An Exploration of Vicarious Posttraumatic Growth in Sex Offender Treatment Providers

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Author Note

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Abstract

This study examines the experiences of five clinicians who are currently practicing as sex offender treatment providers (SOTP) from Washington state. An essential component of the phenomenological approach to qualitative research is to represent the subjective experiences and perspectives of the study participants. As such, the semi-structured interview format and use of open-ended questioning served the purpose of capturing the essence of the participants' experience from their perspective. The data were then coded and analyzed to identify the emerging patterns and themes within the participants' experiences. The research resulted in four major themes: 1) Negative Personal and Professional Aspects of SOTP work, 2) Holistic Approach to Treatment Achieved through Clinician Empathy and Client Accountability, 3) Adaptive Coping Skills, and 4) Positive Personal and Professional Aspects of SOTP Work. These emerging themes serve as a framework for discussion and further exploration regarding the experience of SOTPs and the roles of vicarious trauma, empathy, and vicarious posttraumatic growth.

This research revealed that SOTPs are a population of clinicians regularly exposed to the graphic details of their clients' sexual offenses and are thus susceptible to experiencing vicarious trauma. The emerging themes from this research, however, revealed that their experience also transcends the effects of vicarious trauma and is representative of individuals who have endured vicarious posttraumatic growth as a result of their meaning-making processes.

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List of Abbreviations

ACC	Anterior cingulate cortex
CSDT	Constructivist self-development theory
C-REP	Context representation
HPA	Hypothalamic-pituitary-adrenocortical axis
PTG	Posttraumatic growth
PTSD	Posttraumatic stress disorder
SOTP	Sex offender treatment provider
S-REP	Sensation-based representation
STS	Secondary traumatic stress
VPTG	Vicarious Posttraumatic Growth
VT	Vicarious Traumatization

Chapter 1

"If there is meaning in life at all, then there must be a meaning in suffering. Suffering is an ineradicable part of life, even as fate and death. Without suffering and death human life cannot be complete" (Frankl, 1946/1984, p. 88). This quote from *Man's Search for Meaning* (Frankl, 1946/1984) was written by Viennese psychotherapist Dr. Viktor Frankl and is based on his own experience as a survivor of Auschwitz, the infamous Nazi concentration camp (Benvenga, 1998; Frankl, 1946/1984). His approach to psychotherapy is best described as an individual who "embraced both the light and dark sides of human existence and believed that inevitable human suffering could contribute to meaning and achievement in life" (Benvenega, 1998, p. 3). Frankl's work contributed to the emergence of the positive psychology movement alongside other influential theorists who shaped our current understanding of human suffering and well-being, including Abraham Maslow and Carl Rogers (Benvenega, 1998).

The human experience inevitably involves a degree of suffering, whether in the form of setbacks, obstacles, failures, losses, sickness, or death (Sumsion &Wong, 2011). According to Manning-Jones et al. (2017), as much as 80% of the general population will experience a traumatic event in their lifetime. While all individuals unavoidably experience a degree of psychological suffering (Benvenega, 1998), whether or not the experience is internalized as a traumatic event is subjective to the individual (McCann & Pearlman, 1990). As such, it matters how individuals respond to unanticipated adversities (Wong, 2011). Traumatic events raise questions regarding the purpose and meaning of life, or questions about the fairness and controllability of the world (Barrington &

Shakespeare-Finch, 2012). Wong (2011) further explains this state of distress in the aftermath of trauma:

> Without a sense of coherence, life is incomprehensible, unpredictable, and unsettling. Without a sense of order and understanding of how the world works, we would have difficulty achieving hardiness. Without a clear sense of self-identity, we would not know what to do with our lives. (p. 74)

Despite life's inherent unpredictability, humans are motivated to develop cognitive frameworks that are designed for efficiently processing, understanding and navigating the world (Cohen & Collens, 2013). These frameworks, which relate to self, others, and the world provide us with a sense of security founded in the expectation that we will not go without our basic needs (e.g., physical safety, interpersonal connections; McCann & Pearlman, 1990). While some suffering is predictable, individuals exposed to profound trauma experience an unanticipated threat to their existing cognitive frameworks and, consequently, a threat to a sense of personal safety and security. Traumatic experiences that significantly threaten an individual's preexisting framework can propel this person into a state of psychological distress (Pearlman & Saakvitne, 1995). Those that experience rumination, flashbacks, and intrusive thoughts following a traumatic event are inadvertently frantically evaluating and making sense of the trauma to "fit" the experience into an existing framework and reestablish security (Tedeschi & Calhoun, 2004). Though initially unpleasant, some can take this cognitive process one step further and experience profound psychological growth as a result of broadening their preexisting framework to make sense of the trauma and identify ways in which it positively shaped their worldview (Cohen & Collens, 2013; Tedeschi & Calhoun, 2004).

Historically, the research literature on trauma predominantly focuses on the individuals experiencing the traumatic event firsthand. Research has since emerged examining the experience of mental health professionals tasked with working with individuals in the wake of profound trauma. Researchers Lisa McCann and Laurie Pearlman (1990) coined the term *vicarious trauma* (VT) as a means of explaining the emergence of posttraumatic stress symptoms in individuals vicariously (i.e., indirectly) exposed to trauma as a result of empathically engaging with details of their clients' traumatic material (e.g., listening to stories, narratives, experiences). The research literature to date notably focuses on the deleterious effects of trauma-based work, highlighting consequences such as compassion fatigue and burnout (Adams & Riggs, 2008; Chouliara et al., 2009; Devilly et al., 2009; Iliffe & Steed, 2000; Schauben & Frazier, 1995). Like the individuals who experience the trauma directly, mental health professionals are also able to experience positive psychological growth following vicarious exposure to traumatic material (Arnold et al., 2005; Hyatt-Burkhart, 2014).

The first study on vicarious traumatization in a sample of therapists (N = 188) cited empathic engagement with clients trauma material as a precursor to experiencing VT: "We define vicarious traumatization as the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae" (Pearlman & Mac Ian, 1995, p. 558). While acting as an inherent risk factor for VT, empathic engagement with clients' trauma material is also implicated as a moderating variable in obtaining positive outcomes as a result of trauma-based work (Brockhouse et al., 2011; Linley & Joseph, 2007). The term vicarious posttraumatic growth (VPTG) first emerged to explain the phenomenon of

individuals' experiencing positive outcomes as a result of vicarious exposure to trauma (Tedeschi & Calhoun, 1996). This theoretical construct is defined in further detail throughout the present review. Briefly, the term VPTG refers to enduring, positive psychological change experienced in the aftermath of vicarious exposure to trauma (Tedeschi & Calhoun, 2004).

The concept of VT was originally developed to explain and describe the experience of mental health professionals working with victims of sexual abuse (McCann & Pearlman, 1990; Kadambi & Truscott, 2003). It is now well documented that professionals working with victims of sexual abuse can experience VT as a result of repeated exposure to clients' trauma histories (Baird & Jenkins, 2003; Brady et al., 1999; Nen et al., 2011). The construct of VT has since been used in sexual abuse treatment research to describe and explain the negative psychological and interpersonal effects experienced by professionals working with perpetrators of sexual abuse as well (Baum & Moyal, 2018; Hatcher & Noakes, 2010; Kadambi & Truscott, 2003; Way et al., 2004). Several studies have offered support for the experience of VPTG in professionals vicariously exposed to clients' trauma material (Arnold et al., 2005; Barrington & Shakespeare-Finch, 2013; Linley & Joseph, 2007; Tedeschi & Calhoun, 1996). Currently a limited number of studies report the positive outcomes experienced by professionals providing psychological treatment to sexual offenders as a result of their work (Dean & Barnett, 2011; Hatcher & Noakes, 2010; Kadambi & Truscott, 2006). As such, the present review explores the mechanisms of VT and VPTG and the role of empathy in the experience of Sex Offender Treatment Providers (SOTPs).

Vicarious Traumatization

Prior to the latest revision of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013), the criterion for posttraumatic stress disorder (PTSD) in the previous four editions included the following qualifiers to define exposure to trauma: direct personal exposure, witnessing of trauma to others, and indirect exposure through trauma experience of a family member or close friend (Pai et al., 2017). The limited definition of trauma outlined in earlier versions of the diagnostic manual parallels the vast majority of the trauma research literature that exists to date, which narrowly focuses on those directly experiencing trauma. The publication of the *DSM-5* (APA), however, reflects the broadening of preexisting conceptualizations of trauma to include a fourth exposure type in the criteria for PTSD: repeated or extreme exposure to aversive details of a traumatic event (Pai et al., 2013). Importantly, researchers had examined this phenomenon well before the revisions to the *DSM-5*. Researchers McCann and Pearlman (1990) were the first to propose the construct of 'vicarious traumatization' to explain the experience of individuals repeatedly exposed to traumatic material as a direct result of their work (e.g., trauma therapists). Pearlman and Mac Ian (1995) conducted the first empirical study of the effects of trauma work on therapists and provided this still relevant definition of vicarious trauma:

> The transformation that occurs within the therapist as a result of empathic engagement with clients' trauma experiences and their sequelae. Such involvement includes listening to graphic descriptions of horrific events, bearing witness to people's cruelty to one another, and witnessing and participating in traumatic reenactments. (p. 558)

The *transformation* refers to the disruptive, enduring psychological effects of trauma-based work that leads to a shift in perspective about self, others, and the world (Barrington & Shakespeare-Finch, 2013). The perspective shift encompasses changes in perception of personal and professional identity, spirituality, individual capacities and abilities, and psychological needs. The psychological needs most vulnerable to the harmful effects of VT are those related to safety, trust, intimacy, and control (Sabin-Farrell & Turpin, 2003). The symptoms of VT that accompany this transformation mirror the symptoms of PTSD, including intrusive and disturbing thoughts and imagery, heightened startle response and hypervigilance, avoidance and emotional numbing, negative affect, irritability and aggression, impaired concentration, and the somatic effects of headaches, nausea, and insomnia (Pearlman & Saakvitne, 1995). It is important to note that VT occurs as a result of repeated exposure to traumatic material over time, it is not considered VT if the trauma symptoms emerge as a result of one interaction with a client (McCann & Pearlman, 1990).

Often, VT is misunderstood as a representation of other constructs cited in research examining the deleterious effects on individuals working in helping professions, including *secondary traumatic stress* (STS), *compassion fatigue*, and *burnout* (Jenkins & Baird, 2002). The overlap in terminology illustrates the spectrum of possible effects on individuals in helping professions, though the differences reveal the distinctly unique experiences and mechanisms of change that each construct represents. Secondary traumatic stress and compassion fatigue both define the emotional response and PTSD symptoms that emerge as a result of engaging in trauma work. Figley's (1995) original definition of STS, which they noted may be used interchangeably with compassion

fatigue, focused on the associated symptoms, such as hypervigilance and avoidance, that emerge in the context of any type of engagement with trauma work (e.g., first responders, mental health workers). According to Baird & Kracen (2006), this immediate response to trauma is both "quantitatively and qualitatively different" (p. 182) than what is being examined in therapists with VT, who endure years of bearing the traumatic stories of clients. Both secondary traumatic stress and compassion fatigue point to the symptoms of engaging in helping professions, whereas VT implies internal cognitive change that fundamentally alters the way the individual relates to self, others, and the world (Baird & Kracen, 2006; Jenkins & Baird, 2002). Burnout describes the "emotional exhaustion resulting from job strain, erosion of idealism, and a reduced sense of accomplishment and achievement" (Sabin-Farrell & Turpin, 2003, p. 453). The definition of burnout does not include the enduring psychological changes inherent in VT, such as the loss of sense of safety and security in the world (Sabin-Farrell & Turpin, 2003). Further, burnout may occur within any profession, whereas VT is specific to work with trauma survivors (Sabin-Farrell & Turpin, 2003).

Secondary traumatic stress, compassion fatigue, and burnout address cognition, emotional, behavioral, and physical responses as a result of exposure to traumatic material (Sabin-Farrel & Turpin, 2003). The definition of VT inherently covers the overt and subclinical trauma reaction observed in these similar constructs (Baird & Kracen, 2006; McCann & Pearlman, 1990). The point of distinction in the definition of VT, however, is the focus on the enduring transformation that occurs within the trauma worker as a direct result of empathic engagement (Baird & Kracen, 2006); VT implies a

change in the therapist marked by a fundamental shift in their sense of self and worldview (Baird & Kracen, 2006; McCann & Pearlman, 1990).

Cohen and Collens' (2013) meta-analysis of the VT literature revealed four key themes representative of the enduring changes reported by therapists: emotional reactions, physical reactions, schema changes, and changes in behavior. The emotional responses reported by participants as a result of repeated exposure to clients' trauma narratives included feelings of sadness (Satkunanayagam et al., 2010; Schauben & Frazier, 1995; Shamai & Ron, 2009), anger (Iliffe & Steed, 2000; Satkunanayagam et al., 2010; Schauben & Frazier, 1995; Steed & Downing, 1998), fear (Schauben & Frazier, 1995), frustration (Satkunanayagam, et al., 2010; Steed & Downing, 1998), powerlessness (Satkunanayagam et al., 2010), helplessness (Schauben & Frazier, 1995; Steed & Downing, 1998), despair (Splevins, Cohen, Stephen, Murray, & Bowley 2010), and shock (Pistorius et al., 2008; Splevins et al., 2010; Smith et al., 2007; Steed & Downing, 1998). Participants also reported strong somatic reactions, which they attributed to their experience of VT that included fatigue, insomnia, numbness, and nausea (Steed & Downing, 1998; Pistorius et al., 2008).

The enduring and intrusive change to schemas is the hallmark feature of VT. Cohen and Collens (2013) noted that therapists frequently cited changes to their sense of safety in the world as a result of repeated exposure to clients' trauma narratives. Participants described experiencing the world as generally unsafe as a result of empathically engaging with their clients' trauma histories (Bell, 2003; Benatar, 2000; Clemens, 2004; Illife & Steed, 2000; Pistorius et al., 2008; Schauben & Frazier, 1995). Schema shifts related to personal and other safety was observed in participants' reports of

feeling generally mistrustful of others, especially for those working with trauma material related to sexual abuse (Clemans, 2004; Illife & Steed, 2000; Pistorious et al., 2008; Schauben & Frazier, 1995). Further, participants from several studies perceived the emotional, somatic, and behavioral symptoms associated with VT to negatively impact the quality of their work as well (e.g., feeling emotionally detached from work, difficulties maintaining appropriate boundaries, and difficulties establishing trust with clients; Clemens, 2004; Schauben & Frazier, 1995; Shamai & Ron, 2009).

Theory of Vicarious Trauma

The theoretical basis of VT originates from the constructivist self-development theory (CSDT; Cohen & Collens, 2013; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). The CSDT implies that individuals construct their realities through the development of cognitive structures or schemas (Cohen & Collens, 2013). The term *schema* refers to an individual's beliefs, expectations, and assumptions about self, others, and the world (Cohen & Collens, 2013). Schemas fundamentally encompass the preexisting assumptions about the way the world is organized and formed through the internal and external experiences of the individual (Axelrod, 1973). For example, individuals tend to have schemas that the world is a generally safe place to be. If a person did not believe this to be true, we would likely observe an individual who lives in constant fear. To illustrate the critical point that individual experiences shape subjective schemas, imagine a person who has grown up in a war-torn part of the world marked by poverty and violence. This individual would likely have a different schema of personal safety compared to an individual growing up in an upper-class suburb and would thus approach situations differently because of their past experiences. Schemas filter each

experience and interaction in the world and fit these into an existing schema, or the schema is altered to incorporate the new information through a process of accommodation.

