VICARIOUS TRAUMATIZATION

The Impact on Therapists Who Work With Sexual Offenders

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This article reviews the descriptive and empirical literature examining vicarious traumatization in therapists treating sexual offenders. Vicarious traumatization in sexual offender therapists is described, including an examination of the relationships between vicarious traumatization and client, therapist, and setting and therapy characteristics. Special attention is given to those unique factors that contribute to the development of vicarious traumatization in this group, as well as consideration of why therapists treating offenders or victims may differ in their experience and development of vicarious traumatization. Evidence from the research reviewed suggests that sexual offender therapists do experience symptoms of vicarious traumatization. Factors most strongly associated with the development of vicarious traumatization in sexual offender therapists include professional experience, treatment setting, and coping strategies employed by the therapists. Implications and recommendations for professionals and policymakers are discussed.

Key words: *sexual offenders; vicarious traumatization; occupational stress; secondary trauma; therapists*

INDIVIDUALS WORKING IN caring professions are among the occupational groups identified as being at high risk of work stress (Smith, Brice, Collins, Matthews, & McNamara, 2000). In fact, employees of the National Health Service reported greater occupational stress and minor psychiatric disturbance than did other job groups in the United Kingdom (Wall et al., 1997). The task of working with people who have experienced physical or emotional harm can be challenging, and some research has suggested that this experience extends to those providing treatment to perpetrators of abuse as well. Despite extensive research investigating the effects of traumatic exposure on therapists who work with victims of sexual abuse, there is limited empirical literature on the impact on those working with abusers. This article reviews the literature examining the impact on those who work with sexual abusers. The purpose of the article is to describe the experience of therapists working with sexual abusers and consider why the phenomenon in this population is different from other care professionals. A second goal is to address what factors are related and contribute to the development of traumatic reactions in this group of therapists.

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KEY POINTS OF THE RESEARCH REVIEW

- Two theories provide a framework within which to understand VT responses in sexual offenders: Constructivist Self-Development Theory (McCann & Pearlman, 1990) and Phases of Impact Theory (Farrenkopf, 1992).
- Some factors thought to be related to VT in sexual offender therapists were not supported, including the presence of one's own personal trauma history, high proportions of trauma-related cases, and the treatment modality or type.
- Qualitative analyses suggest that sexual offender therapists do experience symptoms consistent with a description of VT. Although estimates vary, a meaningful proportion of therapists describe intrusion, avoidance, and hyperarousal. Specific examples include intrusive thoughts, avoidance behaviors (e.g., alcohol abuse), suspiciousness of self and others, hypervigilence, and various psychological correlates (e.g., depression, anxiety, and irritability/frustration).
- Specific factors were associated with descriptions of VT in sexual offender therapists:
  - Mixed findings were reported for the relationship between therapist professional experience and symptoms of VT. However, one study noted an interaction such that those with the least and most amount of experience as measured by years treating sexual offenders were most at risk for VT.
  - Coping seems to play an important role, although the findings are somewhat surprising. Numerous studies conclude that positive coping (e.g., support, self-care, exercise) mitigates the negative effects of trauma work. However, other research suggests that both positive and negative (e.g., alcohol abuse, pornography use) coping are related to increased symptoms of VT.
  - Secure settings (e.g., prisons and secure hospital units) are associated with greater VT, compared with less secure and community settings, which may be a product of the hardened environment, isolation, or dangerousness of the client population.

THE THERAPIST'S EXPERIENCE OF CLIENT TRAUMA

Effects of trauma exposure were first observed in the late 1970s in emergency and rescue workers who displayed symptoms similar to the trauma victims they helped. This phenomenon of the transfer of trauma prompted investigation of individuals working with victims in various capacities, such as disaster relief workers, nurses and physicians, and crisis and hotline workers (Alexander & Atcheson, 1998; Follette, Polusny, & Milbeck, 1994; Lyon, 1993). An important distinction arose from the study of working with trauma such that the type of reaction depended on the nature of exposure (Stamm, 1995). Those working with acute trauma, such as emergency and rescue workers, were exposed to the trauma directly; this has been described as primary trauma. People working with or supporting those who had been traumatized, such as therapists and family members, were affected by the trauma indirectly; this was defined as secondary trauma (J. T. Mitchell & Everly, 1995).

In 1995, Stamm published a review of the literature examining the impact on therapists of working with traumatized clients. She commented that the issue was not whether such a phenomenon existed but what it would be called. Although there is no consistently used term, the most common labels to describe secondary trauma include compassion fatigue, countertransference, secondary traumatic stress, burnout, and vicarious traumatization (see Jenkins & Baird, 2002). Although other labels have been employed and were included in researching this article, the shared emphasis on the helper's experience is the focus, and so one term will be used to represent the findings summarized here. The term *vicarious traumatization* (VT), coined by McCann and Pearlman (1990), will be used because it is the most widely referred to in both the victim and perpetrator literatures, reflects the cumulative nature of the impact of secondary trauma, and invokes the concept of experiencing the feelings of another *as if* one has experienced them directly, resulting in the traumatic reactions observed in the treating therapist.

