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Abigail Kirschbaum
Factors Affecting Turnover and
Turnover Intention Among
Clinicians Who Work with Sex
Offenders

ABSTRACT

This study is a qualitative analysis of interviews from 11 clinicians who work with sex offenders concerning the relationship between organizational factors, client and clinician characteristics and turnover. Initial findings revealed that the majority of participants did not struggle with turnover or turnover intention. Of participants who did experience turnover intention, factors cited as influencing turnover intention ranged from organizational factors, personal reasons and characteristic specific to the population. Vicarious trauma and burnout were also factors reviewed as influences of turnover and turnover intention. Other findings such as specific characteristics of the clinician, characteristics of the client, external/organizational factors, and specific effects of the work were discussed but not directly related to the clinician's turnover or turnover intention. Since the major predictor of turnover and turnover intention are organizational factors rather than personal factors or factors related directly to the population, there may be a great deal that managers and policy makers can do to prevent turnover intention among clinicians who work with sex offenders.

FACTORS AFFECTING TURNOVER AND TURNOVER INTENTION AMONG
CLINICIANS WHO WORK WITH SEX OFFENDERS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2013

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CHAPTER I

INTRODUCTION

Social workers and clinicians in general have difficult and demanding jobs. In a report on the difficulties of the social work profession, the Center for Workforce Studies cited increasing paperwork, unmanageable caseloads, and problems with difficult clients, as well as staff shortages and reduced availability of adequate supervision as demands of the social worker's job. These demands are accompanied by confusing legislation and challenging guidelines that have increased the conflicting and disparate demands on social workers (Bransford, 2005). Literature has suggested that these demanding job conditions can be antecedents of burnout (Söderfeldt, Söderfeldt, & Warg, 1995). Moreover, clinicians who feel burned out and frustrated with their jobs are more likely to have higher rates of absenteeism and turnover (De Croon et al., 2004). Clinician turnover is a serious problem for administration because turnover can negatively affect the quality, consistency, and stability of client services (Mor Barak, Nissly, & Levin, 2001). Clinician turnover not only causes psychological distress in remaining staff members or in new and inexperienced workers who fill vacated positions (Powell & York, 1992), but it can lead to client mistrust of the system (Geurts, Schaufeli, & De Jonge, 1998) and financial problems for the organization (Kompier & Cooper, 1999). In light of the literature, further examination of the factors that influence turnover and turnover intention would be beneficial to help reduce turnover in current and future clinicians.

Previous models of job stress (e.g., Karasek & Theorell, 1990; Demerouti et al., 2001) have suggested that there are two critical job conditions that influence job strain outcomes such as turnover: job demands (e.g., role stress, case load) and job resources (e.g., supervisory support, job autonomy). The current research has demonstrated that both job demands and

resources have particular effects on a clinician's burnout and turnover intention (Houkes et al, 2003; Lee & Ashforth, 1996; Mor Barak et al., 2001; Söderfeldt, Söderfeldt, & Warg, 1995; Um & Harrison, 1998). Other studies have focused on examining how job demands and job resources interact in explaining burnout or turnover intention (Bakker, Demerouti, & Euwema, 2005; Dollard et al., 2000; Nissly, Mor Barak, & Levin, 2004; Posig & Kickul, 2003).

Despite the significant contribution of many studies that examine turnover, turnover intention, and factors that may influence turnover intention, few have examined these issues specific to clinicians who work with sex offenders. In order to retain clinicians who work with sex offenders and who are experiencing emotional distress at work, it is important to determine how specific organizational conditions, clinician characteristics, and client characteristics affect a clinician's decision to leave his or her job. Therefore, the exploration of all of these factors when considering turnover and turnover intention is critical to understanding the multiple factors involved in clinicians' decision to remain in or exit the field of sex offender treatment.

The purpose of this study is to examine multiple factors that may influence turnover or turnover intention among clinicians who work with sex offenders. Organizational factors, characteristics of the clinician, and characteristics of the clients will be examined in the context of turnover. Findings will be analyzed through qualitative data analysis techniques.

CHAPTER II

LITERATURE REVIEW

This literature review will examine scholarly research focused on the occupational side effects of working as a sex offender therapist. Studies will be critically examined on how different aspects of working as a therapist, such as emotional reactions, supervision, burnout, and vicarious trauma can affect one's turnover intention and job retention. Finally, several organizational factors that affect turnover intention and job retention will be reviewed. Throughout the literature the results will be analyzed through the lens of how these factors directly or indirectly affect therapists' turnover intentions who work with sex offenders.