The foundation of CSDT is that individuals engage in the process of understanding, or making meaning of, their experiences in the world (Devilley et al., 2009; Pearlman & Mac Ian, 1995). This meaning-making process thus occurs and recurs as new information and experiences are integrated into an individual's beliefs and systems of meaning (Devilley et al., 2009). If an individual is unable to assimilate the information into an existing schema, the original schemas are "challenged" (i.e., confronted, questioned; Cohen & Collens, 2013). Therapists, for example, exposed to detailed narratives of clients' traumatic experiences may experience changes to their existing schemas as a result. If a therapist is unable to accommodate or assimilate the new information, they may experience VT (Sabin-Farrell & Turpin, 2003).

McCann and Pearlman (1990) identified the following basic psychological needs that encompass an individual's set of personal schemas: intimacy, esteem, power, dependency/trust, safety, independence, and frame of reference (i.e., an individual's attribution as to why events occur; Illife & Steed, 2000). Trauma can disrupt these core schemas, though the impact is unique to the individual depending on which of these psychological needs (e.g., schemas) are essential to the individual's sense of wellbeing in the world and how severely the trauma disrupts (e.g., challenges) these existing schemas (Illife & Steed, 2000). According to Devilley et al. (2009), CSDT applied to the trauma experience is used in an attempt to "understand an individual's adaption to trauma as an interaction between personality, personal history, the traumatic event, and its social and

cultural context" (p. 374). When experiencing trauma or VT, the information (i.e., the trauma material) does not typically fit into an existing schema because the individual has no prior exposure to similar information in his or her past. As such, the original schema (e.g., the world is safe) becomes invalidated (e.g., the world is not always safe and requires caution) or even shattered (e.g. the world is inherently unsafe and there is nothing to be done about it; Cohen & Collens, 2013). Barrington and Shakespeare-Finch (2013) emphasized the ability for trauma to "shatter the global beliefs that people hold" (p. 90).

From the CSDT framework, trauma work in a clinical setting focuses on integrating the trauma experience into an individual's existing beliefs and systems of meaning (Devilley et al., 2009). Essentially, the new information needs to incorporate into the existing belief through a process called accommodation (Cohen & Collens, 2013). Park (2010) defined global belief systems as the beliefs, goals, and subjective feelings that comprise broad views regarding justice, control, predictability, and individual self-views that form the schemas in which individuals interpret their experiences of the world. An individual may experience an event that fits into their existing global beliefs, thus allowing them to integrate the experience into their current schema without issue. If the experience is discrepant with existing belief systems, however, the individual is likely to appraise the event as distressing because it threatens one's sense of controllability and comprehensibility in the world (Park, 2010). Individuals will typically report that they have control over their lives and that the world is reasonably good and fair (Barrington & Shakespeare-Finch, 2013). However, beliefs of

controllability and fairness in the world are often devastated and destroyed following the experience of a traumatic event (Barrington & Finch, 2013; Park, 2010).

Sabin-Farrell and Turpin (2003) noted cognitive theories of memory processing in PTSD as a potential contributing process to explain the phenomenon of VT in therapists. The researchers included the cognitive model of persistent PTSD proposed by Ehlers and Clark (2000), which states that it is the perceived presence of the current threat that maintains PTSD. Sabin-Farrell and Turpin (2003) explained that therapists working with traumatized clients are exposed continuously to further trauma material, suggesting that it is likely the perceived threat of ongoing traumatization that leads to VT. McCann and Pearlman (1990) also allude to the cognitive theory of memory process in their research on VT and describe how neutral stimuli can trigger therapists to have trauma memories or flashbacks that are relevant to clients' traumatic experiences. The stimuli then become associated with traumatic experiences in the therapist's memory system (Sabin-Farrell & Turpin, 2003).

The effects of trauma exposure are not merely isolated to flashbacks and memories of the events but can result in enduring changes to the neurobiological structure of the brain (Bremner, 2006). For the purpose of this review, it is useful to explore the neurobiological implications of trauma and how these may contribute to the enduring changes observed in individuals vicariously exposed to trauma (Rasmussen & Bliss, 2014).

Neurobiological Implications of Trauma

The neurobiological processes that can occur in the aftermath of trauma fundamentally alters the brain, creating a host of negative psychological and

physiological symptoms that contribute to an enduring change in the affected individual (Bremner, 2006). Trauma researchers have speculated that the neurobiological changes observed in humans as a result of direct exposure to trauma are comparable to the impact on individuals vicariously exposed to trauma (Rasmussen & Bliss, 2014). While there are no direct studies on the neurobiological effects of VT, there is emerging animal research using adult male mice which demonstrates that simply witnessing a traumatic event is associated with an increased stress response resulting in observable neurobiological alterations (Warren et al., 2013). For the purposes of this review, it is valuable to explore the possible neurobiological implications of VT based on the existing research on the effects of direct exposure to trauma and how this may contribute to enduring changes in personality, behavior, and worldview seen in individuals vicariously traumatized.

When an individual is exposed to something that they perceive as a profound stressor, such as a traumatic event, the body engages in a psychobiological regulatory process referred to as *allostasis*. According to Iribarren and colleagues (2005), allostatic regulation encompasses a range of behavioral and physiological functions designed to regulate the body's response to a profound stressor (e.g., trauma exposure). Mariotti (2015) explained that the stress response clearly has a physical (objective) component as well as a psychological (subjective component). The psychological stress response is considered to be a subjective reaction based on the individual's perception of the stressor and their perceived ability to adapt to the stressor. Mariotti (2015) further explained that the individual's perceived ability to control or adapt to the stressor largely influences the severity of the stress response (e.g., the physical/objective component) and how efficiently the stress response is deactivated once equilibrium is recovered.

Structural and functional abnormalities in the prefrontal and limbic areas of the brain, both of which are involved in cognitive and emotional processing, are associated with PTSD (Fragkaki et al., 2016). Findings from a recent meta-analysis assessing cognitive impairments of individuals with PTSD (n = 846) compared with a population of healthy controls (n = 520) indicated that those with PTSD evidenced volumetric reductions in the following brain regions: amygdala, hippocampus, and anterior cingulate cortex (O'Doherty et al., 2015).

Amygdala. The amygdala, located in the temporal lobe, plays an essential role in emotional memory processing. It is involved in emotional processing, acquisition, expression, fear conditioning and generalization, and regulation of fear and traumatic memories (Fragkaki et al., 2016). The function of this system is to detect perceived threats to safety in the environment and activates the sympathetic nervous system (e.g., fight or flight response). The sympathetic nervous system is activated by a release of cortisol into the bloodstream, which is our bodies' main stress hormone (Fragkaki et al., 2016). It provides the body with a burst of energy via a release of the hormone epinephrine (e.g., adrenaline) into the blood stream to prepare the body to react (e.g., fight or flight) to the perceived stressor/threat (Prager et al., 2016). The release of epinephrine into the blood stream results in physiological changes such as increased heart rate and blood pressure to send energy to muscles, and rapid breathing to increase oxygen flow. Chronic overactivation of the amygdala results in an ongoing stress response that can have serious deleterious effects such as weight gain (Chao et al., 2017), cognitive impairments (Lupien et al., 2009), sleep disturbances (Heinrichs et al., 2003), and sexual dysfunction (Hamilton & Meston, 2013) Studies using neuroimaging research indicate

that reductions in amygdala volume in individuals with PTSD are associated with poorer inhibitory control (e.g., ability to focus on relevant stimuli in the presence of irrelevant stimuli), increase in self-reported impulsivity, and increased PTSD symptoms, especially those associated with hypervigilance and re-experiencing (e.g., flashbacks; Depue et al., 2014). Research indicates that individuals with PTSD evidence hyperactivation of the amygdala in addition to reductions in volume, resulting in a chronic state of hypervigilance and hyperarousal to trauma reminders (Fragkaki et al., 2016).

Hippocampus. The hippocampus plays a vital role in memory processing and the regulation of the hypothalamic–pituitary–adrenocortical (HPA) axis. Specifically, the hippocampus is involved in the formation of long-term declarative memory (i.e., memory of facts and events) and memory processing (e.g., encoding, storage, and recall; Fragkaki et al., 2016). Research indicates that individuals with PTSD commonly evidence a significantly smaller hippocampus compared to trauma-exposed and trauma-exposed healthy individuals (O'Doherty et al., 2015). Individuals with PTSD commonly report difficulties with memory as a result (Fragkaki et al., 2016).

Research on the neurobiological effects of PTSD also points to hippocampal dysfunction as a viable explanation for the strong reactions (e.g., hypervigilance, flashbacks, increased heart rate) to trauma reminders that, typically, in the present context are not actual dangers or threats to safety (Brewin et al., 2010). Research from animal studies indicates that the hippocampus is required in memory processing, which subsequently means that it also is responsible for the associations made between the memory of the traumatic event and contextual stimuli that serve as trauma reminders (Acheson et al., 2011. Acheson and colleagues (2012) explained that the hippocampus is

critical for encoding memories where multiple cues serve as reminders of a traumatic event; however, the hippocampus does not play a role in forming discrete cue associations. This is further explained by Brewin (as cited in Acheson et al., 2012) through the dual representation of intrusive memories in PTSD, which involves two forms of memory, one of which is dependent upon the hippocampus. According to Brewin's model of intrusive memories, the hippocampal-dependent memory system is referred to a *context representation* (C-rep) and contains memories of the special context of an event (Acheson et al., 2012; Brewin et al., 2010).

The second form of memory is a *sensation-based representation* (S-rep) of the same event (Acheson et al., 2012; Brewin et al., 2010). The S-rep may be activated by an environmental cue and activates the corresponding C-rep, which allows the event to be placed in the appropriate context and prevents it from being re-experienced as if in the present (Acheson et al., 2012). According to Brewin et al. (2010) hypotheses, the intrusive memories associated with PTSD are caused by strong S-reps for the traumatic event and impoverished or event C-reps due to decreases in hippocampal function. The reduction in C-rep functioning results in the individual feeling as though they are re-experiencing the threat (i.e., flashbacks) in the present when they encounter a trauma reminder (Acheson et al., 2012). While further research is needed, it is a glimpse into the enduring impact of trauma on the brain.

Anterior Cingulate Cortex. The anterior cingulate cortex (ACC) is located in a unique position within the brain connections to the prefrontal cortex (e.g., cognitive functioning) and the limbic system (e.g., emotional; Stevens et al., 2011). The ACC plays an important role in the pathophysiology of PTSD due to its role in the regulation of the

stress response (e.g., regulating heart rate and blood pressure; O'Doherty et al., 2015). The ACC is also involved in affect regulation (i.e., managing unpleasant emotions), decision-making, and empathy (Lavin et al., 2013; Stevens et al., 2011). The underlying theory of the role of the ACC in PTSD is that the symptoms emerge as a result of hyperactivity in the amygdala in response to stimuli perceived as threatening coupled with a failure of the ACC to manage and inhibit the stress response (O'Doherty et al., 2015). Neuroimaging studies offer further support for the role of the ACC in the maintenance of PTSD symptoms as evidenced by reduced volume and reduced activity of the ACC in individuals with PTSD compared with healthy controls (O'Doherty et al., 2015).

The enduring change brought on by direct exposure to trauma and possibly VT (Rasmussen & Bliss, 2014) clearly impact an individuals' ability to function effectively in the world, especially when overwhelmed with stimuli that is perceived as threatening as a result (Acheson et al., 2012; O'Doherty et al., 2015). As discussed, these neurobiological changes may also impact areas of the brain associated with empathic engagement with other individuals (Lavin et al., 2013; Stevens et al., 2011). Empathy is an important tool for promoting change in the context of the therapeutic relationship (Castonguay & Beutler, 2006; Norcross et al., 2011). Empathic engagement with clients' trauma material is considered to be a vital component in the etiology of VT (Pearlman & Saakvitne, 1995a) and is thus explored in further detail for the purpose of this review.

Vicarious Trauma and Empathic Engagement

"We think we listen, but very rarely do we listen with real understanding, true empathy. Yet listening of this very special kind, is one of the most potent forces for change that I know" (Rogers, 1967, p. 134)

Therapists' empathy is the ability to accurately sense the feelings and personal meanings that the client is experiencing and communicate this understanding to the client (Rogers, 1975). A therapist's ability to convey accurate empathy facilitates a therapeutic alliance in which the client feels heard, understood, and accepted (Rogers, 1980). Watson et al. 2013) explained that in addition to facilitating a positive alliance, therapist's empathy also enables change in the clients' internal representation of self. Carl Rogers (1980), pioneer of the humanistic psychology movement and proponent of empathy as a therapeutic tool explained, "As persons are accepted and prized, they tend to develop a more caring attitude towards themselves" (p. 116).

Research demonstrates a correlation between a therapist's empathic engagement and positive therapy outcomes across different therapeutic orientations (Castonguay & Beutler, 2006; Norcross et al., 2011). Elliott et al. (2011) conducted a meta-analysis to assess the relationship between empathy and psychotherapy outcomes based on the experiences of 3,599 clients across 59 samples. The findings from the meta-analysis indicated that therapists' empathy in the therapeutic relationship accounts for roughly 9% of the variance in therapy outcome (Elliott et al., 2011). Further, these findings suggest that empathy typically accounts for more outcome variance than specific treatment methods (Elliott et al., 2011). These findings were supported across theoretical orientations, treatment formats, and client problems (e.g., psychopathologies). Importantly, the researchers maintain that empathy is not necessarily provided by the

therapist, but rather a co-created experience between therapist trying to understand the client trying to convey their experience to the therapist (Elliott et al., 2011). Research also demonstrates similar findings in work with challenging populations. For example, Blasko and Jeglic (2014) conducted a study of male offenders and found that perceived bond formation with their therapist significantly negatively correlated with risk for re-offense.

Despite clear empirical support for empathy as a powerful mechanism of change in the relationship between therapist and client, empathic engagement is also a factor in the experience of the therapist's VT. The pioneers of VT research, Pearlman and Saakvitne (1995), explicitly stated, "Vicarious trauma can affect anyone who engages empathically with trauma survivors" (p. 281). The pitfalls of empathy in the therapeutic relationship within trauma-based work is cited even in more recent publications of VT research. Arnold and colleagues (2005) indicated that empathic engagement with difficult trauma material could lead to *empathic strain*, a result of an adverse countertransference reaction that impacts therapists' ability to remain objective and maintain therapeutic boundaries. Empathic strain, according to the researchers, typically falls into one of two categories: repression or withdrawal of empathy or empathic enmeshment (Arnold et al., 2005). The researchers noted that repression or withdrawal of empathy may manifest as denial, detachment, avoidance, or minimization of a client's trauma experience; whereas empathic enmeshment may emerge as overidentification with a client or over-idealization of a client (Arnold et al., 2005). Ultimately, the VT literature does not necessarily highlight the benefits of empathy in trauma work and instead focuses on the heightened risk this creates for VT.