VT is described as a transformation in the therapist as a result of working with a client's traumatic experiences. VT includes three primary characteristics: (a) pervasive impact, which affects every aspect of the therapist's life; (b) cumulative effect, in that each exposure to the trauma reported by the victim increases the risk and impact of the trauma response in the helper; and (c) potentially permanent effects. The primary symptoms of VT include

disturbances in affect tolerance, cognitive frame of reference, interpersonal relationships, psychological needs, and identity. The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*; American Psychiatric Association [APA], 2000) acknowledges that learning about traumatic events experienced by friends, family, or a close associate can contribute to symptoms of posttraumatic stress disorder (PTSD), and this may be particularly disturbing "when the stressor is of human design" (p. 464). Some theorists have argued that similar symptoms arise in therapists exposed to narratives of traumatic events (McCann & Pearlman, 1990; Rosen, 2004). According to McCann and Pearlman (1990), clinicians described a broad spectrum of disturbance, which included a number of symptoms in addition to the anxiety-based reactions of PTSD (APA, 2000). The phenomenon of VT includes depression, substance abuse, somatic complaints, and dissociation, all comorbid with the experience of anxiety (McCann & Pearlman, 1990). Trauma reactions can be divided into three categories, according to the *DSM-IV-TR*: intrusive, avoidant, and arousal symptoms. Intrusive symptoms include persistent reexperiencing of the traumatic event, such as images and thoughts, physiological reactions, and dreams. Avoidant symptoms describe a general numbing in responsiveness and avoidance of trauma-related stimuli. Last, symptoms of hyperarousal, such as hypervigilence and difficulty concentrating, are also examples of trauma reactions.

Mechanisms of Vicarious Traumatization

The concept of VT emerged from constructivist self-development theory proposed by McCann and Pearlman in their seminal 1990 article on trauma therapy. The development of the theory was based on the use of various psychological orientations and theories, namely self-psychology, object relations, and social cognitive theories, which the authors had used in their own practice treating survivors of traumatic life events. Constructivist self-development theory asserts that the adaptation observed in trauma survivors is a product of their pretrauma personality characteristics and the salient aspects of the traumatic events, within the context of relevant social and cultural variables. These elements combine to redefine an individual's cognitive schema and therefore the process of constructing and interpreting their reality. In applying constructivist self-development theory to the study of trauma, the authors identify seven psychological needs, which are cognitively manifested as schemas. The seven needs are intimacy, esteem, power, dependency, trust/safety, independence, and frame of reference (attributions). McCann and Pearlman argue that the experience of trauma can disrupt any one or multiple needs, and it is the particular disturbance that is a reflection of the individual's experience of the trauma and its impact.

Just as there are various terms used to describe the concept of VT, so too are there many explanations for the mechanisms by which VT develops. Although few specific theories have been applied to VT in therapists working with sexual offenders, a brief summary of some theoretical conceptualizations of VT in general can provide a framework within which to interpret research findings. A number of mechanisms of VT have been suggested, including countertransference, empathic engagement, and cognitive adaptations, such as those described in constructivist self-development theory.

Countertransference, a commonly proposed explanation for VT (Pearlman & Saakvitne, 1995), involves the therapist's experience of responses to the client within the psychotherapeutic relationship (Sabin-Farrell & Turpin, 2003), whereas VT is related to changes taking place in the therapist's life. The processes suggested to be involved in the interaction between countertransference and VT are decreased self-awareness, increased defenses, and challenges to identity and beliefs (Pearlman & Saakvitne, 1995). In their commentary, C. Mitchell and Melikian (1995) identified a number of countertransference issues specific to sexual offenders, including sadistic and aggressive fantasy, polarization of the client (victim vs. offender), and barriers to empathic engagement with the client (e.g., focusing on the offense or the offender's denial).

An important aspect of the therapeutic relationship that may be linked to the development of VT is empathy. The process of empathizing with clients requires clinicians to accurately identify and vicariously experience the emotions and responses *as if* encountering the events and feelings firsthand. According to Figley (1995a), the process of empathizing with traumatized clients makes therapists vulnerable to being traumatized by the material as well. This emotional contagion effect may be linked to research on memory, which suggests that thinking and remembering are not distinct processes. Therefore, once an image is generated in response to empathizing with one's client, it can later be recalled as the therapist's own memory, along with the associated feelings the therapist experienced at that time, thereby creating a traumatic reaction in the therapist (Pearlman & MacIan, 1995; Stamm, 1995).

In one of the earliest writings on VT reactions in sexual offender therapists, Farrenkopf (1992) proposed a model describing the cumulative impact of working with this difficult population. In this theory on the *phases of impact*, the therapist is proposed to go through four phases. The first phase, *shock*, suggests that therapists experience shock, fear, and a greater sense of threat and vulnerability. Phase 2 is called *mission* and describes the therapist's adaptation and desire to help while at the same time repressing emotions and reactions to the sexual offences. In the third phase, *anger*, therapists exhibit a confrontational style and intolerance of criminal attitudes. The fourth phase, *erosion*, is the continuation and amplification of Phase 3, where therapists feel resentful, depressed, and a sense of futility. Farrenkopf suggests that as an alternative to *erosion* therapists may regain their motivation and therapeutic compassion and are able to tolerate working with sexual offenders while maintaining their efforts and emotional engagement. This theory has yet to be tested empirically.

In their review of the literature on VT, Sabin-Farrell and Turpin (2003) attempted to synthesize the various concepts used to describe trauma reactions in therapists. They identified four important elements of vicarious trauma:

1. cognitive, emotional, behavioral, and physical responses, which might be considered as a normal response to hearing traumatic material
2. symptomatic responses, which might be considered extreme versions of the responses described in Number 1
3. cognitive changes in beliefs and attitudes
4. additional effects on interpersonal and occupational functioning

The authors reviewed the evidence for psychological and cognitive impairments in therapists working with victims and concluded that the evidence is generally weak and inconsistent and that more support exists for symptomatic responses than cognitive effects. They acknowledged that methodological issues might obscure findings but ultimately call into question the validity of VT. Questions surrounding the validity of VT are also relevant in its application to sexual offender therapy. Although these theories are widely cited in the literature on therapists working with victims, little theoretical framework has been developed and applied to the sexual offender therapist field. As such, no empirical investigation has tested the validity of the proposed mechanisms with sexual offender therapists, but rather support for components of some theories are inferred from related results. Although the study of VT is quite new with this population, a lack of theoretical grounding in the existent research weakens the ability to assess its validity, describe a unitary phenomenon, and identify related and contributing factors. To promote the consideration of the theoretical basis, one must first consider whether or not the existing research supports, at a minimum, the presence of some transformation as described in the definition of VT, affecting the therapist's sense of self, other, and the world.