General Findings on Turnover Intention in Human Services

Job satisfaction of clinicians is important for both the agencies and the clinicians, as clinicians who derive satisfaction from their occupation are more likely to retain their job and provide high quality services to clients (Acker, 1999; Oberlander, 1990). In 1992 it was estimated that 80% to 85% of all mental health monies were spent on labor (DHHS, 1992). Recruitment and job retention among mental health workers are two high priority issues for state Mental Health Directors (Lippincott 1990). High rates of turnover among community mental health workers have been reported in statewide reports (Dunn & Menz, 1992; Ben-Dror, 1994) with an estimated five to seven year turnover rate for the entire public mental health workforce (KamisGould & Staines, 1986). Turnover can be time consuming and costly when the recruitment process and training is taken into account (Alexander, Bloom, & Nuchols, 1994; Pinder & Das, 1979). Turnover can also cause disruption in the quality of care that clients receive by disrupting the client-provider relationship (Barak, Nissly, & Levin, 2001; Smith, 2005; Ben-Dror, 1994).

The literature provides insight into factors that affect job retention and turnover intention. In a metaanalysis of 25 articles concerning the relationship between demographic variables, personal perceptions, and organizational conditions it was found that burnout, job dissatisfaction, availability of employment alternatives, low organizational and professional commitment, stress, and lack of social support are the strongest predictors of turnover or intention to leave (Barak, Nissly, & Levin, 2001). In a nationwide survey of Psychosocial Rehabilitation Services (PSR), Blankertz and Robinson (1997) found seven variables that predict turnover intention: younger age, higher emotional exhaustion, a feeling of lower job fulfillment, the lack of a perception of a career path, having a Master's degree, having held a previous job in PSR, and working with clients who have both MI and AIDS. Drake and Yadam (1996) also cite emotional exhaustion as a factor that can potentially affect job retention.

Further, Geurts, Schaufeli, and Dejonge (1998) suggested that the more employees feel emotionally exhausted, the more they feel the need to engage in negative communication with colleagues. In their study, burnout and turnover intention were explored from a social psychological perspective. Their results revealed that the more employees were engaged in negative communication with their colleagues about management, the more they felt strengthened in their perception of inequity in the employment relationship. The perception of inequity resulted in two forms of withdrawal: intention to leave the organization (i.e. "behavioral" withdrawal) and emotional exhaustion, ("psychological" withdrawal such as depersonalization).

In a later study by Geurts, Schaufeli, and Rutte (1998) that examined how absenteeism and turnover intention are indirectly related to perceived inequity in the exchange relationship with the organization, results demonstrated that the relationship between perceived inequity and

turnover intention was fully mediated by poor organizational commitment. Further, poor organizational commitment was partially triggered by feelings of resentment that were associated with perceived inequity. In another study that examined emotional exhaustion and turnover intentions among clinicians, Knudsen, Ducharme, and Roman (2006) reported workload measures, low autonomy, and a lack of distributive justice significantly predicted emotional exhaustion, while coworker support was inversely associated with exhaustion. Their research, along with others', also found that the emotional exhaustion was a significant predictor of turnover intention (Knudsen, Ducharme, and Roman, 2006; Laschinger, Leiter, Day, & Gilin, 2009).

Ito, Eisen, Sedeer, Yamada, and Tachimary (2001), used the National Institute for Occupational Safety and Health job stress questionnaire to examine psychiatric nurses' intention to leave their job in relation to their perceived risk of assault, their job satisfaction, and their supervisory support. Results identified significant predictors of turnover intention as younger age, fewer previous job changes, less supervisory support, lower job satisfaction, and more perceived risk of assault. Job satisfaction and pay satisfaction were factors that came up in the literature a number of times in relation to turnover intention and actual turnover, although most often in studies involving nurses rather than social workers or other mental health clinicians (Singh & Loncar, 2010). However, Weaver, Chang, Clark, and Rhee (2007) conducted a longitudinal study of public child welfare workers that developed predictors of turnover which found job satisfaction, case load and role conflict as the best predictors of turnover.

Other studies have indicated organizational conditions as being factors that can affect turnover and turnover intention (Acker, 2004; Smith, 2005; Mitchell, Mackenzie, Styve, & Gover, 2006). These organizational supports ranged from having support within the agency,

supportive supervision, having an intra-organizational network, the organization having similar values to the clinician, job autonomy, and having an employer that promotes a life-work balance. Although these studies on turnover and turnover intention are informative, they do not directly speak to the specific experience of the clinician who works with sex offenders. Shelby, Stoddart, and Taylor (2001) offered one of the few studies that examined burnout among clinicians who work specifically with sex offenders; reporting them as having higher levels of emotional exhaustion, depersonalization, and personal accomplishments compared to the reported norms. However, this study does not directly link emotional exhaustion, depersonalization, and personal accomplishment as factors that affect turnover or turnover intention.