Posttraumatic-Growth

The research literature on trauma predominantly focuses on the deleterious psychological effects of PTSD defined in the *DSM-5* (e.g., hypervigilance, intrusive thoughts, distressing emotions, somatic reactions). Posttraumatic-growth (PTG), however, is an emerging topic of trauma research focusing on the positive psychological changes that can occur in individuals following exposure to a traumatic event (Barrington & Shakespeare-Finch, 2013; Tedeschi & Calhoun, 2004). Progress in the treatment of PTSD involves a gradual return to baseline functioning and the absence of posttraumatic stress symptoms (e.g., hypervigilance, flashbacks, intrusive thoughts). The experience of PTG, however, transcends return to pre-trauma functioning and reflects adaptive changes in the following three domains: (a) sense of self, (b) interpersonal relationships, and (c) life philosophy (Barrington & Shakespeare-Finch, 2013; Tedeschi & Calhoun, 1996/2004).

Analogous to the theoretical basis of VT, the CSDT provides the framework for understanding the phenomenon of VPTG. The CSDT maintains that individuals construct their realities based on their experiences in the world and their interpretations of these experiences (Cohen & Collens, 2013). The reality that the individual constructs interact with preexisting schemas and impacts the development of new schemas. Schemas influence how we make sense of our experiences and inevitably includes a process of identifying sources of meaning and purpose within these experiences (Tedeschi & Calhoun, 2004). A traumatic experience can create a state of psychological crisis for the individual who is unable to process and accommodate the information into their existing schemas. Tedeschi and Calhoun (2004) define a psychological crisis as "the extent to

which the fundamental components of the assumptive world are challenged, including assumptions about the benevolence, predictability, and controllability of the world; one's safety is challenged, and one's identity and future are challenged" (p. 4).

For psychological growth to occur, the traumatic material must challenge the individual's assumptive world significantly (Arnold et al., 2005; Cohen & Collens, 2013; Tedeschi & Calhoun, 2004). PTG thus occurs as a direct result of the cognitive struggle within the individual to make sense of the trauma and accommodate the information into their schema for adaptively processing the experience (Cann et al., 2010). This cognitive process of integrating trauma material may manifest in one of three ways according to prominent trauma theorists: no change to previous schema (i.e., "assimilation"), positive change to previous schema (i.e., "positive accommodation"), and a negative change to previous schema (i.e., "negative accommodation"; Cohen & Collens, 2013, p. 571). Importantly, PTG differs from the definition of *resiliency* frequently cited in the trauma recovery literature. Resiliency refers to the ability to function effectively (i.e., carry on with life and cope) following highly challenging or traumatic life circumstances (Tedeschi & Calhoun, 2004). The term PTG implies an experience of marked, enduring personal growth that occurs within an individual as a direct result of exposure to a traumatic event. Resiliency is a cognitive process of accommodation of highly challenging material into existing schemas. PTG and VPTG are associated with positive accommodation and imply a growth beyond the baseline functioning, whereas psychopathology and distress indicate negative accommodation (Linley & Joseph, 2007). For positive accommodation to occur, an individual must learn to adjust their existing beliefs in a meaningful way to accommodate the trauma material.

Barrington and Shakespeare-Finch (2013) explained that the shattering of beliefs associated with trauma and VT creates a significant barrier in one's ability to make meaning of the event and obtain favorable outcomes. In a state of psychological crisis following direct or vicarious exposure to trauma material that threatens the assumptive world, an individual typically endures a state of automatic cognitive processing in a frantic effort to make sense of the experience marked by the intrusive symptoms associated with posttraumatic stress (e.g., intrusive thoughts and images, negative intrusive rumination; Tedeschi & Calhoun, 2004). Individuals must eventually learn to detach from the pre-trauma assumptions and beliefs that maintain this state of distress. Tedeschi and Calhoun (2004) explain that the distressing rumination following trauma exposure is a necessary precursor for psychological growth. This state of psychological crises indicates that the trauma material significantly challenged the individual's pre-trauma worldviews to the extent that preexisting goals, beliefs, or philosophies feel unattainable in the construction of a new reality post-trauma. PTG begins when the individual forms new goals and expectations that allow them to feel as though they are moving forward once again (Tedeschi & Calhoun, 2004). The growth informs a narrative of pre-trauma functioning and post-trauma functioning where the individual can identify how they experienced the three domains of growth associated with PTG (e.g., (a) sense of self, (b) interpersonal relationships, and (c) life philosophy; Barrington & Shakespeare-Finch, 2013).

Vicarious Posttraumatic Growth

Research suggests that those in helping professions exposed repeatedly to details of traumatic events are vulnerable to experiencing posttraumatic stress symptoms in the

aftermath (e.g., VT; Cosden et al., 2016; Devilly et al., 2009; Jenkins & Baird, 2002; Kadambi & Truscott, 2003; McCann & Pearlman, 1990; Nen et al., 2011; Pearlman & Mac Ian, 1995). Amidst reports of the deleterious psychological effects and inherent challenges associated with trauma-based work are accounts of positive growth attributed to trauma-based work. The concept of VPTG emerged in the first study to explore the positive outcomes of working with trauma survivors in a sample of psychotherapists (N = 21; Arnold et al., 2005). All participants in the study reported experiencing negative symptoms as a result of their trauma work, such as intrusive thoughts of the trauma material, flashbacks, anger, anxiety, fear, helplessness, avoidance, struggles with empathic engagement with clients, exhaustion, and self-doubt (Arnold et al., 2005). Despite these negative consequences of trauma work, all participants also reported some form of significant, enduring positive outcomes as a result of engaging with clients' trauma material (Arnold et al., 2005). The most frequently cited positive outcome in the study (n = 19) was the experience of witnessing and encouraging their clients' PTG, which led to positive change in the therapists' themselves regarding a sense of self-reliance and capacity for growth. Many clinicians (n = 18) endorsed enduring, trait-oriented changes in the self, such as increased levels of sensitivity, compassion, insight, tolerance, and empathy (Arnold et al., 2005). Several clinicians indicated an increased openness to the spirituality of others and growth in terms of their own spiritual beliefs as a result of their trauma work. Other positive benefits noted in this study included reports of a deeper appreciation for the strength and resilience of the human spirit, living life more fully, treating others with greater kindness and gratitude, and becoming more emotionally expressive with loved ones (Arnold et al., 2005). According to the authors,

these findings suggest that the benefits of trauma work for clinicians has been vastly underestimated and shrouded in previous literature by the adverse outcomes of trauma work (e.g., VT; Arnold et al., 2005).

Barrington and Shakespeare-Finch (2013) conducted a qualitative study to assess VT in clinicians ($N = 17$) working with refugee survivors of torture and other various traumas in Australia. Similar to the findings of Arnold et al.'s study (2005), the current study indicated that while all clinicians in the study reported vicarious trauma reactions as a direct result of their work, these same individuals also reported areas of personal growth indicative of VTPG (Barrington & Shakespeare-Finch, 2013). Participants reported growth in three key areas: changes in life philosophy, changes in self-perception, and changes in interpersonal relationships. Under the domain of changes in philosophy, clinicians reported a greater understanding of and empathy for the experiences of others, an increased sense of gratitude and appreciation for their loved ones, and a deepening/strengthening of their spiritual beliefs (Barrington & Shakespeare-Finch, 2013). Changes in self-perception included reports of increased confidence in their professional roles and a greater sense of strength in their personal lives when confronted with adversity, as well as feeling greater satisfaction in their work (Barrington & Shakespeare-Finch, 2013). The clinicians also reported positive changes in their interpersonal relationships as a result of the changes mentioned above to a sense of self and philosophy/worldview. For example, most clinicians spoke about greater intentionality in their relationships in terms of investing their time in those they felt shared similar values and beliefs (Barrington & Shakespeare-Finch, 2013). The findings

of the study offer further support for the positive psychological growth that occurs when clinicians exposed to trauma material engage in a process of meaning-making.

Consistent with earlier research examining the positive changes experienced by clinicians working with clients' trauma histories (Arnold et al., 2005; Barrington & Shakespeare-Finch, 2013), Hyatt-Burkhart (2014) conducted a qualitative study to understand various components of the experience of mental health workers *(N* = 12) working with multiple traumatized children and adolescents. The participants were prompted to discuss the "benefit(s)" of their work. Notably, all the participants in the study endorsed experiencing some degree of personal growth as a direct result of their work. Consistent with earlier research (Calhoun & Tedeschi, 1999), the positive changes reported by the participants fell into one of three domains of VPTG: self-perception, interpersonal relationships, and philosophy of life. In terms of positive changes in self-perception, participants reported greater open-mindedness and tolerance, as well as increased flexibility and adaptability (Hyatt-Burkhart, 2014). Changes in interpersonal relationships indicated by the participants included a deeper appreciation for family and friends; greater awareness and attentiveness within their personal and professional relationships; and an enhanced sense of value in their relationships (Hyatt-Burkhart, 2014). Finally, changes to life philosophy included deeper appreciation for their own lives in comparison with the complicated lives of the clients they work with (Hyatt-Burkhart, 2014).

The research conducted by Linley and Joseph (2007) offers compelling evidence for empathic engagement as a moderating variable for posttraumatic growth following repeated vicarious exposure to clients' trauma material. Specifically, in a study of VPTG

in a sample of therapists ($N = 365$), the therapeutic bond was the most significant predictor of positive psychological changes (Linley & Joseph, 2007). The researchers explained, "the therapeutic bond may represent the therapist's empathic connection with his or her clients, and thus serves as the channel through which the therapist experiences positive psychological changes in grappling vicariously with the suffering and distress of his or her clients" (Linley & Joseph, 2007, p. 399).

Vicarious Posttraumatic Growth and Empathic Engagement

Prominent researchers (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995) on VT unanimously state that empathic engagement is a necessary prerequisite to experiencing the shift in the sense of self and worldview that accompanies the deleterious effects of VT. Examining the role of empathy for therapists as a moderating variable in VPTG, Brockhouse et al. (2011) described empathy as "the art of understanding, reflected in perspective taking, standing in another's shoes, tolerance, openness, uncritical judgment, and unconditional acceptance" (p. 736). Brockhouse and colleagues (2011) state that empathy "reduces the psychological distance between therapist and client [and thus may] enhance" the impact of vicarious experience and increase the need for accommodation of schema (p. 741). The accommodation process may initially come at the cost of profound psychological distress (e.g., VT), but also opens up possibilities for a profoundly positive outcome as evidenced in the experience of VPTG (Brockhouse et al., 2011). In a study of therapists ($N = 118$), Brockhouse and colleagues (2011) reported that empathy was a positive predictor of therapist's growth following vicarious exposure to difficult trauma material. The results

of this study point to the importance of the therapist's empathy to achieve the positive effects of VPTG following VT (Brockhouse et al., 2011).

Vicarious Trauma and Vicarious Posttraumatic Growth in Sex Offender Treatment Providers

The VT research clearly illustrates the profound costs on clinicians' wellbeing as a result of empathic engagement with trauma-based work. Noted in the underlying theory guiding the phenomenon of VT, individuals construct their own realities and thus have exhibited different reactions than others when confronted with narratives of traumatic experiences. While some trauma narratives are subjectively more difficult to process than others, the VT literature notes the heightened risk for VT inherent in clinicians who work with victims or perpetrators of sexual abuse (Hatcher & Noakes, 2010; Kadambi & Trescott, 2003; Schauben & Frazier; Slater & Lambie, 2011). Clinicians who work with sex offenders specifically confront material that brings a heightened awareness of sexual violence and troubling sexual behaviors, interests, and arousals (e.g., pedophilia; Slater & Lambie, 2011). Sex offender treatment providers (SOTPs) are licensed mental health professionals who have obtained professional certification in the provision of court-mandated sex offender treatment. Throughout the course of treatment, an SOTP will likely engage in the following standard procedures: processing of the sexual content of an offender's behaviors and fantasies, processing of cognitive distortions related to sexual offending acts and problematic thoughts, and addressing problematic behaviors (e.g., lying/manipulation, treatment adherence; Hatcher & Noakes, 2010). For effective treatment to occur, the nature of this work necessitates a willingness to engage in processing the sexual content of offender's behaviors and fantasies, as well as the

processing of cognitive distortions related to sexual offending behaviors and problematic thoughts (Hatcher & Noakes, 2010). As a result of exposure to this difficult material, SOTPs are at a heightened risk for the psychological impact of VT (Hatcher & Noakes, 2010; Kadambi & Trescott, 2003; Schauben & Frazier, ; Slater & Lambie, 2011).

In a study examining VT in a sample of sexual offender treatment providers, participants reported hypervigilance, avoidance behaviors (e.g., avoidance of walking alone at night), engaging in behaviors to increase personal safety (e.g., extra security at the home), negative affect (e.g., distress, irritability, or nervousness), and intrusive thoughts (e.g., offence details) as a result of engaging in their work (Hatcher & Noakes, 2010). Schauben and Frazier (1995) found significant correlations between the percentage of sexual violence survivors in counselors' caseloads and symptoms of PTSD, self-reported VT, and disruption in beliefs.

Sandhu and colleagues (2012) conducted a small exploratory study of the emotional impact on staff members engaging in sex offender treatment with a population of intellectually disabled offenders. Common themes of emotional distress from empathically engaging in their work emerged, with several participants reporting that they have to emotionally disassociate and compartmentalize their work (e.g., deliberate avoidance of thoughts about the victims' experience) to engage in their work with the offenders (Sandhu et al., 2012).

Haneen and Haj-Yahia (2016) conducted a qualitative study interviewing social workers involved in the treatment of sex offenders to understand the intrapersonal and interpersonal impact of engaging in this type of work. Regarding the intrapersonal impact, participants reported having initial feelings of disgust towards the offenders when

initially assigned a case with some reporting that it was difficult to remain professional during the first interaction due to initial feelings of rage and disgust (Haneen & Haj-Yahia, 2016). They reported intrusive thoughts about the traumatic material and difficulties disengaging from thoughts once away from work (e.g., nightmares, intrusive mental imagery, hypervigilance; Haneen & Haj-Yahia, 2016). Regarding interpersonal issues, the participants described problems with parenting manifesting as extreme anxiety and vigilance about the possibility of their children being sexually abused. Further, they reported difficulties in their intimate relationships as a result of feelings of sexual aversion/low sex drive, feeling overly suspicious of others, and feeling as though it has led to a negative change in their overall worldview (e.g., loss of innocence; Haneen & Haj Yahia, 2016). Further, research suggests that these providers are vulnerable to stigma by association as a result of their work, which can result in feelings of profound loneliness and even a need to apologize to friends, family, and colleagues for their work (Haneen & Haj-Yahia, 2016; Hardeberg Bach & Demuth, 2018; Hatcher & Noakes, 2010).

Despite the increased risk for VT in SOTPs, research thus far does not necessarily indicate that these professionals' evidence significantly higher rates of burnout or compassion fatigue compared with other mental health professionals (Slater & Lambie, 2011; Hatcher & Noakes, 2010; Clarke & Roger, 2007; Kadambi & Truscott, 2003). In one study, a majority of treatment providers (85%) reported moderate to high levels of pleasure and job satisfaction associated with their SOTP work and reported the following positive subjective changes: greater acceptance of individuals, a greater belief in individual worth, and an increased understanding or awareness of individual behaviors or

motives (Slater & Lambie, 2011). Hatcher and Noakes (2010) also examined the effects of engaging in sex offender treatment for therapists and found that participants reported increased confidence in skills, ability, and contribution to their professional role. Further, the participants also reported increased acceptance of differences and vulnerabilities in self and others and a greater call to challenge injustices and inequalities seen or heard daily, particularly those of a sexual nature (e.g., sexual exploitation, sexism, social inequality; Hatcher & Noakes, 2010). Kadambi & Truscott (2003) noted that, contrary to initial expectations, participants who identified working primarily with sex offenders did not exhibit significantly higher degrees of vicarious trauma than the criterion reference group of mental health professionals. These studies suggest that even though SOTPs are theoretically a group of mental health professionals at the most considerable risk for the deleterious effects of VT, these professionals are not experiencing active VT symptoms and, in fact, report markedly high workplace satisfaction in the studies to date (Dean & Barnett, 2011; Slater & Lambie, 2011; Hatcher & Noakes, 2010).