WORKING WITH PERPETRATORS OF SEXUAL AGGRESSION

The process of providing therapeutic intervention requires the therapist to listen to graphic descriptions of the traumatic events, to witness the client's reenactments or recollections, and all the while be empathically engaged with the client. Given recent evidence about the role therapist characteristics can play in affecting sexual offender treatment outcome,

these emotional reactions require close monitoring, as they are in direct conflict with those therapist characteristics found to be most necessary for effective sexual offender treatment, namely, empathy, warmth, and respect (Marshall et al., 2003; Marshall et al., 2002). In addition to their own reactions, sexual offender therapists may also be affected by the offenders' reactions to the abuse, such as denial, arousal, victim-blame, or remorselessness. This balance has implications for VT when we consider how the therapist manages these responses. At the systemic level, therapist reactions and their consequences may affect the quality of therapy and thus the management of risk for reoffence and the protection of potential victims.

What is the extent of VT in sexual offender therapists? During the past two decades, researchers have begun to examine and describe the experience and extent of VT in sexual offender therapists. In a recent survey of trauma in therapists, the authors concluded that more than 50% of sexual offender and survivor therapists reported symptoms of trauma reactions in the clinical range as measured by the Impact of Event Scale–Revised (IES-R; Way, VanDeusen, Martin, Applegate, & Jandle, 2004; Weiss & Marmar, 1997). Although no comparison group was included, and no norms currently exist for clinicians, these levels of distress are comparable to those published in other studies for related clinician populations (see Ghahramanlou & Brodbeck, 2000; Kassam-Adams, 1995). In a study examining 67 male and female sexual offender therapists in Australia, participants were asked to complete the IES-R and describe characteristics of their work (Steed & Bicknell, 2001). Forty-six percent of respondents reported a moderate or high risk of developing compassion fatigue, and 38% were described as at moderate to high risk of developing burnout (which has been purported to be a predictor or sign of untreated VT; Figley, 1999; Pearlman & Saakvitne, 1995; Stamm, 1995). More specifically, Steed and Bicknell (2001) analyzed the domains in which therapists reported difficulty based on the IES-R and found that therapists were experiencing mild disruptions in intrusive (15.4%), avoidant (12.5%), and hyperarousal (8%) symptoms.

The constructivist self-development theory posits that prolonged therapeutic engagement with victims who have been traumatized can lead to changes in one's sense of self, others, and the world. Many studies have shown that therapists who work with victims and perpetrators experience a variety of trauma-related symptoms. Approximately one third of sexual offender therapists described symptoms of hypervigilence pertaining to their own safety and their own interpersonal behavior (Bengis, 1997; Farrenkopf, 1992). Sexual offender therapists also described feeling mistrustful of others in general, but particularly of those who have regular access to children either through work, family/friends, or volunteering. As a consequence of this suspiciousness, therapists have described attributing malevolent motivations to seemingly innocent interactions. Hypervigilence regarding one's own and others' behavior exemplifies the schematic shift described as a hallmark of VT (McCann & Pearlman, 1990) and appears to be a commonly observed reaction to the delivery of sexual offender treatment.

Although no longitudinal investigations have examined the effects of sexual offender therapy, research has described some of the psychological correlates associated with VT. A descriptive study of 135 sexual offender therapists included both open-ended and true or false questions about the respondents' experience of VT (Rich, 1997). Therapists described feelings of depression, anxiety, isolation, vulnerability, and a decreased trust in others. They also expressed feeling ill equipped to manage stress, reported experiencing flashbacks of work material, and reported overidentification with their clients. In similar descriptive studies where participants are invited to describe characteristics of their work and their personal experiences, researchers have noted emotional hardening, anger, and irritability (Farrenkopf, 1992), as well as fatigue, frustration, and cynicism (Edmunds, 1997). These descriptions offer some evidence of ill effects in sexual offender therapists and suggest that the symptoms may be associated with their work. However, these findings are not conclusive based on limitations in study design, operationalization, and

appropriate comparisons (e.g., base rates, other care professionals).

Factors Related to Vicarious Traumatization in Sexual Offender Therapists

Many factors have been implicated in research aimed at identifying correlates and predictors of VT in therapists working with perpetrators of sexual aggression. These variables can be organized into three categories: client characteristics (e.g., psychopathology, motivation for treatment), therapist characteristics (e.g., gender, history of abuse), and therapy characteristics (e.g., setting, modality). The research in each domain will be reviewed separately.

Client characteristics. In a presentation to the Association for the Treatment of Sexual Abusers (ATSA), Ellerby, Gutkin, Smith, and Atkinson (1993) compared some of the characteristics of difficult-to-work-with clients with those characteristics common to sexual offenders. These characteristics included a lack of motivation for change and resistance to therapy; psychopathological behaviors, including depression, suicidal ideation, and personality disorders; lying, passive-aggressive style, and client dependency; and working with groups stigmatized by society. This list is particularly relevant for sexual offender therapists because virtually all of these characteristics can be found in sexual offenders.