Findings on Therapists Who Work with Sex Offenders

Although there has been little research on the turnover intentions of sex-offender clinicians, there is a body of literature that has examined the emotional responses, burnout, and vicarious trauma experienced by these clinicians". This section will review these findings to provide a context for understanding turnover intentions among this population of clinicians.

Emotional and Physical Responses

Multiple factors have been linked to turnover and turnover intention, with emotional exhaustion being one of the most common (Blakerts & Robinson, 1997; Cropanzano, Rupp, & Bryne, 2003; Lee & Ashforth, 1996). There are many complex emotions stirred up when working with sex offenders that could potentially lead to emotional exhaustion. This section of the literature review will examine the research on the emotional aspects of working with sex offenders. Keeping with the focus of this study, this section will also examine this literature for how emotional responses are associated with therapist's turnover or turnover intentions.

Working with sex offenders can provoke strong emotional reactions of anger and disgust, which can both negatively affect the therapist (Briere, 1989), and the effective provision of treatment (Reddon, Payne & Starzyk, 1999). Therapists who experience emotional hardening, defined as “dulling of emotions” or “emotional distancing”, are more likely to have difficulty feeling and exhibiting empathy for their clients (Farrenkopf, 1992). Therapists’ characteristics are prone to affect the client’s experience of the therapeutic relationship. Unresponsiveness, confrontation, criticism, sarcasm, and other observable behaviors coming from the therapist are directly experienced by the client (Dunkle & Friedlander, 1996). If therapists who work with sex offenders begin to experience too many of these strong negative emotions, and possibly letting these negative emotions affect their behavior or character, as stated previously, it is likely to negatively affect their rapport with clients. This may be another factor that could drive therapists away from the field.

Work with sex offenders has been recognized as a highly stressful area of intervention (Maletzky, 1991). Specifically, it has been acknowledged that therapists who work with sex offenders tend to feel burdened, frustrated and alone, much like their clients do (Hanson & Scott, 1995). They also experience considerable anxiety provoked by a natural question of whether or not they too could be an aggressor or a victim, leading them to misgivings about their self-image (Bengis, 1992). All of these negative experiences and emotions could impact one’s desire to remain in the field of treatment of sex offenders.

There are a number of studies that have examined the negative impact that working with sex offenders can have on therapists. A common theme is loss of trust and innocence, with therapists reporting the increased awareness of how unsafe the world is and having decreased trust in other people (Freeman-Longo, 1997; Jackson et al., 1997). Therapists who work with

sex offenders also tend to feel more vulnerable to violence in regards to themselves and their families (Bengis, 1997; Ellerby, 1998; Jackson et al., 1997; Rich, 1997) and in turn increase their vigilance and safety precautions (Bengis, 1997; Farrenkopf, 1992; Jackson et al., 1997). Feelings of discomfort in caring for or touching children were also reported as negative impacts of working with sex offenders. This discomfort results from the fear that others could perceive their touch as sexual (Edmunds, 1997; Freeman-Longo, 1997).

Negative influences are not the only factors directing therapists away from or towards continuing their work with sex offenders. The majority of studies have examined the negative implications of working with sex offenders; however, far fewer have looked at the potential positive effects of working with this population. Scheela (2001), for example, interviewed therapists who work with sex offenders within a hospital setting specifically focusing on positive implications of working with this population.

The author found that although the therapists interviewed discussed many of the same negative experiences as other therapists who work with sex offenders, they all expressed excitement about working in a “challenging new area”. One of the participants commented, “We’re on the cutting edge, pioneers”. Therapists reported feelings of honor and privilege in working with sex offenders. They felt “rewarded” knowing that they “made a difference in someone’s life.” They enjoyed being able to witness their client’s change and growth. And with that, felt their work constructive because it contributed to making the community safer. One therapist referred to his work as actually being like a “battery charger”, because he was “doing something good and people [were] better off for my work.” This would undoubtedly have a huge impact one’s desire to stay in the field of treating sex offenders.

Scheela's study gives insight into some of what may be keeping therapists in the field of treating sex offenders. Her analysis doesn't directly speak to job retention or turnover intention for therapists who work with sex offenders. It could be that just the mere presence of having some of these positive experiences buffers against or negates the negative experiences. It could also be that as long as the positive experiences outweigh or outnumber the negative then the therapist will be more inclined to stay in the field of sex offender treatment.

