles, as well as their families. I will never do that again. Working with sexual offenders introduced me to crap I wish I would never hear of. If I would have known how it was going to affect me personally I wouldn't have entered the field. You lose your innocence about life.

I struggle most with not becoming cynical of other people's motives outside this special population.

Parenting/children

I am much more paranoid about issues such as level of supervision and children birthday parties in community settings than I was before working with sex offenders.

The most difficult aspect of working with sex offenders is looking at children through their eyes. I no longer have the ability to look at children as purely as I once did. Innocent childish behaviour can now be seen through the lenses of a sexually deviant person. I hate that part of this work.

While having children has contributed to my understanding of the potential impact towards physically/sexually victimized children and their caregivers and correspondingly contributed to my attempts at becoming more thorough in treating sex offenders, I also believe that working with offenders has contributed to occasional preoccupation of my family's safety, unwarranted suspicions towards offenders whom assault children and perhaps harshness in my assessment of offenders whom have a history of, or appear to be, potentially vengeful. In addition, assessment interviews/treatment sessions with particularly angry/dangerous offenders and

these feelings subside. Over time, I have noticed that my concerns of becoming overprotective have become easily outweighed by the sense of security I feel while taking the extra precautions to address these concerns.

SUPPORTS TO ASSIST IN COPING WITH STRESSORS

What helps me deal with stress and to survive and to do a good job working with sex offenders is exercise, prayer, a supportive family, friendships, colleagues, regular time off, other interests, respect in the community, reasonable income and a realistic believe about what I can do and remembering who has the problem (e.g., the sex offender), if he doesn't progress.

Diversification

My passion for sex offender treatment channels me in different directions within this field.

I have a good work environment and love working with the spouses, couples and families of our offenders. I also teach at local university which helps me stay balanced and challenged

I combine training, supervision, therapy and research as part of my profession.

I feel that a sex offender treatment provider should strive to combine his/her practice to include both adolescent and adult perpetrators. This provides both perspectives and variation and ultimately lessens stress.

Private practice allows me the opportunity to conduct research which helps to recharge my batteries.

Attitudes Towards Work/Clients

I see my clients as people who have done a monstrous thing not as monsters themselves. This attitude allow me to connect with clients at a level which allows me to have a positive impact.

I found that having victim contact and focusing on the victim needs in the treatment of the offender has been the best way to maintain a healthy perspective.

Support People

My support system is co-workers, agency support and first and foremost my family.

I have had some difficult experiences with sex offenders. The work time I had was when a sex offender I was seeing killed two children. I almost quit working at the time. However, I had a lot of support from the others on the team. If I have learned anything about sex offenders, it is to always be part of a treatment team.

I am very fortunate to have the support of my co-facilitator and members of my therapy team from the outset of my practice.

Practice/Clients

We do not knowingly accept rapists or anyone into treatment who has a violent history.

Being able to make choices about my time and level of involvement with direct client services helps to manage my work.

I refuse to see aggressive offenders on an outpatient basis if I regard them as high risk, which they typically are.

I think doctors, due to the structure of their discipline, are better able over time to set boundaries. I can provide therapy and medication but the real work must come from the patient. If he is unwilling, I do not perceive that as being a failure on my part.

Needing to find a way to process all the "dirt" we are presented is of great importance.

Going into private practice has helped to deal with the stress as there is decreased political turmoil to contribute to overload.

I do better when I do not have contact with the victims.

Personal Issues/Therapy

Dealing with my own issues and traumas has assisted me to deal with stressors in this work.

If you are mostly satisfied in your personal social and marital life chances are you will have a positive attitude at work

Experience

After 13 years I no longer experience the anxiety that was present when I began to deal with sexual offenders. I feel much more seasoned as an experienced therapist generally and particularly with sex offenders, having developed a good theoretical foundation for evaluation and treatment at work

REWARDS POSITIVE ASPECTS OF WORK

I have been working with sexual offenders for 10 years, and still enjoy the challenge. but, I have paid a price.

Altruistic

I really like my work. I find it brings helpfulness (some men really do transform their lives in positive ways, and it is a variable reinforcement schedule) and helps me fulfil gods call to social action and better my community by lowering the potential for new victims, this week.

I really enjoy my work, feel we are highly successful in facilitating clients recovery and protecting the community, and don't really want to work with any other populations.

Client Change

I think professionally the work I do with offenders is extremely gratifying when they choose to 'become' someone new when they struggle and the own their deviance and control it.

The thing I like best about my work with the sex offenders is that I get to see them complete treatment.

I have felt tremendous satisfaction for the work I have done with adolescent sex offenders. Despite the struggles and frustrations inherent in the work I enjoy the challenges that arise. It seems that every youth in the program presents at least one redeeming quality which makes it possible to see past the abuser to the child that can be helped.

Calling

I enjoy the work and have felt a sense of mission and a calling to do this work.

It helps me fulfil gods call to social action

Rewarding, Intersitng, Challenging

I am well trained and find my work rewarding.

The work with offenders is rewarding and interesting.

I find this population provides work that is challenging, interesting, rewarding and yes, even fun.

I really enjoy this work. It is challenging and worlds away from traditional therapies.

Working with sex offenders is very regarding as it helps making society safety and helps the client in dealing with his/her own traumatic past.

The work is quite rewarding as a direct function of the challenge.

General

I love my work and will continue to find ways to stay alive

IMPORTANCE OF RESEARCH

Very much needed!

Glad to see this topic being researched s I have often felt misunderstood by others in the community regarding the type of work I do.

This type of research may help me learn to better take care of myself.

Made me thing of my own mental health.