Despite this assertion, no study has examined the relationship between offender characteristics and symptoms of VT in sexual offender therapists. Demographic data are typically the only qualities described in most studies. Client characteristics were often included in articles as sample descriptors and were not included in analyses of VT. In one examination of the effect of client characteristics on sexual offender therapists, Edmunds (1997) requested 130 female therapists and 146 male therapists belonging to ATSA to describe the characteristics of their work and the clientele to whom they provide services. As with much of the work in this area, the survey questions are typically generated by the authors and are not based on psychometric data. Based on these summaries, the author reported that 89% of therapists working with perpetrators had caseloads of 91% to 100% male sexual abusers. According to Edmunds's review, most sexual offender therapists also worked with adolescent offenders (68%), and a small proportion included female offenders, nonperpetrators, and/or nontrauma-related clients. Research on therapists providing treatment to victims has found that as the proportion of trauma-related clients increases, so too does the likelihood of VT symptomology (Kassam-Adams, 1995; Munroe, 1991; Schauben & Frazier, 1995). Given the challenges of these clients and the theoretical support for the cumulative effect of working with trauma-related clients, it is surprising that so little research has examined the client's contribution to the development of VT.

Therapist characteristics. A significant amount of research has been devoted to the examination of therapist characteristics and their contribution to the development of VT. In 2004, Way and her colleagues compared 347 victim and sexual offender therapists solicited from professional organization membership lists through the mail (American Professional Society on the Abuse of Children and ATSA). Participants completed the IES, the Childhood Trauma Questionnaire (Bernstein & Fink, 1998), and a closed-ended survey questionnaire collecting demographic data, information about client and therapy features, and indicators of coping skills. In terms of therapist characteristics, the authors noted a gender difference, such that approximately 89% of therapists working with victims were female, compared with 50% of therapists working with offenders. The authors found no differences between therapists working with sexual offenders and victim therapists on other demographic information, including age, ethnicity, or length of time providing sexual abuse treatment.

Despite the fact that gender differences consistently exist between therapist groups (perpetrator or survivor), little research has explored the correlates and effects of gender differences in sexual offender therapists. In one examination of 98 sexual offender therapists drawn from ATSA, Jackson, Holzman, Barnard, and Paradis (1997) reported no gender differences with

respect to symptoms of burnout. However, there may be some evidence for gender-specific VT reactions. Given that most sexual offenders are male, there is some suggestion that male therapists tend to overidentify with offenders and describe the experience of a collective guilt (Edmunds, 1997). Some theorists have suggested that male therapists feel shame on behalf of the male sex and engage in a hypercritical analysis of their own sexual behavior and their way of interacting and showing affection to children (Farrenkopf, 1992). Given that women evidence twice the rate of PTSD as men, and gender differences are noted with respect to risk factors, comorbidity, and treatment response in trauma victims generally (Bowman & Yehuda, 2004; Kimerling, Ouimette, & Wolfe, 2003), one might expect differences in rates of VT.

A significant discrepancy in the literature exists regarding the degree of education and training of therapists who work with perpetrators. Based on Edmunds's (1997) survey described above, 53% of sexual offender therapists had a master's degree in psychology or a related counseling program and described high levels of ongoing training and professional development. Fifty-three percent of participants reported receiving up to 50 hours of sexual-offender-specific training per year, and 52% reported receiving adequate supervision to do their job effectively. Similar results were found by Jackson and his colleagues (1997). In a qualitative summary of 98 members of a professional organization, 84% of respondents felt that they received adequate supervision, and 97% of the therapists treating sexual offenders held a master's or doctoral degree in psychology or a related counseling field. Conversely, in their comparison between therapists who treat victims and those who treat perpetrators, Way and her colleagues (2004) found that those treating perpetrators were more likely to have a bachelor's degree or less compared with therapists who treat victims. Although in both investigations participants were drawn from the same professional organization, they were published 7 years apart, and differences may reflect changing educational requirements or a shift in implementation of treatment (i.e., facilitators rather than psychologists deliver services).

Training and/or experience are often considered protective factors by those studying the development of vicarious trauma reactions. Ellerby's (1998) dissertation on Canadian therapists treating sexual offenders documented inadequate sexual-offender-specific training before working with these clients, and then minimal opportunities for ongoing professional development. The respondents also felt they received inadequate supervision. Despite mixed reports on the practice of training and supervision, some research has found no relationship between years of professional experience and VT symptoms (Way et al., 2004). Conversely, other studies have suggested that greater experience, as measured by years working with a particular population, may in fact be a risk factor in the development of VT (Steed & Bicknell, 2001). The notion is that the longer one works with a difficult client group, the more vulnerable one is to the negative impact of such work, in other words, the cumulative effect described in the definition of VT. In an analysis of the relationship between professional experience and VT in 67 sexual offender therapists, Steed and Bicknell (2001) found a trend toward an interaction between therapist symptom severity and years of experience based on responses to the IES-R and the Compassion Fatigue Scale (Figley, 1995a). Their results suggested that those newest to the field (< 2 years) and those working with sexual offenders for the longest (9 to 12 years) were most at risk for developing symptoms of VT, including intrusive, avoidant, and hyperarousal symptoms as well as burnout. However, those therapists working with sexual offenders between 2 and 4 years were least vulnerable to symptoms of VT. An additional finding was that previous work as a therapist with general populations had no relationship to the experience of VT, suggesting that this observation may be a product of delivering sexual offender therapy specifically.

Research on VT in victim therapists suggested that symptoms of PTSD as measured by the IES (Horowitz, Wilner, & Alvarez, 1979) were not related to exposure to other client problems or diagnoses (personality disorders, psychotic disorders; Kassam-Adams, 1995)

and were only observed in those therapists working with trauma-related clients. To date, no research has examined differences in VT between those who choose to discontinue their therapeutic work with sexual offenders and those who continue, but one might hypothesize that those experiencing the negative symptoms of VT may be likely to change their work type or the populations with which they work, whereas those who remain in this field may have experienced Farrenkopf's (1992) alternative response to *erosion* in the phases of impact theory and adapted to this type of work. Therefore, research examining the role of experience may reflect those therapists who have developed coping strategies to manage vicarious trauma symptoms, or wrongfully suggest that no effect for experience exists. Prospective research examining when and why people leave this field may help to elucidate this issue.