Similarly, in previously cited studies, the concept of emotional reactions effecting turnover or turnover intentions for therapists who work with sex offenders is not directly addressed. This study will focus more closely on how both the positive and the negative reactions associated with working with sex offenders relates to job turnover and retention.

Burnout

Burnout is conceptualized as a psychological syndrome manifested in response to chronic emotional and interpersonal stress on the job and is most widely defined by the dimensions of exhaustion, depression, and inefficacy (Maslach, Schaufeli, & Leiter, 2001). Burnout has recently had an influx of interest in the scientific world. This section of the literature review will explore the research that has been conducted around burnout, specifically focusing on burnout in therapists who work with sex offenders. And again, it will be examined through the lens of how burnout may or may not affect job turnover and retention.

Being a therapist can be a precarious profession. The nature of the work of a therapist as well as the role expectations are stresses that therapists are encountered with daily. Therapists run the risk of experiencing symptoms of burnout and possibly being impaired by burnout. The burnout and turnover rates of therapists working in community mental health agencies are astounding (Kottler, 1993). Guy and Liaboe (1986) suggest that many therapists have noticed

increased negative experiences in their ability to relate meaningfully with friends and family. Faber (1983) found that more than half of those conducting therapy reported a decrease in their emotional investment in their own families. This can lead to therapists reducing their circle of friends and/or support system, and socializing less during their career. Therapists working in community agencies, or private practice, often work in systems that value giving to others but provide little support for oneself. Because of this, therapists can lose their ability to cope with or resolve stressful events in their professional and personal lives (Corey, Corey, & Callanan, 1993).

There is a significant amount research that argues emotional exhaustion as the most significant dimension of burnout (Maslach, Schaufeli, & Leiter, 2001; Schaufeli & Taris, 2005). Several studies (Ellerby, 1998; Jackson, Holzman, Barnard, & Paradis, 1997; Layton, 1988; Polson & McCullom, 1995) point to the fact that therapists who work with sex offenders are significantly influenced by their work in ways that produce multiple emotional and physical ailments manifesting cognitively and/or in the workplace; which jeopardizes both the therapist's well-being and treatment efficacy. Though it is clear that therapists who work with sex offenders are up against a great deal, this data does not suggest that they experience higher levels of burnout or further, that they are more likely to change their careers.

As seen through this literature review, the potential problems and stressors that come along with working with sex offenders are well recognized. Everall and Paulson (2004) believe that burnout is a potential response to the emotional stress of working with this population. Abuse-specific therapists (i.e. those working with sex offenders and substance abuse clients) exhibit evidence of cognitive disruptions at levels higher than other, general mental health professionals (Everal & Paulson, 2004; Pearlman, 1996; Pearlman & Saakvitne, 1995; Rich, 1997).

Lee et al. (2010) surveyed 204 therapists who worked with sex offenders using the Counselor Burnout Inventory (CBI), a 20-item measure of counselor burnout. The CBI contains items reflecting characteristics of feelings and behaviors that would indicate various levels of burnout. The 20 items measured are divided into five sub-scales: Exhaustion, Incompetence, Negative Work Environment, Devaluing Client, and Deterioration in Personal Life (Lee et al., 2007). Their results found that therapists working with sex offenders and/or survivors had higher scores than general mental health professionals on the Devaluing Client and Deterioration in Personal Life factors of the CBI (Lee et al., 2010). However, this does not necessarily imply that they have higher rates of burnout compared to general mental health professionals.

As stated earlier in this section, burnout is an indication of the therapists growing inability to manage their emotions while interacting with clients. However, most empirical studies surrounding burnout do not directly measure emotional demands at work. For example, how often does the therapist have to show or control certain emotions? Rather, studies analyze organizational variables as potential predictors of burnout.

Vicarious Trauma

Clinicians who work with sex offenders are likely going to be listening to trauma stories. The last 20 years has produced a large body of research looking at the effects of working with traumatized individuals and trauma work. This section will examine the literature that speaks to vicarious trauma while working with sex offenders. It will also critically examine how this may or may not affect turnover or turnover intention for clinicians who work with sex offenders.