Purpose of the Study

The research to date gives substantially more attention to the deleterious effects of trauma work, such as the symptoms associated with VT and the enduring change this can have on providers. The focus on the adverse effects paints a rather pessimistic picture that trauma work is inherently related to enduring damage to the therapist's emotional stability, interpersonal relationships, sense of personal safety, willingness to engage in their work, and ability to sit with their clients and experience genuine empathy. This heightened focus on the hazards does not provide a comprehensive look at the outcomes of this type of work as it neglects the potential for positive growth (Brockhouse et al.,

2011). The limited, though growing, research on VPTG in mental health workers sheds light on the capacity for substantial personal and professional growth for providers who can effectively process the problematic material and positively accommodate it into their assumptive world. Importantly, it also emphasizes the necessity for empathic engagement with clients to obtain these positive outcomes (Brockhouse et al., 2011).

The purpose of the present study is to add to the existing research literature demonstrating the potential for enduring, positive changes to occur for mental health workers who are vicariously exposed to traumatic material. Specifically, the present study explored the experience of clinicians working as SOTPs. This population was chosen to address the gap in the existing research that suggests SOTPs are at heightened risk for the deleterious effects of VT (Haneen & Haj-Yahia, 2016; Sandhu et al., 2012; Slater & Lambie, 2011; Hatcher & Noakes, 2010; Kadambi & Trescott, 2003; Steed & Bicknell, 2001), yet appear to report substantial workplace satisfaction and personal growth as a result of their work as well (Dean & Barnett, 2011; Slater & Lambie, 2011; Hatcher & Noakes, 2010). SOTPs are inherently exposed to difficult material that highlights the capacity for people's manipulation and abuse in such a detailed manner that providers have likely not experienced.

Not only does the existing literature overwhelmingly cite the risk for VT in SOTPs, but it also cites behaviors such as emotional detachment, compartmentalization, avoidance, and repression of emotions as mechanisms that treatment providers utilize to 'manage' their difficult work with offenders (Haneen & Haj-Yahia, 2016;; Hatcher & Noakes, 2010; Kadambi & Trescott, 2003; Sandhu et al., 2011; Slater & Lambie, 2011Steed & Bicknell, 2001). The research thus sends the message that (a) empathic

engagement is a risk factor in working with sex offenders and (b) measures should be taken to suppress empathic engagement actively (e.g., avoidance and emotional repression) as a means of coping with work involving sex offenders.

Brockhouse and colleagues (2011) stated that an increased understanding of how trauma work can lead to positive outcomes for providers has important clinical implications (e.g., role retention, enhanced clinician well-being, and improved therapeutic outcomes). As such, this study sought to draw out the experience of these providers to examine the positive and negative impacts of this difficult work. A qualitative methodological approach was selected for this particular study as it allows the participant to tell their story in a meaningful way, from his or her unique perspective, while the researcher guided them through this exploration. For this particular study the uniqueness of each individual's experience and perspective is where the valuable data lies. Conversely, a quantitative approach may have limited the extent to which participants' unique perspectives were described. The present study sought to understand and describe the lived experience of SOTPs with a focus on addressing the overarching research question of whether individuals in this field report positive personal and professional gains as a direct result of grappling with the inherently difficult content of this work and the role of empathy in the therapeutic relationship.

Chapter 2

This chapter will provide an outline for how the study was conducted. The philosophical worldview, research questions, and the study design will be described. Additionally, the risks to participants, data analyses procedures, and methods to promote study trustworthiness are explored.

Philosophical Worldview

The constructivism worldview assumes that individuals strive to understand the world around them and construct a subjective reality in the process based on their experiences (Creswell, 2014; Merriam & Tisdell, 2016). According to Merriam and Tisdell (2016, qualitative research guided by this worldview aims for an in-depth exploration focused on the participants' interpretations of their experiences, how they construct their subjective reality, and the meaning each of them attributes to these experiences. The constructivist worldview maintains that reality is subjective and is continuously shaped based on an individual's lifetime of experiences. The present study used the constructivist worldview to guide in-depth exploration of the ways in which participants have been uniquely shaped, both personally and professionally, by their lived experience as a SOTP and the meaning they attribute to these experiences.

Research Questions

Guided by qualitative methodology, the researcher conducted individual, semi-structured interviews with eligible participants (see Appendix C) to investigate the experience of SOTPs with a focus on addressing the overarching research question of whether individuals in this field report positive personal and professional gains as a direct result of their therapeutic work as well as their process of coping with their clients'

offense narratives. This necessitated a holistic exploration of the SOTP's experience guided by the following research questions:

1. What is the experience of SOTPs in the state of Washington?
2. How do SOTPs process the traumatic material from their work with sex offenders?
3. How do SOTPs describe their approach to treatment with sex offender clients?
4. What positive effects of their work (e.g., psychological, behavioral, interpersonal) do SOTPs report?
5. What negative effects of their work (e.g., psychological, behavioral, interpersonal) do SOTPs report?

Research Design

Methodology

The present study design employed a phenomenological approach to qualitative research. A phenomenological study describes the meaning for several individuals of their lived experiences of a concept or a phenomenon. The present study was interested in examining the phenomena of VT and VPTfG as experienced by SOTPs (Merriam & Tisdell, 2017). The group under investigation for the present study was all individuals currently registered through the Department of Health as SOTPs in Washington state.

Participants. Recommendations for population sample size within the phenomenological approach to qualitative research vary from one to ten participants (Starks & Brown, 2007). Creswell (2014) recommends three to ten participants for phenomenological research. As such, the present study strived to obtain a minimum of

three participants. Eligibility for participation in the study required that individuals be currently licensed as SOTPs in WA State (see Appendix C for the Washington Administrative Code for license requirements for certification as a SOTP). Briefly, the Washington Administrative Code (246-930) states that SOTPs must have obtained 2000 hours of direct experience in the evaluation and treatment of sex offenders to obtain certification. This study assumed that certified providers represent a sample of individuals who have at a minimum been vicariously exposed to explicit details of their clients' sex crime(s). This in-depth processing of potentially difficult material is considered a significant risk factor for VT. The participants in this study were over the age of 18 and included both male and female participants.

Professionals working in inpatient treatment settings (e.g., corrections, psychiatric hospitals) and community mental health settings were excluded from participation. The rationale behind the exclusion criteria is based on the research indicating significantly higher rates of reported burnout in mental health providers working in corrections (Boothby & Clements, 2002; Senter et al., 2010), community mental health (Rohland, 2000), and inpatient psychiatric or hospital settings (Vredenburgh, Carlozzi, & Stein, 1999) compared with providers working independently or in group practice settings (Rupert & Kent, 2007; Rupert & Morgan, 2005). Burnout is defined throughout research as encompassing three dimensions: emotional exhaustion (i.e., feeling depleted, overextended, fatigued), depersonalization or cynicism (i.e., negative and cynical attitude towards one's consumers or work), and reduced personal accomplishment (i.e., negative self evaluation of one's work with consumers or work in general; Morse et al., 2012). While the concept of burnout may initially appear to overlap with the construct of VT,

burnout does not encompass the enduring transformation inherent in VT, which is marked by a fundamental shift in sense of self and worldview (i.e., perceived loss of safety and security; Sabin-Farrell & Turpin, 2003). Further, burnout may occur within any profession, whereas VT is specific to work with trauma survivors (Sabin-Farrell & Turpin, 2003).

Research examining the correlates and antecedents of provider burnout indicate organizational-environmental variables, including excessive workload, role conflict, time pressure, an absence of job resources (especially supervisory and coworker social support), a lack of autonomy, and perceived unfairness or inequity in the workplace (Morse et al., 2012). Further, organizational factors appear to be a more powerful predictor of burnout than individual characteristics (e.g., gender, years of experience, years of education; Morse et al., 2012). As such, providers working in inpatient and community mental health settings were excluded from the present study due to the profound negative impact of organizational factors reported in these settings, which may have negatively biased an examination of the experience of working with sex offenders on an individual level.

Recruitment. The present study recruited providers listed on the Washington State Directory for Sex Offender Treatment Providers via email using a standardized script (see Appendix E) to request voluntary participation in the study. The Washington State Department of Health updates the SOTP directory annually and includes the contact information of providers actively providing treatment in the community. The study thus employed convenience sampling based on the availability of participants who meet criteria as a SOTP in the state of Washington and access to their contact information.

There are currently 99 providers listed on the directory that meet criteria for participation in the study. Eligible participants who responded to the recruitment email and expressed interest in participating in the study were placed onto a separate list of eligible providers created for use only by this researcher. The researcher hoped to obtain a sample that is geographically diverse and thus representative of providers from various counties in Washington State. To achieve this, eligible participants from the same counties were placed into one group, such as the King County SOTPS. The researcher then wrote the names of each of the eligible participants within the same county on individual pieces of paper. Their names were placed into a hat and the researcher blindly drew names to select participants randomly for interviews. The extent of this process depended on the number of eligible participants expressing interest and the diversity of their geographic locations. The county locations of the participants are not included in this report to maintain participant confidentiality.

Measures and Types of Data. In a qualitative study, the researcher is considered to be the primary instrument for data collection and data is obtained through various sources of information (e.g., transcripts from interviews, behavioral observations, field notes; Merriam & Tisdell, 2016). Sources of data in the present study included a brief demographic questionnaire, audio recordings and transcripts from the individual interview and field notes noted by the researcher during and after the interviews.

Demographic Questionnaire. Participants were given a brief demographic questionnaire prior to the interview (see Appendix D). The purpose of the questionnaire was to obtain potentially useful information about the participants to inform a richer context for data analysis (Creswell, 2014).

Interviews. The researcher conducted in-depth, individual interviews in-person and via phone, lasting between 45-60 minutes. To elicit participant exploration of their experience, the researcher used an inductive investigative strategy to guide the data collection process. Rather than deductively testing hypotheses, researchers use in-depth interviews to build concepts, suggestions, or theories based on the data collected (Merriam & Tisdell, 2016). The present study used a semi-structured protocol to guide the interview process (see Appendix A). Brief prompts were also used to follow up on participants' responses to obtain a comprehensive response that helped to answer the overarching research questions. Each interview was audio recorded and transcribed verbatim as sources of data to identify patterns and themes that emerged. This assisted with reliable and valid interpretation of the data for emerging themes and patterns (Creswell, 2014). Details regarding the collection, safe storage, and dissemination of audio recordings and transcripts as part of the research are included in the consent form (see Appendix B) and were also reviewed with the participants by the researcher during the process of obtaining informed consent prior to the interview process.

Field Notes. Field notes are considered an essential component of thorough qualitative research and are used to enhance data analysis (Creswell, 2014; Phillippi & Lauderdale, 2018;). Researchers recommend providing field notes on the study context, specifically including relevant information on the geographic location of the interview and type of setting (e.g., office space; Philippi & Lauderdale, 2018). Field notes were used in the present study and included observations of the participants taken throughout the interview. This comprised nonverbal behaviors noted throughout the interview (e.g., hand wringing, tearfulness), baseline affect, changes in affect when responding to

interview questions, and general appearance (Creswell, 2014; Phillippi & Lauderdale, 2018). Details regarding the collection, safe storage, and dissemination of field notes as part of the data collection process are included in the consent form (see Appendix B) and were also reviewed with the participants by the researcher during the process of obtaining informed consent prior to the interview process.

Study Procedures

Data was collected through in-depth, semi-structured individual interviews with participants certified as SOTPs in the state of Washington. Participants participated in the data collection phase after they had signed a consent form (see Appendix B). The process of consent included the researcher verbally obtaining informed consent to ensure that each participant was aware of the study procedures, limits to confidentiality, and understood his or her right to drop out of the study at any point in time and have the data removed from the study. Participants were given two options for the interview format: an in-person interview scheduled at a mutually agreed upon location or a phone interview.

In-person interviews occurred at the participants personal office space, which allowed for privacy (e.g., did not threaten confidentiality). The phone interview option was provided in the hopes of minimizing restrictions on obtaining participant data from providers throughout the state. Each interview was audio-recorded and transcribed verbatim. Additionally, field notes were taken directly following each interview.

At the beginning of each interview, the researcher disclosed her professional status as an Affiliate SOTP, meaning that the researcher is in the process of obtaining licensure as a SOTP. This personal information was disclosed for the purpose of full transparency regarding the motivation behind the researcher's decision to pursue this

research topic. Further, it allowed for efficiency during the interviewing process as the researcher was knowledgeable in regard to the SOTP terminology and procedures utilized by the participants.

Participant Risks

There were minimal risks associated with participation. Participants risks included any distress as a result of discussing their personal experiences.

To minimize the risks, each participant was given a copy of their consent form, which included available resources for crisis intervention. Participants were also informed prior to study participation that they may choose not to participate in this study at any time for any reason. This was explained to each participant in person, as well as outlined in the written consent form. Prior to study participation, participants were also informed that there will be no negative consequences for refusing to participate or refusing to answer any questions asked. Participants were further informed of their right to pause the interview and request breaks as needed. The researcher was prepared to provide reminders of their right to refuse to answer throughout the interview and request breaks as needed in the event that a participant became noticeably distressed.

Methods to Promote Study Trustworthiness

Methods to promote study trustworthiness in qualitative methodology are used to assess the rigor of the qualitative data findings as well as enhance the overall quality of the study (Baxter & Jack, 2008). This included providing enough detail in the report of the study findings so that readers can assess the validity or credibility of the work (Baxter & Jack, 2008; Guba, 1981). Credibility in qualitative research refers to "the truth of the

data or the participant views and the interpretation and representation of them by the researcher" (Cope, 2014, p. 89).

Reflexivity

Reflexivity in qualitative research refers to the researcher's continuous process of engaging in self-reflection to increase awareness around how subjective actions, feelings, and perceptions may influence the research (Darawsheh & Stanley, 2014). It is an opportunity for the researcher to self-disclose any biases, assumptions, and beliefs that could influence the research (Creswell & Miller, 2000). Reflexivity in qualitative research fosters transparency of the researcher's subjective role throughout data collection and analysis to promote research credibility (Darawsheh & Stanley, 2014). As part of the reflexivity process in the present study, this researcher acknowledged personal experiences that may have influenced the research. Of note is this researcher's role as an affiliate SOTP in Washington State at an outpatient private practice clinic. Consequently, this researcher had directly worked with convicted sex offenders in both individual and group treatment settings. Further, this researcher has conducted psychological evaluations with individuals charged with a sex offense(s). This involved reviewing police reports containing the often times graphic details of the offense, including offenses against children. This study was inspired by the researcher's own process of coping with this difficult material as well as subjective observation of enduring psychological and interpersonal change, both positive and negative, as a result of working as an affiliate SOTP. This researcher recognized that personal involvement with this clinical population could lessen the objectivity of the study. In order to promote credibility, the researcher utilized triangulation, third party peer raters, and member-checking to promote

trustworthiness and to address biases in data analysis based on personal involvement with this work (Cope, 2014).