According to constructivist self-development theory, one's pretrauma characteristics can influence a trauma reaction. Therefore, it makes sense that therapists' personal experiences have been considered in the development of VT. Research conducted on the influence of personal trauma history in victim therapists found a relationship between trauma history and vicarious trauma symptoms (Sabin-Farrell & Turpin, 2003). Kassam-Adams (1995) concluded that, based on multiple regression analyses, three variables together accounted for the most variance in the prediction of VT symptoms in victim therapists, namely, being female, having survived a personal trauma, and the number of traumatized clients therapists had worked with during the course of their career. However, other research has found that the therapist's trauma history has no predictive utility, and authors argue that VT is best predicted by high levels of stress, negative coping, and cognitive evaluations (Follette et al., 1994).

In a study of therapists who treat victims and perpetrators, 75% of respondents reported an undefined history of childhood abuse, including sexual, physical, and emotional victimization, with no differences between the groups (victim or perpetrator therapists) on trauma history or IES scores (Way et al., 2004). In her descriptive study of sexual offender therapists, Edmunds (1997) found that 54% of respondents reported lifetime psychological (22%), physical (11%), and sexual (21%) victimization. Furthermore, females represented a larger proportion of therapists who had been victimized (27% of females, 16% of males; Edmunds, 1997; Way et al., 2004). One study drawing from the same ATSA sample found that only 25% of respondents identified themselves as survivors of trauma, and found no differences on indicators of psychological distress when they compared the small group of survivors with a randomly selected group of participants with no history of trauma (Ennis & Horne, 2003).

Although no research has compared the rates of victimized therapists across specialization, it seems noteworthy that consistent across studies, a significant proportion of those working with both victims and perpetrators have suffered some form of maltreatment. However, no investigation has examined what role prior trauma history plays in the prediction of VT symptoms for sexual offender therapists. Given some evidence of disproportionately high rates of maltreatment history in this population, Kassam-Adams (1995) has raised issues of self-selection and related issues of entering such a specialization to indirectly process and address one's own abuse issues. The constructivist self-development theory would suggest that the impact of trauma work might be a function of unmet psychological needs. Taken together, the consequences for the therapist and quality of therapy may be affected by trauma history and should be examined further. This has important implications for issues of therapeutic alliance, transference/countertransference, and therapist self-care.

When considering issues of self-care and addressing personal needs, coping is likely an important mediator of the response to traumatic experiences and difficult work. Both positive (e.g., seeking support and supervision, physical exercise, spiritual practices) and negative (e.g., alcohol abuse, pornography use) coping have been examined in therapists who work with sexual offenders. In her study of sexual offender therapists, Edmunds (1997)

found that 10% of therapists reported increased alcohol abuse during the previous year regardless of gender. Way and her colleagues (2004) found that younger therapists used more positive and negative coping, and this was related to greater levels of both intrusive and avoidant symptoms. In fact, positive and negative coping were the only significant positive predictors of vicarious trauma in sexual offender therapists. Using regression analysis to predict vicarious trauma symptoms, the authors examined the differential predictors for avoidant and intrusive symptomology and found that positive and negative coping contributed to the variance accounted for over and above historical and demographic variables, such as age, sex, trauma history, and work experience in understanding VT. The addition of positive professional coping, including supervision and training, did not make a significant contribution. The same model was examined for intrusive symptoms, where virtually an identical pattern was found, such that positive and negative coping positively predicted intrusive symptoms, beyond demographic variables and professional coping.

Conversely, other research on sexual offender therapists has noted an inoculation effect for positive coping. For example, positive coping in general was linked to improved work performance in sexual offender therapist (Thorpe, Righthand, & Kubik, 2001). Additional evidence of positive effects comes from a study by Ennis and Horne (2003). Fifty-nine participants returned a mail survey including a clinician survey collecting demographic, client, and work-related data, as well as the Los Angeles Symptom Checklist (King, King, Leskin, & Foy, 1995). In a model that tested the predictive utility of sexual offender contact hours, peer support, family support, and supervision hours, only peer support was found to be significantly negatively associated with general psychological distress and PTSD symptoms. Coping, positive or negative, is clearly implicated in VT. However, the variable role of positive coping is somewhat puzzling, because so often positive strategies are encouraged to relieve work-related stress. One explanation may be rooted in the correlational nature of the research. It is possible that therapists who initially employed poor coping strategies, resulting in VT, were also attempting to improve self-care and combat the negative symptoms and therefore endorsed both methods of coping. Another hypothesis is that perhaps negative coping has a stronger effect than positive coping and therefore counteracts the impact of healthy strategies.

One potential moderator of the relationship between positive coping and VT may be the differential impact of personal/professional supports and the extent to which one feels supported in their work. In their presentation to ATSA, Ellerby and his colleagues (1993) reported that approximately 70% of sexual offender therapists reported that they felt uncomfortable and needed to justify their work when asked. Approximately 90% described a negative reaction from others when they described their occupation. The authors explain that therapists working with sexual offenders face alienation within professional contexts and at times experience hostility from victims and those working with victims. One wonders, given some evidence of the positive effects of personal or social coping (Ellerby, 1998; Ennis & Horne, 2003), whether therapists can mitigate VT through consistent support from those around them?