It is important to start off by distinguishing between the different terms used to discuss trauma experienced by therapists. Two terms commonly used are “Secondary” traumatic stress and “Vicarious” trauma. Secondary traumatic stress refers to the phenomenon in which the

trauma worker experiences symptoms similar to those seen in people with Post-Traumatic Stress Disorder (Figley, 2002; Sabin-Farrell & Turpin, 2003). The term vicarious trauma refers to personal transformations experienced by trauma workers resulting from cumulative and empathetic engagement with other's traumatic experiences that can lead to long term changes to an individual's way of experiencing themselves, others, and the world, and symptoms that may parallel those of their client (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

McCann, Sakheim and Abrahamson (1988) have presented a Constructivist Self-Development Theory which outlines the development of vicarious traumatization. In this theory, schemas about the self and the world are vulnerable to disruption as a result of exposure to trauma. Traumatic experiences are most likely to affect schemas related to each individual's most central need areas. Adaptation to trauma is the result of an interaction between life experiences and the developing self. These developmental issues include identity, psychological needs, schemas about self and the world, and ego resources. When the environment presents information that cannot be assimilated into existing schemas, accommodation must occur (Piaget & Inhelder, 1969). New or modified schemas are developed. When trauma presents a challenge to the individual's schemas, painful identity, emotional and interpersonal changes occur (McCann and Pearlman, 1992).

Constructivist Self-Development Theory explains one's adaptation to trauma as an interaction between his or her personality and personal history and the traumatic event and its context, within the social and cultural contexts for the event and its aftermath. Because the theory takes into account the individual's/clinician's own personal history and/or characteristics as well as the social and cultural context, it will be helpful to view the data collected from this study through the lens of the Constructivist Self-Development Theory. For the purpose of this

study, organizational factors such as an agency's environment or policies will be viewed as the social and cultural context.

According to Constructivist Self-Development Theory, therapist's vicarious traumatization is an adaptive response to traumatic content disclosed by clients (Pearlman & Saakvitne, 1995). Therapists develop adaptations as self-protection against the emotionally traumatic experience of exposure to another's traumatic content (Farber, 1983). These changes are cumulative and pervasive and can affect every area of the counselor's life. They are also potentially permanent as they are regularly reinforced by each subsequent exposure to recurring traumatic content disclosures inevitable in the profession (Trippany, White-Kress, Wilcoxon and Allen, 2004).

Seven schemata have been identified which are especially susceptible to trauma-induced alteration. These include (1) the individual's personal frame of reference about self and others in the world; (2) safety; (3) dependency and trust; (4) power; (5) esteem; (6) independence; and (7) intimacy (Curtois, 1993; McCann and Pearlman 1992). McCann and Pearlman (1990) also argue that these cognitive shifts that result from exposure to traumatic client material may create a general emotional distress in therapists, including heightened anger, guilt, fear, grief, shame and inability to contain intense emotions. It is very likely that these cognitive shifts may interfere with effective functioning in the therapeutic role (Herman, 1997).

Warnings are offered that if the effects of vicarious traumatization are not managed in positive ways, they can inadvertently be managed in negative ways (Ruzek, 1993). Lindy (1988) has identified therapists' defenses, which he judged to interfere with the therapy process. These include distancing from the client through "avoidance, disavowal and clinging to the professional role," as well as distancing from one's own feelings by "isolation, generalization and intellectualization." Dalenberg (2000) also warns in her discussion of counter-transference that

suppression of affect could be a disguised version of PTSD. She also recommends emotional disclosure to a support system regarding the indirect experience of the client's trauma as a means of keep those effects from damaging the therapy process and perhaps even the client.

It is clear that vicarious trauma is a real concern to therapists who work with sex offenders. However, it is not clear whether or not vicarious trauma affects job satisfaction or job retention. This study will more precisely look at how vicarious trauma may affect therapist's job job turnover intentions and retention.

Organizational Factors

Bureaucratization, controls introduced by funding sources (i.e. insurance agencies, Medicare, and/or Medicaid) and limits on autonomy are often characteristics of the social service workplace. This section of the literature review will examine how these organizational factors influence therapists' work experience, turnover, and turnover intention. Although there are few studies that look specifically at organizational factors and how they directly affect therapists who work with sex offenders, most of the literature can be generalized from general mental health professionals to those with specialty clients, such as sex offenders.

Dressel (1984) took a structural approach to explain what is referred to as the "service trap." She maintained that despite the setting, the services provided, or the needs addressed, the difficulties that social workers are experiencing are with the larger system. Derber (1983) broke down the different ways in which an organization maintains control over their workers. Ideological control by the organization is the loss of control by the worker over input into organizational policy and decision-making. Bureaucratic control refers to the worker's loss of control over auxiliary workers/support staff. Productive control is the loss of decision-making power over scheduling, caseloads, and the pace of one's work. Technical control is the worker's

loss of autonomy over the content of the actual work and how it gets done. These aspects of control are important, given that job autonomy, as reviewed in an earlier section of this literature review, is a factor in predicting job satisfaction and retention.