Triangulation

The researcher used the validation strategy of triangulation in the study to promote data credibility (Baxter & Jack, 2008). This involved utilizing multiple data sources to explore the phenomenon of VT and VPTG from multiple perspectives (Baxter & Jack, 2008). Triangulation may be conducted across data sources (e.g., multiple participants) and methods (e.g., interview, observations, documents; Creswell & Miller, 2000). The multiple sources of data in the present study included audio-recordings of the interview, verbatim transcript of the interview, field notes, and behavioral observations. Each of these data sources were coded and compared "based on the principles of idea convergence and the confirmation of findings" (Baxter & Jack, 2008, p. 556).

Third-Party Peer-Raters

Reliability in qualitative research is achieved through consistency (Leung, 2015). To promote consistency in the present study third-party peer raters (e.g., a colleague from a graduate program; dissertation committee members) also coded the data to establish reliability of the study findings. The third-party peer rater independently coded the data sets, which was followed by a meeting where the third-party peer rater and the primary researcher discussed their findings and came to a consensus on the emerging codes and categories (Baxter & Jack, 2008).

Member Checking

The researcher utilized a process of member checking to promote consistency in the research findings (Baxter & Jack, 2008). Creswell and Miller (2000) emphasize

member-checking as a crucial technique for establishing credibility in qualitative research. The process involves providing each study participant with a copy of their individual interview transcript as well as the researcher's interpretations of the data (Baxter & Jack, 2008). The purpose of utilizing member-checking in the present study was to provide participants with an opportunity to discuss and clarify the results, address any misrepresentations of their experience, and to contribute to new or additional perspectives to promote credibility of the research findings (Baxter & Jack, 2008).

Chapter 3

Results

This study explored the experience of SOTPs in Washington State using a phenomenological approach to qualitative research. This research framework was used to give voice to the lived experience of these individuals and offer an opportunity for each participant to share their unique narrative. The catalyst for this research topic was the identification of a disparity in previous research and literature examining the experience of these clinicians with a specific focus on approach to treatment, as well as the negative and positive personal and professional impact of engaging in this type of clinical work. To study how SOTPs experience their clinical work, the research was guided by the following overarching research questions:

1. What is the experience of SOTPs in the state of Washington?
2. How do SOTPs process the traumatic material from their work with sex offenders?
3. How do SOTPs describe their approach to treatment with sex offender clients?
4. What positive effects of their work (e.g., psychological, behavioral, interpersonal) do SOTPs report?
5. What negative effects of their work (e.g., psychological, behavioral, interpersonal) do SOTPs report?

This chapter presents the findings that emerged through the process of data collection involving a total of five participants currently licensed and practicing as SOTPs in Washington state. The interview protocol used to guide the individual interviews with each of the participants provided an opportunity for the participants to

explore their experiences and convey this in their own words. Once each interview was collected and transcribed based on the audio recordings from each interview, this researcher utilized a phenomenological approach to data analysis. This approach involved carefully reviewing and coding the transcripts and field notes for emerging patterns, or categories, that conveyed commonalities across the participants' interviews. The categories were then clustered based on similarities in the experience of the participants and were then placed into groupings with overarching themes. The data analysis process led to the emergence of 16 categories, which were then placed under four key themes that conveyed the participants' experience.

Data Analysis Procedures

Data analysis in qualitative research occurs throughout the data collection process (Creswell, 2014). An example of this is the use of field notes and behavioral observations throughout the interview process that note emerging themes and patterns as the interviews occur in real-time. The semi-structured interviews thus allowed the researcher to explore salient aspects of the interview related to the experience of SOTPs.

For the purpose of the present study, the researcher engaged in an inductive approach to data analysis. The researcher thoroughly analyzed each of the data sources (e.g., audio recordings, interview transcriptions, field notes) for emerging concepts, patterns or themes. The outcome of inductive analysis is the development of categories into a model or framework that summarizes the raw data and conveys key themes and processes (Thomas, 2006). Categories from the various data sources are developed through the analytic process of coding. Coding in qualitative research involves the researcher thoroughly examining the text (e.g., transcripts, field notes, behavioral

observations) obtained throughout data collection and assigning codes to these segments of text. Codes were determined as short phrases or single words that effectively summarized key characteristics of the participants unique experience as SOTPs (Saldana, 2016). For example, in the present study multiple statements that expressed the difficulties of SOTP work were initially coded as "difficult experiences" before being further categorized based on emerging patterns and themes. The researcher engaged in a process of reading the data sources line-by-line and coding for emerging themes and patterns. It is of note that coding in qualitative research is not just labeling portions of the text; it is also a process of creating a critical link between the data collection and their explanations of meaning (Saldana, 2016). According to Saldana (2016), patterns in qualitative coding are defined as repetitive, regular, or consistent occurrences of data that appear at least more than twice in the research data. The codes were then analyzed further through a process of categorization, where codes are placed into similar categories to identify overarching themes (Saldana, 2016). These overarching themes organized the data in a way that permitted the researcher to connect the experiences and perspectives of the participants into a cohesive, meaningful narrative.

The ATLAS.ti coding software played an instrumental role in analyzing the data for emerging themes in the present study (Muhr, 1992/2019). The software does not code the data automatically. Rather, the software allows for the efficient storage and organization of the data in one accessible location to further manage and analyze the data during the coding process (Saldana, 2016). For example, the participants' transcripts were saved on the ATLAS.ti software (Muhr, 1992/2019). The researcher was then able to go through each transcript, line by line, and created notes in the margins of the transcript

with emerging codes based on common phrases, words, and essence capturing statements conveyed throughout the transcript. The researcher was able to compare notes for each transcript in one location on the ATLAS.ti software, allowing for efficient analysis of the codes and emerging patterns across the sources of data (Muhr, 1992/2019). Thus, each step of data analysis was saved throughout this process due to the data management capabilities of the ATLAS.ti software (Muhr, 1992/2019).

Description of the Participants

The requirements for participation in this study were individuals licensed as SOTPs in Washington state at the time of data collection. Refer to Appendix which details the WAC for license requirements for certification as a SOTP. Professionals working in inpatient treatment settings (e.g. corrections, psychiatric hospitals) were excluded from participation in this study. The description of the five participants is addressed broadly to protect the anonymity and confidentiality of the participants. Participants One, Two, and Five identified as female, and Participants Three and Four identified as male. The education level of the participants varied slightly. Participants One, Four and Five had their doctorates in psychology, while participants Two and Three had master's degrees in mental health. Participant Three was the only participant from Eastern Washington and the remaining participants lived in Western Washington. The participants consisted of three female clinicians and two male clinicians. One participant resides in Eastern Washington and the remaining four live in Western Washington. Each of the participants worked in a group practice setting. The years of experience amongst the participants ranged from six years of practice as a licensed SOTP to 45 years of licensed SOTP work. Finally, the settings of the participants varied as well. Participants

One, Two, and Four worked in outpatient group practices settings, while participants Three and Five worked in individual practice settings.

Emerging Themes

Theme 1: Negative Personal and Professional Aspects of Sex Offender Treatment Provider Work

Exposure to Graphic Content. Throughout the interview process, each participant referenced the difficult content they were exposed to while conducting SOTP therapy and evaluations. Participant One shared her experience of working with clients convicted of viewing child pornography:

> I think child pornography are probably the more difficult for me to read and evaluate. Like when you read the description, the detective's descriptions of the images and what specifically was looked at, and the specifics of the pornography, those are pretty difficult.

Prior to working with a sex offender as a client or for an evaluation, the SOTPs often read the police reports, detectives' descriptions, and, if there was an identifiable victim, the victims' narratives of the offense. Participant Four described his reaction to a situation where he had to hear a client describe, in graphic detail, raping a young child: "I just . . . I just got overwhelmed . . . That didn't happen for me very often. I was okay, but I wasn't okay that time. I was revolted, and I just couldn't do it." Participant Five described a similar reaction of feeling physically ill as a result of the content she reads during evaluations: "Every now and then I get one that makes me nauseous." Participant Five also said, when talking about a particularly violent sex offender she had worked with, "That one gave me the creeps just because he was so cold and calculating."

It was apparent that hearing about abuse against children was particularly difficult for the participants. Participant Four explained, while discussing some of the negative attitudes other providers have about treating sex offenders in community settings, "The politically difficult thing and the painful thing is you can't help what happened to the last child. We can't do anything about that." Participant Five acknowledged that she conducted psychosexual risk evaluations with offenders who had also themselves been victims of sexual abuse:

> Well I do a lot of risk assessments and sometimes I hear a lot of bad stuff that happened to these poor people when they were young, and now they're acting out. Sometimes that bothers me, that a child is treated so horribly by neglect and abuse.

While the participants each acknowledged having to listen to difficult content, a majority of them described how they no longer feel affected by the offense narratives of their sex offender clients. Participants One and Five both admitted that their work has made them "jaded" and "detached" from the difficult content, while participants Three and Four described feeling "unaffected" by the difficult content after years of practicing as a SOTP.

Stigma Associated With Sex Offenders. A common hardship of this work endorsed by the participants was their perceived difficulty in talking with others (e.g. friends, relatives) and colleagues (e.g., clinicians in other fields) about the nature of the work they do as SOTPs. Participant One explained that she found it easier to discuss her work with individuals she feels closer to. Otherwise, she may be more reserved due to awareness that this subject matter may be difficult for others to process:

> Usually like if I am meeting somebody for the first time, that's not where I go. [I will] say I work in counseling or something like that . . . And then if they keep asking me and I want them to stop then I will be like, 'I work with sex offenders' and they will be done with the conversation pretty quickly . . . people don't want to hear about it.

However, Participant One did state that she is open to discussing the topic if others are:

> But in terms of like, somebody wanting to have a conversation with me about it, I mean, I'd be up for it. I mean, sometimes people do, but for the most part, I think sexual violence is a really hard thing for people to wrap their heads around.

Participant Two noted a similar experience of the difficulty of working with this population: "I had a guy that I was seeing who was like 'Your job is the worst, you're depressing. I can't handle hearing about it.'" Participant Five explained that she prefers to discuss her SOTP work with other clinicians in the field of sex offender treatment as well as her friends in similar helping professions who are less resistant to discussing the subject matter, "Because [my colleagues] get it. And you're not offending them like you would a normal person, who'd go, 'Don't tell me that!'"

Each of the participants noted the negative stigma attributed to sex offenders. Participants Three and Four both described sex offenders as the "lepers" of society to illustrate this profound stigma. Participant Two described the personal impact of the stigma, "There are times where you have to be careful not to identify too much with your clients and like taking on the stigma attached to them." This participant then outlined the barriers to advocating for this population due to the negative perspective of others (e.g.,

professional colleagues, peers, etc.) towards the clinicians working with sex offenders without being prompted to discuss this particular topic by the researcher.

Participant Four, who has been working as a SOTP in Washington for many years, explained that throughout his career he has observed a significant decline in the number of offenders receiving the Special Sex Offender Sentencing Alternative, which is a sentence assigned to low risk offenders that permits them to serve their sentence in the community rather than facing a prison sentence. He attributed this decline to the general public's concern about the ability to treat these individuals and the consequent risk for recidivism: "Yeah, there's a tremendous fear in the general public's ideas that you can't treat this effectively. That's one fear." Participant Two explained how this societal stigma actually prevents these individuals from seeking help prior to committing an offense:

> And then it's also being aware of how that kind of misinformation, and that kind of torches and pitchfork mentality encourages people to continue offending because they're scared to get help.

Participant Three described the negative views towards sex offenders that he experiences from law enforcement (e.g., police officers, probation officers): "Yeah. They're just, 'Once a sex offender, always a sex offender,' so they'll say. They don't believe people can help get help." He further stated, "So the sex offenders get the short end of the stick and are treated unfairly." As an SOTP, each of the participants has involvement with the Department of Corrections (DOC) in their work to assist with the management of offenders. Sex offenders are given a Judgment and Sentence when convicted of a sex offense, which outlines the rules they are to uphold while under supervision of the courts. SOTPs are tasked with reporting any violations to the Judgment and Sentence to their

client's supervising Community Custody Officer (CCO) as well as any violations against the treatment contracts they signed in order to work with the SOTPs. Two of the participants described the difficulties encountered while working within these systems.

When asked about how work with sex offenders impacted him professionally, Participant Three described the change in his worldview towards law enforcement:

> Well it's given me a negative view on law enforcement. I've been told I've been lied to them several times, and I think they're just real prejudiced to sex offenders. I think they think that, I don't even go to the law, the sex offender leveling committee meetings. I'm invited every month, but I quit going years ago 'cause it just turns my stomach. They hate sex offenders and they lie. They'll lie to get them in trouble. They embellish, exaggerate. And I've caught them flat lying. It's just gross. So, I don't know. I don't feel like that we're on the same side.

Participant One stated that she had a really positive experience working with DOC for her teenaged clients, but described more difficulties with adult clients:

> So I had found in the last, gosh, two or three years in particular, working with DOC has been really rough. Mostly because guys are getting thrown in jail for like really stupid things and they're especially getting thrown in jail for, and this has really changed our practice. Like especially getting thrown in jail when they mess up and it's, they've violated their rules, they shouldn't have done that. But they're also trying to be honest and accountable about it. And then if they report that to their CCO, they get thrown in jail for 30 days.

Participant One also described how difficult it could be to advocate for these clients in the context of DOC relationships, "And sometimes I can, but for the most part they

couldn't [*sic*] care less about what I have to say." Participant Three described a similar issue with feeling as though his input was not taken into consideration, "And most often they [law enforcement] don't even consult with me who, well I'm supposed to be the expert." He described a situation that created hypervigilance amongst his clients and colleagues when some of his sex offender clients were arrested during a group treatment session, resulting in a general mistrust of law enforcement as a whole.

Awareness of Threats to Safety. Three of the participants noted an awareness of the threats to personal safety in working with a population of individuals convicted of sex offenses. Participant One explained the precautions she takes as a woman in this field working predominantly with male offenders:

> I don't think I would want to do it if I was just in solo practice. And I think there is a safety issue as a woman doing it probably as a man too, but for different reasons. But like we have had over the years a couple of things that are just like, for lack of a better word, kind of creepy.

Participant One also described how working with sex offenders has impacted her relationship with her nieces and nephews and their safety in the world:

> Like if I'm hearing about like my niece and nephew want to play the Fort, I'm like, 'Don't do it.' Because I'm always sort of thinking about all of the worst-case scenarios. So I think negatively for that.

Participant One also stated that she typically only shares these concerns with "close family" as she is aware that she may be interpreting it through the "lens" (i.e., worldview) of the work she does working with perpetrators of sexual abuse.

Participant Three explained that while he does not personally feel fearful when working with his offender clients that he has been asked about it before, "I'm not afraid of them. I guess some people have [asked if] I am afraid." Participant Four acknowledged that the other therapists in his group practice are not open to working with sex offenders due to their own fears of working with this population. He explained that to mitigate this concern for his colleagues, they will discuss each client as a group prior to accepting them in their offender treatment program to ensure the other clinicians feel safe coming in to work. Participant Four explained his perspective to fear in working with these clients: "If you're afraid of offenders, then it's going to get in the way of you being able to work with offenders." Participant 4 also stated, "There's certain things to be afraid of to be sensible, but you can't live in fear of the offenders."