Implicit in some popular negative reactions toward sexual offender treatment is the assumption that rehabilitation is ineffective. Clinicians also evaluate client outcomes and at times may judge their own competency based on the performance of the individuals in their practice. In working with sexual offenders, therapists' expectations for the client, such as taking responsibility and behavior change or management, may be incongruent with the actual client growth observed. Although this experience is not unique to this specialization, the parallel pressure to *cure* a sexual offender before he/she is released, and the incongruence of one's expectations and the client's performance, may lead to feelings of helplessness, guilt, and questions of competency (Farrenkopf, 1992; Kearns, 1995). Therapists are aware that treatment failure can mean the abuse of another victim. According to one study, recidivism is the most commonly

used measure of success by clinicians treating sexual offenders (Jackson et al., 1997). The threat of reoffence may contribute to therapists' feeling responsible for the client (perpetrator), as well as the safety of potential victims, the community, or society as a whole. To some extent, this responsibility is real, given that therapists who treat sexual offenders are required to evaluate the perpetrator's risk to reoffend and make recommendations about and/or supervise an offender's management in the community. In the survey of ATSA members, Ellerby and colleagues (1993) documented the reactions of therapists after a sexual offender had recidivated, and responses included feeling angry (84%), disillusioned (79%), depressed (74%), incompetent (73%), inadequate (58%), and guilty (42%). One can see how, left unmonitored, such occupational stresses can contribute to negative personal evaluations and greater vulnerability to the potential negative consequences of trauma-related work, and can affect one's sense of efficacy.

The characteristics considered in this section are complex and likely interdependent. Because much of the research is descriptive, statements of association are often not possible, leaving the reader to infer the relationships between various therapist characteristics and the development of VT. Retrospective studies also preclude analysis of preexisting personality characteristics that, according to the constructivist self-development theory of VT, will interact with the trauma material and other relevant sociocultural factors in the individual's unique exhibition of VT. However, based on the results reviewed in this section, some general patterns are worthy of note, at least preliminarily. There is some evidence that despite high levels of sexual abuse in this group of therapists, a history of trauma was not related to VT in sexual offender therapists. Instead, the development of VT appears to be related to the use of coping and, to some extent, the therapist's experience in the field. However, research on both factors has resulted in mixed findings and needs to be replicated in order for researchers to fully understand the impact on VT.

Setting and therapy characteristics. The constructivist self-development theory of VT suggests that the social or cultural environment within which therapists live/work will influence their adaptation to the traumatic material to which they are exposed. In this section, research examining therapy setting, workload, and related factors such as safety, is summarized. These factors are a function of the work but may be independent of client and/or therapist characteristics and therefore contribute their own unique influence to VT.

Many sexual offenders are treated in secure settings, such as treatment centers, forensic hospitals and/or wards, or prisons. Therefore, not surprisingly, between 22% and 43% of sexual offender therapists work in these environments as well (Edmunds, 1997; Shelby, Stoddart, & Taylor, 2001; Way et al., 2004). In a recent dissertation on the impact of sexual offender treatment, Amen (2002) found a trend toward greater symptoms of VT in those therapists who work in a prison setting compared with those who work in community outpatient clinics. She attributed this finding to greater isolation and the emotionally hardened atmosphere of prison settings. In a self-report study, 86 therapists were recruited from the Safer Society referral list and asked about burnout symptomology. Participants worked in a variety of settings, and those recruited from a prison or other type of secure setting reported higher levels of emotional exhaustion, depersonalization, and lower feelings of personal accomplishment compared with those working in outpatient or other community settings (Shelby et al., 2001). The authors found that the facility, inpatient or outpatient, was the only significant predictor of burnout as measured by the Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996). Those therapists who worked with sexual offenders in such a secure setting had also delivered sexual offender treatment for fewer years, had a larger proportion of sexual offender clients, and typically delivered behavioral techniques in a group-therapy format. This finding is somewhat surprising given the obvious stressors of managing sexual offenders in the community when they are able to access potential victims. One explanation for the relationship between secure settings and VT symptomology is the

fact that secure facilities may house more dangerous or difficult offenders compared with community facilities. Although no research has explored differential VT effects based on client characteristics, such as risk level, the effect for setting represents an example where risk may mediate the observed relationship.

Issues of personal safety must also be considered in discussing the work characteristics for sexual offender therapists. Sexual offender therapists have described feeling unsafe as a consequence of their work, regardless of the setting (Edmunds, 1997). In his studies on the impact of working with sexual offenders, Ellerby (1998; Ellerby et al., 1993) reported that both male and female sexual offender therapists have felt threatened or endangered by a client (63% and 79%, respectively). The fear described by these professionals is not without cause, particularly for females, who described violations of personal boundaries by clients (84%) and being sexualized by clients (42%; Ellerby, 1998). In addition, more than 50% of therapists have been verbally or physically attacked by a client (Jackson et al., 1997). The real or threatened attack by a client will exacerbate the experience of vicarious trauma symptoms and may also contribute to the therapist's own experience of primary trauma reactions. No research on sexual offender therapists has distinguished between work-related primary and secondary trauma in the evaluation of the development of VT.

Considerable research has suggested that trauma reactions in therapists are proportional to the therapists' exposure to traumatized clients. In the victim therapist literature, numerous studies suggest that the proportion of trauma clients compared with nontrauma clients may be related to symptoms of VT (Stamm, 1995). In her review of therapists working with sexual offenders, Edmunds (1997) reported that 38% of sexual offender therapists worked 10 to 12 hours per day (see also Jackson et al., 1997). She found that 64% of these therapists had direct client contact between 1 and 20 hours per week, and 20% had more than 31 hours per week of direct client contact. In another study of sexual offender therapists from Canada and the United States, Ennis and Horne (2003) found no correlation between degree of distress and amount of time devoted to clinical work with sexual offenders. Despite descriptions of lengthy workdays with this difficult population, no relationship has been found between caseload as measured by direct contact hours, and symptoms of burnout (Edmunds, 1997; Shelby et al., 2001; Steed & Bicknell, 2001). In fact, those sexual offender therapists with the greatest self-reported symptoms of VT had direct contact with clients 11 to 20 hour per week (Shelby et al., 2001).