Therapists in private practice and in agencies are subject to ideological and technical controls held by insurance companies. Most private insurance companies only reimburse for psychotherapy, diagnosis, and evaluation. If the therapist wishes to be reimbursed by the insurance company the patient/client must have a diagnosis complying with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision (American Psychiatric Association, 2000). This puts the sex offender therapist in a complicated and unique role of deciding what is sexually deviant (warranting a DSM-IV-TR Sexual Disorder code) and then attempting to influence the client to be non-deviant.

Unless a therapist is working outside of a large system/organization, and working privately with private pay clients, they are most likely held captive by the diagnosis needed to get reimbursed. And when there is a reimbursable diagnosis, the therapist often has a limited time to “cure” the client depending on the diagnosis. This is another problematic aspect of working with sex offenders. The idea of “curing” sexual deviancy is somewhat controversial. The results of outcome studies assessing the effectiveness of sex offender treatment programs are often contradictory, ranging from positive effects (Marques et al., 1994; Valient & Antonowicz, 1991), through no effect (Lab, Shields & Schondel, 1993; Pithers, 1999) to negative effects (Furby, Weinrott & Blackshaw, 1989).

Time limits affect the actual technology or use of professional knowledge by the therapists. For example, if only 12 visits are reimbursable, then planned short-term therapy is likely to be used whether or not it is determined to clinically be the best treatment for the client. This leaves the

therapist who works with sex offenders very little autonomy and puts him or her into a position where they are being expected to cure or treat a disorder that may not be curable or treatable. It is possible that this would have a significant effect on the therapist's view of effectiveness in their job, which is directly linked to job satisfaction.

Therapists who do not work in private practice, who are dependent on insurance company reimbursement in a multi sponsor setting (i.e. a government funded community mental health clinic), encounter further constraints on their practice. For example, in some agencies, therapists are encouraged to double-book clients so that outside coverage will still pay for the therapist's time if one of the clients does not show up. In other settings, therapists are pressured to drop clients who do not show up for two consecutive appointments. This could be very problematic for the therapist who treats sex offenders in that their clients may be mandated to treatment, may not desire treatment, and may not be active participants in treatment (Langevin, 2006; Mitford, 1973; Wright, 1973; Miner & Dwyer, 1995; Geer et al., 2001). This again speaks to the therapist's autonomy and efficacy within the system/organization. Further insight into how therapists who work with sex offenders perceive the system they work in and how the system may or may not support the work they are doing with this difficult population will be helpful in understanding intention to leave/stay within the field of sex offender treatment.

In Kim and Stoner's (2008) study on the effects of role stress, job autonomy, and social support on burnout and turnover intention among social workers it was found that social workers with higher role stress experience higher burnout, which in turn increases the likelihood of turnover intention. They also found that job autonomy and social support have a direct negative effect on turnover intention but did not have direct effects on burnout. This conveys the idea that regardless of the therapist's perceived levels of burnout, the lack of job autonomy and social

support increases turnover intention among therapists. This would seem a very important concept in light of the possible lack of control therapists have in some systems/organizations due to policies set forth by the system/organization or insurance companies. It is clear that job autonomy is not only a potential area of concern/conflict for therapists but it is also an antecedent to burnout and turnover intention.

Another antecedent to burnout and turnover intention is role stress (Um & Harrison, 1998; Mor Barak et al., 2001). Literature has suggested that that therapists are more likely to feel burned out when they perceive high levels of role-related stress; characterized by a worker's high role conflict, role ambiguity, and role overload (Soderfeldt, Solderfeldt & Warg, 1995). As noted earlier, burnout is directly related to emotional exhaustion. Research has shown that a therapist's level of emotional exhaustion is greatly affected by the nature and intensity of stress in the work environment (Cordes & Dougherty, 1993). It is clear that therapists who work with sex offenders are dealing with a difficult population and with the difficult, emotional, and stressful topics of sexual deviancy and violence in treatment. These factors combined with a system that offers little role autonomy and increased role stress will hypothetically have a great effect on the therapist's intention to stay in the field of sex offender treatment.