I appreciated taking this survey. I started to think that perhaps some of my withdrawal from others irritability and sleep problems may be related. It's been a big adjustment working with sex offenders, particularly in a prison.

I am thankful that someone is looking at the difficulties and rewards of working with sex offenders as most clinical organization do not possess a clear understanding, or for many even a clue, of what it is like to work with this population. I am always interested in learning how others working with this population manage their own lives. I believe that many therapists are not honest about how working with sex offenders has an impact on their personal lives.

I am glad that someone recognises the stress that this intervention creates but getting administrators to understand is the bigger problem.

I believe that this attempt at assessing treatment provider stress, burnout, depression etc is a long overdue one.

Very important issues for providers to consider for themselves

Finally, someone is asking these questions.

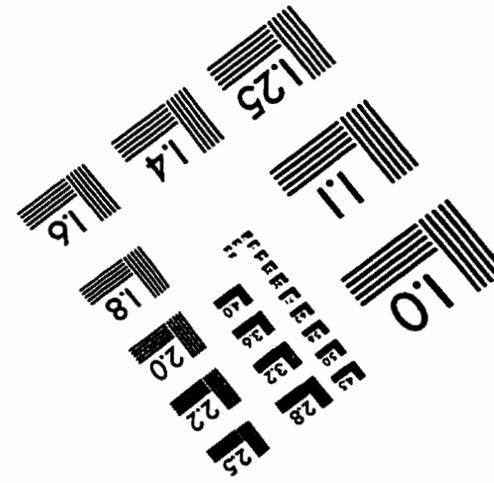
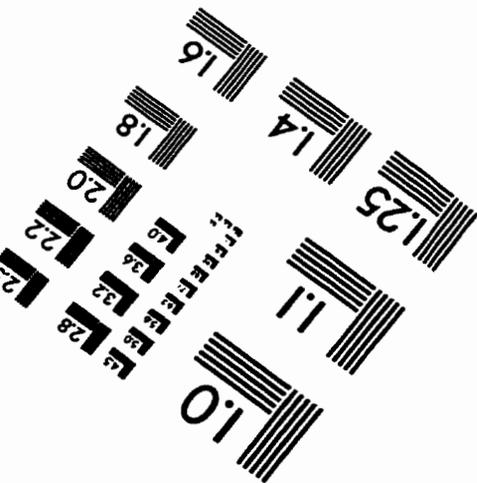
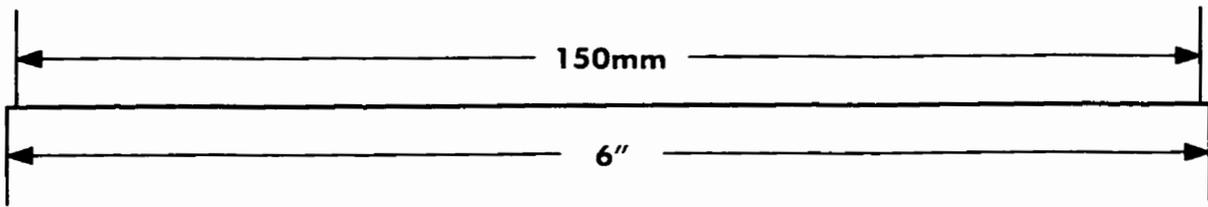
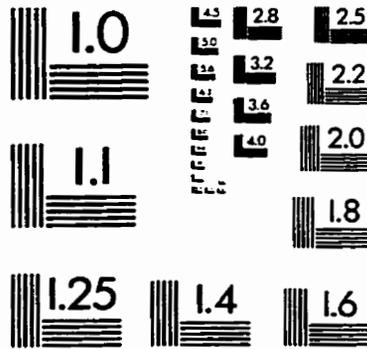
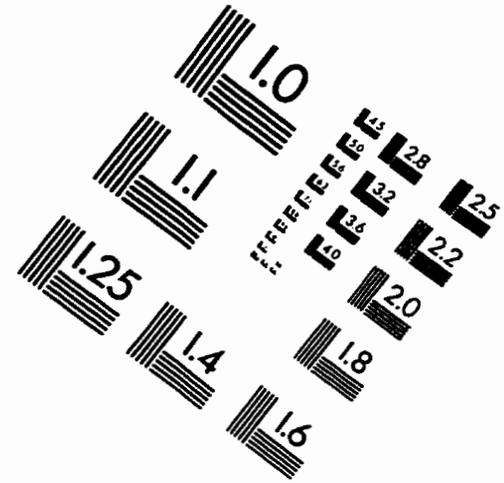
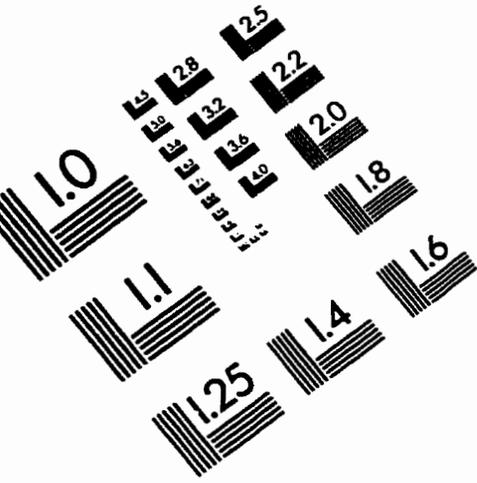
These questions got me to thinking about how important therapist self-care is since I find myself depressed frequently.

The survey was helpful for made to heighten my awareness of possible "warning signs" but also aware of my best preventers of burnout.

I believe I am probably on the edge of burnout and this is a very worthwhile project you are undertaking.

The survey was a wonderful opportunity for self assessment.

IMAGE EVALUATION TEST TARGET (QA-3)



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