In addition to setting and therapy style, the trauma-related material that sexual offender therapists work with is relevant in a discussion of effects for clinicians. Few researchers have considered the psychosexual impact of working with sexual offenders. In his review of the literature on the effects of providing sexual offender therapy, Ellerby (1997) argued that sexual offender therapists may become desensitized to sexual deviance and violence because they are exposed to it so regularly. He goes on to suggest that sexual offender therapists lose their objectivity in evaluating risk because they begin to compare between offences rather than to standards of "normal." As part of their study in 1993, Ellerby and his colleagues undertook a comprehensive analysis of psychosexual functioning in sexual offender therapists. They found that roughly one third of males and females reported decreased sexual interest and behavior (see also Jackson et al., 1997). As a direct result of exposure to deviant sexuality, participants described avoiding or ending sexual contact and being distracted during sexual activity. Both male and female therapists reported sexual fantasies and dreams about clients, felt sexually attracted to clients, and became aroused in response to descriptions of the client's offensive and nonoffensive sexual behavior. Despite assertions that psychosexual consequences exist among therapists working with sexual trauma (Ellerby et al., 1993; Pearlman, 1995; Pearlman & MacIan, 1995), this continues to be an area that is largely avoided in the supervision and training

of therapists. Unfortunately, this research has been descriptive in nature, and so little is known about how sexual offender therapists differ from other therapists and if these effects are in fact a function of the provision of sexual offender therapy.

Based on the limited empirical research to date, therapy characteristics appear to contribute little to the development of VT. However, what does seem to play an important role is the setting in which the services are delivered. Secure and prison settings were consistently related to higher levels of distress. This may be explained by the isolation associated with secure settings, such that the individuals or departments responsible for therapeutic intervention may be structurally separated or restricted. Secure settings are also typically more dangerous because, as mentioned above, therapists are working with higher risk or more problematic sexual offenders.

Much of the research examining VT, particularly in therapists working with sexual offenders, has been qualitative in nature, with the goal being to describe the experience of these professionals and identify patterns in their responses. A second movement in the literature was relational, whereby therapist, client, or setting characteristics were correlated to determine what, if any, relationship existed between particular variables and the experience of VT. Only recently have predictive projects been undertaken. As such, the conclusions drawn are mostly limited to statements of association. However, the results from this research suggest that the therapist's professional experience and coping, along with the work setting, are related to the development of VT in sexual offender therapists.

DISCUSSION

Summary of Findings

Some therapists who work with perpetrators of sexual abuse experience and report vicarious trauma in the moderate to clinical range. These individuals describe a number of worrisome emotions, and researchers have identified many unique and troubling effects, including intrusive thoughts, avoidance behaviors, and hypervigilance. In examining those factors hypothesized to play a role in the development of VT, a number of findings confirmed or contradicted associations often believed to play a role in trauma reactions in therapists.

In most studies of VT in sexual offender therapists, authors have examined the role of personal trauma history in the development of symptoms. Despite a range in proportions (25% to 75%), a meaningful number of therapists have suffered maltreatment. However, contrary to most hypotheses, a history of previous trauma was not related to, nor predicted, symptoms of VT in sexual offender therapists. Other factors, which were not related to VT, include caseload proportions and treatment modality/type.

Some research has suggested that the length of time working with this population may contribute to trauma-reaction symptoms. There was a trend suggesting that both those early on in their careers and those with many years of experience were most negatively affected. In addition, sexual offender therapists working in secure and prison settings reported the highest levels of VT. Finally, the strongest positive predictors of VT in sexual offender therapists were the use of positive and negative coping strategies.

Theoretical Implications

Although research has catalogued many ways that sexual offender therapists have been emotionally and cognitively affected by the work they do, these data have been largely descriptive. More systematic analyses of the relationship between the contributors and consequences of VT as well as mediators and moderators of this relationship are required. Ellerby's research (1997, 1998; Ellerby et al., 1993) has provided a rich description of the schematic shift (cognitive adaptations) and the emotional experiences that are proposed as integral aspects of VT. Despite the descriptive support for explanations of VT, as well as the

mechanisms purported to be involved (e.g., countertransference), the nature of the designs has precluded any statement of cause and effect, and in fact, even associative studies have been limited. An additional concern is that little research has been completed within a theoretical framework, and thus the applicability and validity of the various theories outlined above with respect to VT in sexual offender therapists is largely absent.

Based on the available research, one might propose that experience and coping interact in their relationship to VT via one's pretrauma characteristics and the salient aspects of the trauma described. This relationship exists within the dynamic social and cultural context. These factors are consistent with both the constructivist self-development theory and the phases of impact theory. Those therapists new to working with sexual offenders may find the work especially challenging. This may be particularly true given the nature of the material and the characteristics of both the client and work environment, as well as the lack of training and supervision described by Ellerby (1998). It may be that this group has not developed healthy coping strategies to manage the emotional reactions associated with their work. According to Farrenkopf's (1992) phases of impact theory, this group may be in Phase 1, *shock*, in which they experience feelings of fear and vulnerability. Without personal and professional coping, these more novice therapists may report higher levels of VT and may in fact choose to leave the field altogether.