Social support also plays a role in burnout and turnover intention (Um & Harrison, 1998; Mor Barak et al., 2001). Social support, generally defined, is the supportive interactions or exchanges of resources between people in both formal and informal relationships (House, 1981). Karasek and Theorell (1990) found social support in the work setting as a condition that reduces negative effects of job related stress. Other research suggests that perceived social support in the workplace can decrease the likelihood of burnout among therapists (Houkes et al., 2003) and turnover intention (Mor Barak et al., 2001; Nissly, Mor Barak & Levin, 2005). Consequently, it

is expected that perceived social support would negatively correlate with burnout and turnover intention among therapists who work with sex offenders.

Supervision

While supervision can occur outside of an organization, it is most likely that supervision occurs within the organization for this type of treatment and thus its inclusion in this section verses a separate section. In the 1920's clinical supervision was developed out of the formalization of training in psychoanalysis from the Viennese Institute for Psychoanalysis (Bibring, 1937). The push for clinical supervision came from the recognition of the separation between personal analysis and 'supervisory or control analysis' (Ekstein & Wallerstein, 1972). Since that time, clinical supervision continues as a both a requirement for training and licensure as well as an ongoing model of support and continuing education for therapists in the field of mental health treatment (Raskin, 2005). This section will examine the literature on clinical supervision and it's role for mental health providers; while simultaneously examining the literature for how clinical supervision for therapists who work with sex offenders could potentially influencing them in terms of staying in or leaving the field.

Supervision is widely recognized and promoted as a fundamental aspect of ethical and effective therapy for counseling and psychotherapy practice and is seen as an essential part of continuing professional development (Wheeler & Richards, 2007). Supervision can be used as a tool for supporting the therapist in adhering to the ethical guidelines of their discipline and is a central pillar of the framework that surrounds professional practice. Supervision may also offer a range of support for therapists, a safe place to discuss and process some of the emotional reactions they are having in response to their work.

Although there is a dearth of literature on the topic of supervision for sex offender therapists, there is a larger body of research pertaining to clinical supervision for general clinicians. Social workers gain skills often related to theory; professional growth and support; role modeling of professional and personal qualities; and mutuality through an interactive supervisory relationship (Hensley, 2002). These are important skills and supports that are gained through supervision, but they do not speak to how supervision affected the supervisee's job satisfaction or career longevity.

Bango and McKnight (2006) reviewed the body of research pertaining to clinical supervision in social work. Through their literature review they found that there are certain qualities in supervisors that make them more "prized" by the supervisees, including if the supervisors: (a) are available, (b) are knowledgeable about tasks and skills and can relate these techniques to theory, (c) hold practice perspectives and expectations about service delivery similar to the supervisee's, (d) provide support and encourage professional growth, (e) delegate responsibility to supervisee's who can do the task, (f) serve as a professional role model, and (g) communicate in a mutual and interactive supervisory style. All of the studies reviewed used self-assessment measures of impression of supervisory helpfulness.

Robinson et al., (2005) examined how clinical supervision affects job satisfaction. His findings revealed that clinical supervision, among mental health nurses, was a means to positively impact job satisfaction and ultimately staff retention. Although this study reviews the impact of clinical supervision on mental health nurses, it begs the question of whether or not clinical supervision has the same effect on other mental health providers and specifically therapists who work with sex offenders.

Social work and forensic psychology are two professional cultures that have augmented the literature on supervision for clinicians who work with forensic populations (Mothersole, 2000). Specifically, Kearns (1995) and Ellerby (1998) have reiterated how essential it is to have quality supervision while working with sex offenders. For example, Kearns suggests that therapists who work with sex offenders have the potential to become increasingly isolated from other clinicians and that their work climates often discourage therapists from discussing the negative aspects of their work. Ellerby's (1998) results indicated that therapists viewed supervision as supportive and beneficial because it gave them an opportunity to vent, provided a place in which to receive clinical guidance and direction, and it provided a means of confirmation and validation. Craissati (1998) also speaks to the importance of supervision while working with sex offenders, even while working within a community approach to treatment. Supervision potentially provides a sort of quality assurance; possibly thwarting feelings of isolation, or other negative emotional responses common for clinicians.

Boud et al. (1985) who examined reflection as a way to turn experiences into learning, advocates for the process of truthful exploration of feelings related to the incident being reflected upon, believing that feelings and emotions may be both a significant source of learning and also a barrier. Therapists who work with sex offenders experience a plethora of emotions within their field. It could be possible that supervision offers an opportunity to positively impact their job satisfaction and perhaps their desire to stay within the field. This idea is indirectly supported by Scheela's (2001) study where therapists who worked with sex offenders identified their professional coping strategies used to deal with sex offender treatment work. These strategies included processing issues and concerns with colleagues, having good supervision, and being able to make decisions as a team so that responsibility does not fall on one individual.