Theme 2: Approach to Treatment and Empathy

Holistic Approach to Treatment. Each of the participants presented varied approaches to treating clients in their sex offender treatment programs, some using a cognitive behavioral lens with others incorporating an existential approach. Despite the varying theoretical orientations utilized, a common theme amongst the participants was a holistic approach to treatment. Participant One stated:

> But what I've found through my own dissertation research and then my own kind of process in my own writing that I do, is I think that where we've gotten right now with respect to how we deal with sexual assault is kind of an individualized approach.

Participant Two explained, "And I try to be very looking at each person's individual... Not doing one size fits all treatment."

Participant Three also described an individualized approach to treatment and how this is essential for their success in treatment, "We've compiled what we can give them, depending on who they are and their situation. Learning ability, education, stuff like that, to make sure that they've not just been sitting and daydreaming, and they've been listening." Participant Five also explained how some clinicians might only treat the offending behaviors, but she prefers to take a holistic approach and "treat depression and underlying mental health issues as well."

Clinician Empathy. Driven by a holistic view of their sex offender clients was the theme of approaching these individuals empathically, both in treatment and in their case conceptualizations while conducting psychosexual risk evaluations. The participants discussed the importance of looking at the totality of the individuals they work with rather than exclusively through the lens of their offenses. Participant One explained:

> So just being able to say like, 'Okay this person is not reducible to what they did.' And I can think about how to maybe help them with some of the other issues in their lives that will make it kind of treating the whole person sort of thing.

Participant Three described his approach with sex offenders, "It's more, feel some compassion, empathy for them and try and help them to move on." Participant Three further stated that his faith is a driving factor which allows him to approach his sex offender clients about their offenses without judgment, "I'm Christian. I just ask them, don't judge them. I'm not afraid of them."

Several of the participants also described how clinician empathy affects their sex offender clients in treatment. Participant One described the impact of the group treatment model for sex offenders who begin treatment feeling hopeless about themselves:

> I think it's more of that like 'I'm such a terrible person because of what I did, maybe everyone would be better off if I'm not here'. And I think that group therapy really helps with that, especially when they're able to see the guys who are maybe closer to graduating or completing treatment and they can see like, 'Okay, my life isn't over, I'm able to build something that's meaningful.'

Participant Three spoke extensively about the importance of empathy as a positive treatment influence:

> Well, I took an affiliate on a year ago and when she started I sat her down and just told her that it's going to be important that you lend all of these folks, mostly gentlemen, your ear, E-A-R, your empathy, your attention and your respect, and they'll be eating out of your hand and will jump through hoops for you. And they'll learn, and they'll change, for real. But if we can't give them that and treat them as a person, and give them that respect and that brotherly love, well they're not going to trust you. And when people come in and, something like this, it's just a huge responsibility. And so they see you as kind of a smart person that can help them or a smart person that can hurt them. And we need to make sure that they know that we're compassionate, we care about them and that they're safe and that this is a good place to open up and talk about everything. And even though that they've done something terrible that's hurt somebody badly, that they'll still be given empathy, attention and respect.

Client Accountability. A common theme and an important component of experiencing empathy towards clients for these participants was the need for their clients to convey accountability for their offense. Participant One explained when she is in the

process of evaluating new clients prior to accepting them into their offender treatment program, "We usually staff it is a group…but we're looking for somebody who is, especially with adults, somebody's who's like, 'Yeah I messed up, I really need to do something bout that.'"

Participant 3 also pointed to the importance of accountability for successful treatment:

> My program, they have to agree to letting us really have a lot of latitude of what we know about them and when they are supposed to tell us, information they're supposed to disclose. And then somebody goes through that, and they have to agree, to consent to be completely honest and tell us of partners or sexual behavior, fantasies and attitudes, and we just need them to be an open slate.

Participant 4 expressed a similar sentiment of the need for accountability for success in his sex offender treatment program:

> What you have to do is recognize that if you see somebody in your treatment group that's operating, I don't mean offending, because then we'd kick them out of the program, but getting into some stinking thinking…it's important to get to the point where you come forth and tell us, not to punish them, but to change that so that that wouldn't happen.

Participant Two described the positive regard for her clients that she experiences when they are accountable for their actions:

> I think when people are honest and telling me about their offense and, telling me what exactly happened, like that just feels very humbling that they're able to be

> that open and honest with something that's really shameful and probably the worst thing they've ever done."

Participant Two also noted the importance of modeling accountability, "It's important to, again, model for people that you can be supportive while also holding them accountable." This participant was referring to balancing the dynamics of her role as a SOTP, which requires her to report to the CCOs when her sex offender clients violate the terms of their court ordered boundaries (e.g., contact with minors, viewing pornography).

Theme 3: Adaptive Coping Skills

Consulting With Coworkers. A common coping mechanism for dealing with difficult cases with these participants was debriefing with coworkers about their work with sex offenders. Participant One stated:

> I need to debrief. So like if it's really tough, I will debrief with one of my coworkers just be like, I heard something really bad and I need to tell you about it . . . And then I could just sort of clear it out of my head and not think about it anymore.

Participant Two expressed a similar sentiment with utilizing his colleagues as sources of support:

> We all work really closely as a team here, so I'll talk with my supervisor frequently after. He and I share an office so I kind of debrief. Just usually, if he's around, I debrief with him or I'll debrief with another coworker and just be like, 'Wow, that was interesting.' Or I'll go over and talk with their case manager. A lot of the folks, I see their case managers in a separate building, so I'll just wander over there and make the rounds and tell everyone.

Participant Five also discussed the importance of debriefing with peers, "Generally, I have two ladies who work out of my office [who also worked with sex offenders] . . . So, we sort of get together and talk about that."

Referring Cases as Needed. Other participants noted the need to refer cases to other clinicians if they perceived it would be too emotionally difficult to work with particular sex offender clients. Participant Three explained his rationale for referral when presented with a client he knows he cannot work with, "Some of them, if I thought that I'd be shocked . . . I just wouldn't bring them in." Participant Four described his reasons for referring out difficult cases, including how personal emotions can interfere with effective treatment:

> From my perspective, you have to say, you have to refer that person. You have to consult with whoever your supervisor is. Then after they help you look at your own issues and what's getting in the way and blah blah blah, and if you still can't do it, then refer them because you're not going to be helpful to them if you are revolted by the act.

Compartmentalization. Several participants explained their own process of compartmentalizing the difficult material they encountered through their SOTP work in order to prevent negative emotional and psychological effects, as well as burnout. Participant Five talked about compartmentalizing the victims of her sex offender clients while working with them, "And while I'm still mindful of the impact on the victim, that's not my job." Participant Four also described how focusing on the victims can contribute to burnout, "Because if you look back at the offense or you look back at what happened to the last child, that'll drag anybody down. We just can't go there."

Participant One explained how she copes with the thoughts related to the victim experience:

> So I got something, I refer to it as a black box, but it's really a compartmentalization process. Like, yeah, I think child pornography, reading those cases are so difficult. Animal abuse are really difficult for me. But having listened to stories of people who've been raped and people who perpetrated rape or other kinds of sex crimes for so long, I just have a place where I stick it or it's almost like I don't even stick it, I just clear it out right away, like I don't want to carry it around.

Participant Two described how to mitigate an emotional response during interactions with clients who minimize their offense by using compartmentalization as a clinical skill:

> I mean, I see it as, it's very one of those things that just, 'This is your chance to put your good clinical skills to use and just listen and listen for the things that they are telling you by the things that they aren't telling you'. So, I think that that kind of helps to compartmentalize a little bit so keeps the emotions from bubbling over.

Balancing Case Load. Several participants described the value in balancing their caseload and not exclusively treating sex offender clients. Participant Five recommended, "And . . . treat people who aren't sex offenders so you know that the world is sane" when prompted to explore advice she would give to new clinicians beginning work with sex offenders. Participant Three also explained that he balances his caseload with other types of clients as well and does not work exclusively with a sex offender population. Further,

he explained that working with less challenging cases at first in the community made for a smooth transition into this work as well. Participant One explained that what made this work sustainable at the beginning was the fact that she took it on "really, really slowly." Specifically, she was referring to taking on sex offender clients in small numbers at first. She now reports that her caseload is roughly "90-95%" sex offenders.

Self-Care. Several of the participants touched on their own self-care practice outside of the workplace. Participants Two and Three discussed utilizing regular physical activity (e.g., exercise) as an effective outlet to manage their work stressors. Participants One and Two talked about seeing their own therapist on a semi-regular basis as a way to process the difficult content and stressors they encounter through work with sex offenders. Participant Three mentioned that his Christian faith is a major source of support for him and allows him to approach his sex offender clientele with compassion and empathy. Finally, Participant Two disclosed using mindfulness as an additional method of coping.

Theme 4: Positive Personal and Professional Aspects of Sex Offender Treatment Provider Work

Fulfilling the Need for Competent Sex Offender Treatment Providers. The participants each discussed how they felt motivated by identifying a need for capable clinicians to work with the sex offender population. Participant Four explained his feelings of excitement after first attending a seminar on sex offender treatment with a colleague:

> Whatever we could do to try to get them back into society in a manner that would be more effective, where there would be less chance that they would reoffend is ... I don't know. We get pretty pumped about that.

Participant Three explained that there was high demand in the area he lived in for this type of work and a need for competent clinicians who could effectively treat this challenging population that led him to SOTP work. Similarly, Participant One explained when asked what led her to this field, "I don't know if there was so much a want as awareness. I can do it. So I feel like I should." Participant One explained that she believes not everyone can work with this population, so those that can, should. Participant Five explained that her motivation for this work was driven by identifying a need to improve the assessment process for psychosexual risk evaluations, which are used as a vital source of information to determine the sentence and course of treatment for sex offenders:

> I really was interested in looking at the risk stuff and I had a sense that I wanted to be involved in helping this move forward to where we're doing better risk assessments. Because so many of them are so crappy, we have guys out there rating women with male risk assessments. You cannot do that. We have people just guessing at risk without doing any psychological testing of any sort, or using some sort of, I mean even a personality test. Some of those will tell you risk in general for re-offending for bad behavior. Well, you got to know those things, so I just felt like maybe we could level this up a bit and a lot of people weren't even following the legal guidelines, which tell you, you have to have personality testing, you got to do these things. I thought, well, I would like to do that.

Positive Framing of the Work. An additional theme that emerged amongst the participants in this study was that they discovered through their SOTP work an ability to experience positive regard and a holistic outlook of their sex offender clients. Participant One stated when asked how this work had impacted her professionally:

> Before I went into this work, I probably had really critical views of people who offended. And so it was a pretty big transformation for me to be able to really kind of integrate that, to have that kind of, or one of those core beliefs challenged.

Participant Two stated, "I enjoy the fact that [sex offenders] are challenging to work with. It really makes you check in about what your values are." When asked to elaborate on how working with sex offenders has influenced her values she explained:

> I mean, I think that they've strengthened my idea that everyone has a worst sin and no one should be tossed aside. I don't think people should be judged for the worst five minutes of their life or the worst however long it was. So, it's especially watching folks in group interacting and seeing the change that occurs in them when they have people that they can talk about this stuff with, they don't feel so isolated and it's the one place that they can kind of sort through these things.

Participant Two also talked about using her own experience to consult with other clinicians and potentially reshape their view of individuals who commit sex offenses:

> And now it's, 'Someone might have pedophilia.' So they want to talk to me about that. I mean, I think it's good to have someone that can have those conversations and I've had a lot of conversations that have given people a lot to think about and kind of reframed how they feel about things.

Rising to the Challenge. The participants identified the inherent pressures they experience as a result of their roles as SOTPs. Participant One explained how her work with sex offenders differs from her clinical work with other populations:

> Usually when I'm working with SO [sex offender] clients, I think probably one of the biggest differences is that there's a lot at stake, right. Not only for the community, but for the client and for myself professionally, right? Like I need to make good kind of accurate judgments about what they can and can't do, and what their risk level is.

Participant Five expressed her experience of the pressure on conducting accurate psychosexual risk evaluations on potentially dangerous clients capable of reoffending, "Well, the problem is you've got to worry about if you don't do the best job ever . . . He gets the low-risk and he gets out." This is in reference to the use of psychosexual risk evaluation to determine a sex offender's level of risk and whether he receives jail time or is given a sentence to receive treatment in the community. Participant Four explained the high pressure in treating these individuals as a risk for community safety, "You have to be really, really firm because a potential risk for a child is there. So you have to be tough."

While the participants noted the high pressure of this job, they also mentioned throughout the interview how it strengthened their clinical skills in various ways. Participant Five stated when asked how her work impacted her professionally:

> I think that one of the things it does is it really makes me think more frequently about, are we doing this right? Do we need other options? Am I catching what I need to catch on some of these guys? For at least the evals. When I was treating

> them, I always tried to be alert for things that might be predictors that they were going to drop out or might not comply. And sometimes that's hard if they're not around, they start missing treatment. But I think the most important thing is that it made me much more aware and alert, as well as, again, I want to find better ways to treat. Try a few things and see if it works.

Participant Five also described how this work has improved her listening skills as a therapist and evaluator:

> I've learned the quiet face and to sit and listen. And I think that listening is a good deal because it let's them be heard. They've done terrible things. No matter what it was, it's terrible. But listening is a big skill. Paying attention to what the other needs they have besides the sexual offending.

Participant Four discussed the clinical skills required to effectively work with this population, "This gets tricky, and it takes a really skilled therapist to be able to challenge at the level where we have to challenge and yet have people feel safe enough to be authentic." Finally, Participant One described how her work as a SOTP shaped her ability to look at the whole system involved in effective sex offender treatment:

> So having my foot in the door to be able to say like, 'Okay, this is how else we could deal with people who offend', and see how people can change, but also looking at sort of all the different social and economic factors that kind of come to bear on their decisions to offend. Then I think, well I can be a lot more effective advocate for change in that way, because I can kind of understand like what else might be out there.

Field Notes and Behavioral Observations

Field notes and behavioral observations noted by the researcher during the interviews are utilized to enhance interpretation and analysis of the participants' experience. The additional source of data provides information related to the body language, tone of voice, and observable behaviors of each of the participants. Several themes emerged throughout the collection and analysis of field notes, which are included in this study to provide a richer context for understanding the experience of SOTPs.

Careful Contemplation. Each participant appeared to carefully consider each of the interview questions prior to sharing their response. Participant Three and Participant Five were both conducted via phone and both participants would pause, presumably to consider their response, prior to immediately responding. The researcher noted a similar approach of intentionality in the responses of the participants interviewed in person. For example, Participant One would often pause, look to the ground and nod her head before beginning her response as she considered the question. She also occasionally asked for clarification on what was being asked of her, which appeared to be a concerted effort to formulate an intentional response. Similarly, Participant Two frequently broke eye contact and looked downward after asked a question before providing a thoughtful response that addressed multiple layers of the original questions. Participant Four would also pause before each question and would occasionally fold his hands across his chest and nod his head several times as he considered the question before providing his response.