Following the phases of impact theory, Phase 2 suggests that those therapists who continue to work with sexual offenders adapt and experience a commitment to their work. In fact, research presented above suggests that those therapists between 2 and 4 years into their career report low levels of VT (Shelby et al., 2001). One explanation for this described adaptation is the use of coping strategies, both positive and negative (Way et al., 2004). These strategies help therapists process and avoid the difficult aspects of their work and as such may protect them from the experience of VT. However, it is possible that prolonged use of inappropriate coping, such as the negative strategies used by sexual offender therapists, and what Farrenkopf (1992) described as repressed emotions and reactions, results in the *anger* associated with Phase 3, and emotional *erosion* described in Phase 4. The research suggests that those practicing between 9 and 12 years describe high levels of distress, and this may be a function of poor coping. Although the results are far from conclusive, findings presented in this article provide some initial support for Farrenkopf's phases of impact theory and the application of constructivist self-development theory to VT in sexual offender therapists.

Clearly, there is evidence that sexual offender therapists experience a variety of undesirable reactions that appear related to their work. However, more sophisticated designs (this will be discussed further below) as well as theory-driven research will be more useful in terms of definitively describing the phenomenon and providing meaningful and realistic recommendations for employers and the therapists who provide treatment to these individuals.

Critique and Recommendations for Future Study

Although a number of issues have been identified throughout the article, major methodological themes will be summarized here. First, there are issues of definition that have been reviewed above and will not be repeated here, but the reader is reminded that disparate definitions exist and interfere with construct validity, measurement, and cross study comparison. Embedded in the issue of definition is that of measurement. Currently, most investigators continue to use general trauma questionnaires designed to assess primary trauma, despite the availability of measures designed to assess VT in therapists in general and, more specifically, in sexual offender therapists (Thorpe et al., 2001). In their examination of the construct validity of VT, Jenkins and Baird (2002) found good

psychometrics for the Traumatic Stress Institute Belief Scale (Pearlman, MacIan, Johnson, & Mas, 1992) and the Compassion Fatigue Self-Test for Practitioners (Figley, 1995b). However, none of the studies on sexual offender therapists used either of these measures.

If those studying VT posit there is a difference between primary and secondary trauma, then it should follow that such a phenomenological distinction would warrant the use of measures that assess this unique experience. Although the IES-R is commonly used and boasts good psychometrics, the development sample and their experience was qualitatively different from therapists suffering from VT. It is important that researchers use measures designed to assess secondary trauma reactions in general, and in sexual offender therapists specifically.

Issues of sampling are another potential limitation to the integrity of the research. Most studies examining therapists who provide therapy to sexual offenders drew their participants from members of a professional organization, such as ATSA. Although an appropriate sample, this group does not represent all sexual offender therapists but rather those who have sought membership to a professional group. This sample of convenience raises questions about those nonmembers and their experience, particularly related to issues of coping, self-care, isolation, and training, given the role these factors may play in the development of VT. Another sampling concern in this literature was the lack of healthy control groups and comparison with those therapists working with different but related populations (e.g., domestic abusers). The limited controls against which to test the phenomenon of VT in therapists weakened the conclusions and recommendations gleaned from this research.

Finally, to date, all of the research has been cross-sectional and thus cannot address the etiology of VT. Prospective studies would allow researchers to assess factors such as personality, cumulative exposure, individual differences in adaptation and coping, and effects of training and supervision (Sabin-Farrell & Turpin, 2003). Ideally, research on VT with sexual offender therapists would consider these issues as well as mediating and moderating factors, such as the client, therapist, and setting characteristics reviewed here.

CONCLUSION

Not every person who works with traumatic material develops VT. However, in those therapists who do experience trauma reactions related to their work, there are consistent descriptions of emotional and cognitive change in the individual's sense of self, others, and the world. Left unmonitored, VT reactions may impact therapists and therapy quality. Clearly, those working with sexual offenders describe negative characteristics seemingly associated with their work. However, the nature of the research to date has precluded any definitive comment on what, if any, harmful (and preventable) effects are caused by trauma-related work for sexual offender therapists. The purpose of examining this phenomenon is to understand what differentiates those who experience lasting trauma reactions from those who do not, and in doing so identify both risk and protective factors.

Considering the consequences, both personally to the therapists but also systemically in terms of the quality of the therapy delivered and attrition in the work force, the phenomenon of VT is worthy of further empirical investigation on specific constructs of interest. Based on this review of the literature, both descriptive and empirical future research should be aimed at substantiating and defining the means by which therapist coping, training and experience, and work setting moderate the relationship between the delivery of sexual offender therapy and VT. Research devoted to understanding these mechanisms will promote the generation of practical recommendations about issues such as prevention and supervisory strategies for employers, training facilities, and professional organizations.

IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH

- Research to date on VT and the provision of sexual offender treatment is consistent with theoretical models, including generalized explanations for trauma reactions, such as constructivist self-development theory, as well as descriptions specific to sexual offender therapy, such as the phases of impact theory.
- Based on the processes described theoretically and the findings summarized above, a model is proposed whereby the relationship between sexual offender therapy and the development of VT is moderated by interactions between professional experience and coping strategies, as well as the setting within which one works.
- Training for sexual offender therapists should include education regarding possible effects and guidelines for addressing VT reactions in supervision of clinicians.
- Although mixed, there is some evidence that positive coping, particularly peer or collegial support, may decrease the risk for VT. Institutions and professional organizations can increase the opportunity for peer supervision and forums for discussion such as workshops and listservs, as well as interdisciplinary meetings.
- Left unchecked, psychological reactions in therapists can affect the field of sexual offender treatment in a number of ways:
- Symptoms of VT can affect the integrity of service delivery via the therapeutic relationship, standards of comparison in the evaluation of risk and treatment gain, and general elevations in anxiety and depression.
- Compromised treatment integrity can have long-term effects on the efficacy of interventions and thus the recidivism of offenders.
- Finally, the challenge of managing VT reactions may contribute to the decision for some therapists to stop working with offenders or leave the helping profession completely. To date, the relationship between VT and attrition is unknown.

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