Humor. The participants in this interview were able to find lighthearted moments in an otherwise difficult conversation as they divulged their experience as SOTPs. For

example, Participant Two jokingly stated that she had been called the "Incest Whisperer" when prompted by the researcher to explore her experience of listening to the offense narratives of past clients. While she said it in a joking matter, it was clear that she had a great deal of empathy for this clientele and was not joking about the experience of these individuals, but rather at the gallows humor used by her colleagues. Participant Four also utilized humor when talking about how he would "never" win an award for his work due to his colleagues' negative perceptions of his treatment approach with sex offenders. This participant spoke at length about empathy as a key ingredient of positive change in his work with sex offenders, a perspective he noted is not widely held by the greater community of individuals and thus a primary reason as to why he would not win the award. Participant Three laughingly described microwave popcorn as being a "culprit" inhibiting law enforcement to stay on top of their work with sex offenders. Of note is this participant's strong disapproval for the "prejudices" of law enforcement towards his sex offender clients. Participant One jokingly said that she "swears a lot more" when asked how her work with sex offenders has affected her.

Resigned Gestures. During the in person interviews the researcher observed behaviors that appeared to be made in a response of resignation to the perceived difficulties of their work. For example, Participant Two would often shrug her shoulders while discussing the stigma of working with sex offenders as well as the lack of support for professionals working with this population. It appeared to the researcher as a representation of the, at times, hopelessness of working with individuals with such a significant negative stigma attached to them. Participant Two also went on to discuss how futile it can feel to engage in conversations with others about her work when they have

close-minded perspectives about the population. Similarly, Participant Four also shook his head in a dejected way while discussing the stigma other clinicians hold of working with sex offenders. Participant One at one point during the interview turned her palms upward and shrugged her shoulders, seemingly illustrating a lack of control, when discussing some of the strains of working with law enforcement.

Sharing Resources. Several of the participants enthusiastically shared resources related to advancing the treatment of sex offenders. Participant Two eagerly shared information about a conference for individuals who treat sex offenders, as well as strongly encouraged the researcher view a documentary relevant to sex offenders. Participant Four referenced various books in his office during our interview as well as the names of researchers to investigate who write on the topic of sex offending behaviors. Participant One shared an outline of the treatment used for adolescent offenders with the researcher during the interview as well. Further, each of the participants graciously offered to speak with the researcher beyond the scope of the interview to share resources and consult professionally.

Openness. A final observation made was the genuine openness of each of the participants in their approach to discussing a deeply personal topic. Each of the participants answered every question asked of them during their interviews and was willing to share some of their most challenging professional moments endured. The responses appeared genuine, honest, and approached with a willingness by the participants to explore the impact of SOTP work for the sake of advancing the research. Furthermore, the participants warmly offered to discuss the topic with the researcher

should the need arise in the future to clarify any remaining research questions, as well as offering consultation and professional support.

Chapter 4

Discussion

This phenomenological study explored the experience of SOTPs in the state of Washington. The research aim was to illuminate the lived experience of SOTPs using their unique descriptions of the personal and professional implications of their clinical work with sex offenders. This research offers perspective into the difficult content explored by providers working with this population, how they personally cope, and the positive and negative impact of their clinical work with sex offenders. The purpose of the study was to contribute to the research and literature related to the experience of providers treating sex offenders in a mental health capacity and the deleterious effects of this work, specifically, the experience of VT. The present study is also the first to report on the phenomena of VPTG in SOTPs. The lived experience of five SOTPs residing in Washington State were explored through the data obtained through three in-person interviews and two phone-based interviews with these providers. The aims of this chapter are to interpret the data obtained through this research and integrate the existing literature on this topic with the research findings. Further this chapter will explore the strengths and limitations of the study, as well as provide recommendations for future directions in research on the topic of the experience of SOTPs.

Vicarious Trauma: The Negative Aspects of Sex Offender Treatment Provider Work

The *DSM-5* additions expanded on the conceptualization of PTSD by including "repeated or extreme exposure to aversive details of a traumatic event" as a fourth exposure criterion for experiencing posttraumatic symptoms (American Psychiatric

Association, 2013, p. 271). This criterion is also a requirement for justifying the experience of VT, which implies repeated exposure to traumatic material over time (McCann & Pearlman, 1980). As such, it is reasonable to assume that, at minimum, the participants in this study have been susceptible to experiencing VT during their careers. This is consistent with the existing VT literature noting the heightened risk for VT in clinicians who work with survivors or perpetrators of sexual abuse (Hatcher & Noakes, 2010; Kadambi & Trescott, 2003; Schauben & Frazier, 1995; Slater & Lambie, 2011). The participants reported years of experience working with sex offenders, thus facing repeated exposure to graphic details of clients' offense narratives as well as their sexual desires. Each participant explained how their work necessitates a thorough review of all available data sources related to the offense the client committed, including graphic narratives of the offense detailed through detective reports and the personal narratives of the offenders. This included sex offenses committed against children, child pornography, sexual abuse of animals, and violent acts of sexual assault. Several participants illustrated that they felt strong physical reactions (e.g., nausea, revulsion) as a result of reading through or listening to these often times graphic offense narratives. Feelings of disgust as an initial reaction upon learning details of the sex offenses committed is reflected in the research examining the experience of individuals working with sex offenders (Haneen & Haj- Yahia, 2016). Given the consistency of reports of the participants, exposure to these difficult offense narratives appeared to be an inherent and unavoidable component of sex offender treatment.

Inherent in the definition of VT is the "transformation that occurs within the therapist as a result of empathic engagement with clients' trauma experiences and their

sequale" (Pearlman & Mac Ian, 1995, p. 558). The transformation refers to the disruptive, enduring psychological effects of trauma that are experienced by individuals vicariously exposed to details of traumatic events (Barrington & Shakespeare-Finch, 2013). Thus, an important distinction is that individuals may be vicariously exposed to traumatic material, but unless they experience this enduring change it is not characterized as VT (Pearlman & Mac Ian, 1995). The psychological impacts commonly attributed to VT in the research literature are the changes in an individual's core beliefs around safety, trust, intimacy, and control (Sabin-Farrell & Turpin, 2013). The experiences described by participants in this study appear to align with these same core belief changes and are thus attributed to VT. For example, the awareness of working with a dangerous clinical population emerged as an additional theme amongst the participants. One participant described how this personally impacted her relationship with the children in her family, explaining that her SOTP work jaded her views of their safety, specifically a heightened risk for sexual abuse. This is consistent with previous research examining the changes to schemas of safety regarding the heightened fears these professionals endure regarding their own children and the threat of sexual abuse (Haneen & Haj-Yahia, 2016).

Further evidence of schema changes regarding trust and control noted by the participants included a negative view of law enforcement and barriers to establishing trust with their sex offender clients. Participants described how working with law enforcement led to a perceived lack of control in their roles as providers, as well as a mistrust of law enforcement in general after entering into their SOTP clinical work. Research suggests that evidence of VT in clinicians included feeling as though it was difficult establishing trust with clients (Clemens, 2004; Schauben & Frazier, 1995; Shamai & Ron, 2009). The

participants in this study noted similar barriers in gaining the trust of offender clients, as well as being able to trust them in return. An important component of SOTP work noted by the participants is the mutual trust needed for the relationship to be effective as SOTPs take on the role of ensuring that the offenders are not a threat to community safety. The extensive intake process (e.g., review of all records) and necessity for accountability noted by the participants in this study suggest that they exercise caution in establishing trust with clients and must remain vigilant for potential risks of re-offense throughout

The research examining the experience of SOTPs are reports of experiencing stigma by association as a result of their clientele, which can result in feelings of profound loneliness and even a need to apologize to friends, family, and colleagues for their work (Haneen & Haj-Yahia, 2016; Hardeberg et al., 2018; Hatcher & Noakes, 2010). The participants in this study confirmed this as they expressed similar sentiments that others (i.e., general public, non SOTP clinicians, peers, law enforcement) do not appear as open-minded to working with this population, or discussing the content of sex offender treatment for that matters in outpatient treatment alone and should be subjected to more extreme measures.

Approach to Treatment

An additional theme that emerged through the research was similarities in approach to treatment and evaluation with sex offenders amongst these clinicians. While the participants reported using varied theoretical orientations to guide treatment (e.g., cognitive behavioral therapy, existential therapy), they each reported a holistic approach as best practice to understanding and addressing the unique needs of their sex offender clients. The participants noted that taking into consideration the individual needs was an

essential component of effective treatment. This appeared to be based on a foundation of clinician empathy for their clients in order to produce accurate evaluations and provide effective treatment. The empathy piece seemed necessary for these participants in order to utilize a holistic approach, requiring them to look past the offenses their clients committed in order to examine underlying mental health needs and experiencing positive regard as a means of helping them achieve positive growth. Further, several participants noted how clinician empathy led to positive treatment gains in their sex offender clients. Research supports the notion of clinician empathy is a powerful tool in achieving positive therapeutic outcomes (Castonguay & Beutler, 2006; Elliott et al., 2011; Norcross et al., 2011). These findings are also consistent with 'difficult' client populations (e.g., incarcerated offenders) where the clinicians are also exposed to VT (Blasko & Jeglic, 2014).

A new finding that emerged in this study was the participants' reports that it was easier to experience empathy when their sex offender clients assumed accountability for the crimes they committed. Accountability is noted as a key component of effective sex offender treatment and essentially is the offender taking full responsibility for the crime they committed, without minimizing or justifying their actions (Carter et al., 2004; Evans et al., 2019). A couple of the participants noted that they found it difficult to work with offenders who were callous or even cavalier about their offense behavior. Conversely, Participant One and Participant Two in this study both noted that when their offender clients took accountability, they felt genuine empathy for the vulnerability the offenders displayed in discussing their most shameful behaviors.

Coping

The participants discussed various forms of coping as important components of understanding and effectively processing the challenges experienced through their SOTP clinical work. The most common method of coping reported by these participants was debriefing with colleagues or peers about their work, which is consistent with previous research examining the experience of VPTG in clinicians vicariously exposed to clients' trauma material (Barrington & Shakespeare-Finch, 2013; Linley & Joseph, 2007). This appeared to serve the function of a safe space for the participants to process the challenging content, which allowed them to obtain greater clarity in how best to proceed with their clients. The participants also noted that referring difficult cases to other clinicians was an important component of coping. These participants recognized that their own emotional reactions could be personally depleting as well as inhibit effective treatment. A potentially new finding that emerged in this study examining this specific population of clinicians was engaging in the internal process of compartmentalizing difficult content as an adaptive coping mechanism, such as avoiding over-processing or ruminating about the victims' experience of their offender clients. Several participants reported that they find compartmentalizing the difficult content they were exposed to be an effective means of achieving work-life balance and allowed them to contain any in-depth processing of their offender work within the work setting.

Additional methods of coping commonly reported by these participants were gradually taking on sex offender clients when first beginning this work and balancing out their caseloads with other clinical populations. This seemed to lessen feeling overwhelmed by the severity of the content as well as a way to manage exposure to difficult content. This is consistent with previous research examining factors that may

help mitigate the effects of VT in clinicians engaging in trauma work (Harrison & Westwood, 2009; McCann & Pearlman, 1990). Finally, the participants reported in engaging in personal self-care practices to manage the emotional and psychological strain of SOTP work. This included physical activity, meditation, prayer, and seeing a therapist to process their experience. This finding is also supported by research highlighting the importance of personal coping skills to effectively manage the symptoms of VT (Harrison & Westwood, 2009).

Vicarious Posttraumatic Growth

Under consideration in the present study was whether participants described experiences consistent with VPTG. The research literature suggests that those in helping professions exposed repeatedly to details of traumatic events are also capable of experiencing positive growth as a result of engaging in making meaning of the traumatic material (Arnold et al., 2005; Barrington & Shakespeare-Finch, 2013; Hyatt-Burkhart, 2014). The meaning making process that results in VPTG is best described as making sense of the trauma and accommodating the information into preexisting core beliefs (i.e., schemas) of self, others, and the world (Cann et al., 2010) in order to effectively move past the state of psychological chaos (e.g., constant fear) and instead experiences a newfound perspective that transcends pre-trauma functioning (Cann et al., 2010, Barrington & Shakespeare-Finch, 2013). Leading researchers on VPTG, Tedeschi and Calhoun (2004) explain that individuals must eventually learn to detach from the pre-trauma assumptions and beliefs that maintain this state of distress. Some of the participants in the study reported feeling 'jaded', or unaffected by the content they came across after years in this field. It may actually be what these individuals are experiencing

is accommodation of the trauma material (Tedeschi & Calhoun, 2004). They may use the term 'jaded' due to the stigma associated with the work. This is supported by statements from the participants describing how after years in the field and consequently regular exposure to offense narratives, they experienced significantly less emotional reactions and feelings of disgust. This suggests that after ongoing and repeated exposure to traumatic material that these participants were able to accommodate the details of sexual abuse into their schemas (i.e. worldviews; Tedeschi & Calhoun, 2004).

While each participant noted the obstacles and challenges experienced through providing sex offender treatment and evaluations, they also described reasons for feeling motivated to do the work they do. First and foremost, several participants discussed feeling as though the work they did was needed and thus important. Further, some of the participants noted feeling compelled to serve in this niche of clinical work in part due to the perception that others may not be able to work effectively with this population. Tedeschi and Calhoun (2004) describe how making meaning out of an experience is an important component in achieving PTG. In the present study, finding their work to be meaningful and important is an important catalyst for VPTG. Building on this idea of serving a need, many participants noted how their SOTP work challenged them to be better clinicians. Several participants expressed a drive to improve on the existing systems of treatment and evaluation for this population, which inherently required them to continue pursuing education on the subject matter, honing their clinical skills, and thus expanding the bounds of their clinical training to accommodate effective clinical approaches. Tedeschi and Calhoun (2004) explain that an individual who is confronted with trauma that challenges their assumptive world, it is important to form new goals and

expectations that allow them to feel as though they are moving forward once again. For these clinicians, improving the field within a difficult population appeared to be a pathway in achieving this. Further, the participants noted that they found their work made them better clinicians, which is consistent with previous research on VPTG and reports of clinicians feeling more confident in their professional roles (Barrington & Shakespeare-Finch, 2013; Hatcher & Noakes, 2010).

The positive impacts for the SOTPs did not stop at enhancing clinical skills and filling a need for clinical treatment in the community. The participants in this study each described how their work with sex offenders shaped their view of their clientele and their capacity for change. They reported an ability to offer compassionate care for these individuals guided by a belief system that the offenders are capable of overcoming the crimes they committed and reintegrating safely into the world. This was conveyed through several participants who noted learning to avoid a reductionist view of sex offenders and instead assuming a client-centered approach marked by positive regard. Further, a couple of the participants noted how this empowered them to spread their knowledge with others willing to listen in order to also influence their view of sex offenders as something more than inherently bad and incapable of change. This is consistent with previous research examining VPTG in clinicians where participants evidence feeling increased levels of sensitivity, compassion, insight, tolerance, and empathy (Arnold et al., 2005), as well as greater open-mindedness, flexibility and adaptability (Hyatt-Burkhart, 2014).

Limitations and Recommendations for Future Research

One important limitation of the study is the notion that clinicians who have experienced positive effects of their work may have self-selected for participation in this study. This could mean that participants with more positive experiences may have been more motivated to speak out about their experience and contribute to the research in this field, whereas clinicians who feel burnt out by their work may be less willing to contribute to this type of study.

The present study was also limited by the participants' geographic locations. The participants were exclusively from the state of Washington, with the majority living in Western Washington. It would have been beneficial to learn more from providers throughout the state to identify if there were any differences in the experiences of these providers based on their work in the more densely populated, urban settings of Western Washington compared with the predominantly rural settings of Eastern Washington. Further, future research would benefit from national and international population samples of providers as well. New findings may emerge based on various factors, such as legal guidelines, of mental health workers based on their location. For example, sex offender treatment requirements vary state by state in the United States, which could potentially impact SOTPs roles and the support they obtain from law enforcement to do their work. Further, there are vast differences in incarceration and offender reform procedures internationally compared to the United States, which could affect the perspectives of individuals treating sex offenders and residing in different countries throughout the world. An additional limitation of the present study was the relatively small sample size. While the general minimum requirement for a phenomenological study is one participant,

the sample size of five participants still provides a limited perspective on the experience of SOTPs.

An additional limitation related to the participants was the limited exploration of gender differences in the present study. A recent meta-analysis using findings across 12 studies including 1,623 participants reported on gender differences in trauma symptoms following vicarious exposure to trauma material (Baum et al., 2014). The findings indicated that women are more susceptible to trauma symptoms than males and are also more likely to experience greater symptom severity (Baum et al., 2014). The present study did not directly assess for differences in participant experiences based on gender, though various statements made by the female participants may support the notion of females being at heightened risk for VT. For example, Participants One and Two both described additional measures they take to maintain their personal safety while working with sex offenders, such as ensuring there are other providers on site while working with these clients. Future research examining gender differences is needed in order to better support female SOTPs.

The qualitative methodological approach is attributed as both a weakness and strength in the present study. While the qualitative interviews provide an opportunity for in-depth exploration of the participant experience, quantitative methodology would lend to greater generalizability of the study and could also utilize objective measures of VT and VPTG. For example, implementation of Tedeschi and Calhoun's (1996) Posttraumatic Growth Inventory could provide useful data to support the experience of VPTG in clinicians. Future research would benefit from a mixed methods approach, integrating the qualitative approach to gather rich details of the participant experience

supported by quantitative statistics to further support the objectivity of the research findings.

Clinical Implications

The present study may offer further support for mental health professionals navigating the challenging field of sex offender treatment, as well as providing new perspectives on career sustaining behaviors and opportunities for personal and professional growth. The participants in this study confirmed what is already known through existing research regarding the importance and value of seeking support from colleagues and supervisors to obtain guidance in effectively treating sex offender populations, as well as a strategy for managing the emotional tolls of clinical work (Barrington & Shakespeare-Finch, 2013; Linley & Joseph, 2007). Further, regular consultations with colleagues have demonstrated to be a career sustaining behavior as well as lessen risk of burnout in psychologists (Rupert & Kent, 2007; Senter et al., 2010).

As stated in the literature review, burnout is a similar though fundamentally different construct from VT. Briefly, burnout is considered to be a temporary and preventable aspect of consequence of individuals in helping professions and is associated with diminishment of enthusiasm, emotional energy (e.g., empathy), and decreased sense of meaning in one's work (Kadambi & Truscott, 2003). VT is considered an inevitable consequence of empathic engagement with trauma-based work and manifests as traumatic stress symptoms (Kadambi & Truscott, 2003). The findings in the present study suggest that the experience of VPTG may have significantly reduced the participants risk for experiencing professional burnout. The markers of VPTG in the study included participants' reports of feeling energized by their SOTP work, finding a deeper meaning

in their work, actively seeking out avenues to improve their clinical work and the field of sex offender treatment as a whole, and humanizing their clients through empathic engagement. Experiencing empathy for their clients appeared to be a crucial component of achieving the personal and professional benefits of VPTG for the participants. Future research examining psychoeducation strategies and peer support for SOTPs to facilitate empathic engagement with sex offender clients may reveal the critical role of empathy in reducing risk of burnout in this population of clinicians.

Conclusion

The results of this study lend to the conclusion that the participants in this study experienced VPTG as a result of their work as SOTPs. Previous studies of VPTG note changes to sense of self, such as increased levels of compassion, insight, tolerance, and empathy (Arnold et al., 2005). The participants in this study described how their SOTP work led to a change in their beliefs about individuals who commit sex offenses and their capacity for change, as well as factors contributing to offense behavior. This further resulted in heightened empathy and compassion towards these individuals, which consequently increased their tolerance for the offense details that are an unavoidable aspect of their work. The research literature on VPTG also notes the changes in life philosophy experienced by clinicians (Hyatt-Burkhart, 2014). The participants in this study appeared to adapt the philosophy as a result of their SOTP work that there is an important need for this type of clinical work and if someone is capable of handling the difficult material, have empathy for the clientele, and effectively conduct treatment from a holistic and client-centered approach, that they should do this type of work.

Two of the participants in this study described sex offenders as the *lepers* of society. The Christian Bible frequently used lepers as a symbol of the impure and outcasts of society: "Anyone with such a defining disease must wear torn clothes, let their hair be unkempt, cover the lower part of their face and cry out, 'Unclean! Unclean!. As long as they have the disease they remain unclean. They must live alone; they must live outside the camp" (Lev. 13: 45-46, New International Version). The research findings support the notion of these participants when examining the stigma of sex offenders and how this is comparable to the view of lepers in biblical writings. Similar comparisons can be drawn for the SOTPs who choose, like Jesus and his followers did, to look beyond the surface of these sick individuals and associate with the lepers (i.e., sex offenders), recognize that their sickness is curable, and utilize compassion and empathy to promote healing. There were dangers involved, too, for these disciples as there are many for SOTPs: the risk of stigma by association, physical threats to safety, and a willingness to put their own psychological wellbeing aside to serve a purpose and a need for effective healing with this population of outcasts. Future research is needed on the effects of empathy towards challenging clinical populations and how this may impact others in helping professions to experience the personal benefits of VPTG.

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Appendix A

1. What influenced your decision to begin working with sex offenders?
    a. What specifically interested you in this type of work?
2. Can you describe your approach to treatment with sex offenders?
3. How does it differ from your approach to your clinical work with non-offender clients, if at all?
4. What are some of your personal challenges in engaging in this work?
5. What have you personally gained from engaging in this work?
6. What clinical training did you receive to prepare you for this work?
7. Can you describe your first experience working with a client and hearing details of his or her sexual offense(s)?
    a. What were you thinking? What were you feeling?
8. What is your experience like today when you first sit with a client and hear details of the sexual offense(s)?
    a. What might you be thinking? What might you be feeling?
9. How do you prepare for meeting with a new intake who is a sex offender?
10. How do you cope after hearing the narratives of your clients' sexual offenses?
11. Have your coping methods changed since you began this work?
12. What types of workplace supports do you have in place?
13. How has your work with sex offenders influenced you professionally?
    a. What are the negative effects?
    b. What are the positive effects?
14. How has your work with sex offenders influenced you personally?
    a. What are the negative effects?
    b. What are the positive effects?
15. What advice do you have for clinicians beginning this type of work?
    a. How might you guide them in effective clinical work with this population?
    b. What do you think would be important for a new therapist to know for working with this population?

Appendix B

An Exploration of the Lived Experience of Sex Offender Treatment Providers: The Roles of Vicarious Trauma, Empathy, and Vicarious Posttraumatic Growth

Consent Form
Doctoral Dissertation, *Northwest University*
Victoria Schroder

You are invited to participate in a research study conducted by a doctoral psychology student at Northwest University. The study is being conducted in order to fulfill the requirements for graduation in the Doctor of Psychology program in Counseling Psychology. The purpose of this study is to explore in more depth the experience of sex offender treatment providers.

If you agree to participate in the study you will complete a short interview with the researcher, which will take approximately 45-60 minutes. Interviews will be scheduled according to the most convenient time for the participant and will be conducted in-person or via a computer-based interview online communication software (Zoom). Each interview will be audio-recorded and then transcribed verbatim as sources of data in this study. Audio recording in this study is used to accurately record the information you provide, and will be used for transcription purposes only. In-person interviews will be recorded using the ATLAS.ti application. Interviews conducted via Zoom will be recorded using the software's 'Local Recording' feature. You will have an opportunity to review your individual interview transcript to correct any factual errors or misrepresentations of the data before the research findings are finalized.

There are minimal risks associated with participation. Some individuals may be uncomfortable answering personal questions, however, every precaution will be made to make this experience as comfortable for the participant as possible. The benefit of taking part in this study is the opportunity to contribute further to the research illustrating the holistic experience of sex offender treatment providers.

Participation in this study is voluntary. You may choose not to participate in this study at any time and for any reason. There will not be any negative consequences for you if you refuse to participate. You may refuse to answer any questions asked. All responses are confidential and any identifying information will be removed or redacted. By signing this questionnaire, you are giving permission to use your responses in this research study.

The results from this study will be presented confidentially in a written doctoral dissertation and as a part of doctoral dissertation defense presentation. All raw data forms will be destroyed on or before December 31, 2020. If you have any questions about this study, contact Victoria Schroder via email or phone listed below. If you have further questions, please contact the faculty advisor, Kim Lampson at the email address listed below. You may also contact the Chair of the Northwest University Institutional Review Board (IRB), Dr. Cherri Seese, at cherri.seese@northwestu.edu or 425-285-2413.

If you experience concern or distress following study participation, you may call the crisis line provided below. Participants are also encouraged to seek out support through supervision, consult groups, or through individual therapy if they experience distress following study participation. Please refer to the website listed below as well for access to a network of mental health providers in your area.

Link to crisis lines for each county in WA state: https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-crisis-lines

Crisis Text Line: Text HOME to 741741 from anywhere in the United States, anytime, about any type of crisis.

Find a mental health provider: https://www.psychologytoday.com/us/therapists

Thank you for your consideration of this request.

Victoria Schroder, MA
Doctoral Student/Principal Investigator
victoria.heckart15@northwestu.edu
509-961-6748

Kim Lampson, PsyD
Dissertation Chair
kim.lampson@northwestu.edu

Signature of Consent

By signing on the line below, I agree to the terms stated above and have been given adequate information regarding my participation in the above listed study.

_____

Participant

By signing below, the researcher confirms that all relevant information has been shared with the above participant. No deception or coercion has taken place and all identifying information will be concealed and protected to the best of the researchers ability.

_____

Researcher

Appendix C

Washington State Department of Health: Licensure Requirements for Sex Offender Treatment Providers

Education:

Education history to include a minimum of a master's degree from a recognized institution of higher learning. Applicant must provide an official transcript with degree and date posted, received directly from applicant's program. Transcripts not in English must have an official translation.

Professional experience:

Professional experience required in the field of evaluation and treatment of sex offenders, a minimum of 2,000 hours must be completed. The hours must include at least 250 hours of evaluation experience and at least 250 hours of treatment experience.

Applicant must provide a detailed description of all experience to include hours acquired and calculated face-to-face treatment and evaluation hours.

To qualify for evaluation hours, the applicant must have had primary responsibility for interviewing the offender and completed the written report. In evaluation, the direct provision of comprehensive evaluation and assessment services to persons investigated by law enforcement or child protective services for commission of a sex offense or who have been adjudicated or convicted of a sex offense.

To qualify for treatment hours, the applicant must have had primary responsibility of treatment services with direct relevance to the offender's behavior. In the treatment, the provision of face-to-face individual, group, or family therapy with persons who have been investigated by law enforcement or child protective services for commission of a sex offense or who have been adjudicated or convicted of a sex offense.

Underlying credential:

All applicants are required to hold a credential in another health profession in Washington or a state or jurisdiction other than Washington. This underlying registration, certification or license must be maintained in good standing.

Work history (professional training and experience):

Applicant must list all professional experience activities to include the nature, the practice, and the location.

State license verification:

Applicant shall list all states where credentials are or were held, including where applicant has applied but a credential was not granted. A verification form must be completed and submitted by the jurisdiction where the applicant is or was credentialed. Applicant sends the form to the jurisdiction for completion, and the jurisdiction sends the completed form directly to the department.

Personal data questions:

Applicant must answer personal data questions regarding physical and mental health status; lack of impairment due to chemical dependency or substance abuse; history of loss of license, certification or registration; felony convictions; loss or limitation of privileges, disciplinary actions; and professional liability claims history.

An appropriate explanation and required documentation must be sent with positive answers. If there is a positive answer to the professional liability claims history question, the applicant must send an explanation of the nature of the case, data and summary of care given, copies of the original complaint and the settlement or final disposition. If pending, the applicant must indicate the status.

Additional information/documents required:

- HIV/AIDS Training – four hours
- Successfully passed state exam. Score of 90 percent or above.
- Applicant certification verifying he/she is presumed to know Washington State statutes and rules.
- Signed statement stating the applicant doesn't intend to practice the profession for which he or she is credentialed by another state within the state of Washington without first obtaining an appropriate credential to do so from the state of Washington.
- Professional training obtained within the last three years. List 50 hours of courses, seminars, or formal conferences attended directly related to the evaluation and treatment of sex offenders or victims of abuse.
- Three professional references that can verify the applicant's experience requirement.

Process for approving/denying applications:

We finish final review for approval after a credentialing specialist verifies that the application is fully complete, and complies with requirements in chapter 18.155 RCW and chapter 246-930 WAC. We complete background checks and make sure applicants have submitted required fees. Credentialing supervisors and lead workers have the authority to approve routine applications. The disciplining authority may conduct further review if the credentialing supervisor can't verify the applicant meets all requirements.

We'll formally notify applicants of a denial. Those applicants may request a hearing to appeal the decision.

Renewal and continuing education requirements:

Providers must renew their certification every year on or before their birthday. They're required to submit the appropriate fee and renewal card. Forty hours of continuing education is required every two years.

Appendix D

Demographic Questionnaire

The information requested is completely confidential and will be kept separate from the data collected during the interview.

1. Gender (circle your response): Male Female Prefer not to say
2. Current Occupation: _____
3. Level of education: ____
4. Years Practicing as a Mental Health Provider (total): ____
5. Years Practicing as a Sex Offender Treatment Provider (SOTP): ____
6. Estimate of the percentage of your current caseload receiving sex offender treatment (e.g., 50%): ____
7. Briefly describe your current clinical practice setting(s) (e.g., group practice, private practice in an office space, private practice out of my home):
8. Briefly describe clinical settings you have worked in as an SOTP and the duration of time you worked in this setting (e.g, Prison- 2 years):

Appendix E

Sample Recruitment Email

Dear Colleague,

My name is Victoria Schroder and I am a doctoral student in counseling psychology in the College of Social and Behavioral Sciences at Northwest University in Kirkland, WA. I am writing to invite you to participate in a research study being conducted as part of dissertation research. The purpose of the study is to explore the experience of sex offender treatment providers (SOTPs) in Washington State. You are eligible to participate in this study because you hold certification as a SOTP in Washington State. I obtained your contact information from the Washington State Department of Health Sex Offender Treatment Provider Directory.

If you decide to participate in this study, you will be asked to participate in an individual interview with the principal investigator anticipated to last 45-60 minutes in length. The interview may be conducted in person or via web-based communication platform (e.g., Zoom). Participants are welcome to either option, though location of the provider and the principal investigator may necessitate web-based interviews.

If you'd like to participate in this study, please respond via email to victoria.heckart15@northwestu.edu. Please include your current work setting (e.g., private practice, group practice, corrections, community mental health agency) in your response if you would like to participate.

If you have any questions about the study, please contact me at victoria.heckart15@northwestu.edu or via phone at (509) 961-6748.

Thank you very much.

Sincerely,

Victoria Schroder
Principal Investigator
Study Title: *An Exploration of the Lived Experience of Sex Offender Treatment Providers: The Roles of Vicarious Trauma, Empathy, and Vicarious Posttraumatic Growth*

Contact Information
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