Few articles on supervision speak to the relationship of having supervision or how the quality of supervision relates to staff retention or turnover intention in the field of mental health and specifically sex offender treatment. Whereas Bango and McKnight (2006) discuss dimensions in supervision that are important to supervisees, they do not address whether these dimensions affect supervised outcomes, such as improved job satisfaction, increased professional development and/or performance, or turnover.

Although it is clear through the examinations of literature that clinical supervision most often has a positive impact on mental health providers it is unclear how it directly affects therapists who work with sex offenders. The indirect model reflected from the literature is that quality/good supervision may be associated with job satisfaction and job satisfaction is associated with job retention (Gleason-Wynn, 1995). This study will focus more precisely on how clinical supervision, or the lack thereof, relates to therapists turnover and/or turnover intention within the field of sex offender treatment.

Conclusion

It is clear that for the general therapist, the system and organization they work within has a great effect on their level of job autonomy, role stress and social support. This in turn affects their potential for burnout and turnover intention. What this study hopes to explore is whether or not this is also true for therapists who work with sex offenders. In regards to the clinician's emotional response, Constructivist Self-Development Theory (McCann, Sakheim, and Abrahamson, 1988) was used as a framework through which to understand the emotional experiences of therapists through the interviews.

Turnover has long been a problem in the field of social work (Ewalt, 1991). Social workers and other therapists have demanding jobs. In a recent report on the difficulties of the

social work profession, job demands included increasing paperwork, unmanageable caseloads, and problems with difficult clients, as well as staff shortages and reduced availability of adequate supervision where those mentioned (center for Workforce Studies, NASW, 2006). These are very real concerns for therapists and with the added demand of dealing with a difficult population like sex offenders, the question of what helps to maintain job retention among these therapists is one that could prove to be helpful for future therapists in this field. This study will attempt to move one step closer to answer the question of what directly affects turnover among therapists who work with sex offenders.

CHAPTER III

METHODOLOGY

Design and Purpose

The purpose of the present, qualitative study is to focus on identifying personal and professional experiences of psychotherapists associated with their staying in the field of working with sex offenders as well as their personal and professional experiences associated with their moving away from the field of working with sex offenders. The study was conducted through a qualitative interview; nine of which were conducted via telephone and one being conducted in person.

A qualitative approach was appropriate to the current study for a number of reasons. It allows for a deeper theoretical understanding of the meanings of turnover intention and retention through the use of interviews, it helps fill the gap in the research around the question of what keeps clinicians who treat sex offenders in the field, and it was feasible given the time allowed for the study. This approach was also cost-effective. The disadvantage to content analysis is that it was limited to the examination of recorded communication. This was even more limited with the interviews that were conducted via telephone and the interviewer was unable to observe/record nonverbal communication.

Sample

This study used a non-probability sampling method, or convenience sample. A purposive sampling method was utilized to select professionals and experts. This form of sampling

provided the most efficient method for obtaining subjects that are most appropriate for this type of investigation. It permitted inquiry and allowed understanding of this phenomenon in depth.

Participants were clinicians who were currently practicing in the United States. All participants were currently working with or had had experience working with registered sex offenders, or individuals who identify as sex offenders and/or pedophiles. They all had either a Master's, Doctorate, or MD in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Clinical Psychology, or Psychiatry. Any individuals who do not meet the aforementioned criteria were excluded from participating in the study.

Recruitment for this study was conducted via e-mail to clinicians within McGeachey Hall at Maine Medical Center, my internship agency, asking them for contact information for clinicians that may fit the stated criteria. Because there was only one response from a clinician in Maine I contacted the Association for the Treatment of Sexual Abusers (ATSA). Maine does not have an ATSA Chapter therefore I e-mailed a recruitment letter (see Appendix B) to the New Hampshire ATSA (NHATSA) President, Kimberly Marsh, whose e-mail is public on the NHATSA website. With no response from the NHATSA Chapter, I extended emails, with the recruitment letter, to other ATSA state chapters within the United States. Each potential participant received an e-mail, which included the consent form, information related to the research topic, inclusion criteria, the nature of the participation, and the interview guide (see Appendix D). The researcher ensured that all participants met the aforementioned criteria for participation before proceeding to the interview stage.

The study posed relatively low risks to participants. However, because participants were asked to reflect on past and current experiences some uncomfortable feelings may have arisen.

Participants were made aware, prior to beginning the interview, that all responses were to be confidential. They were made aware that they had the right to refuse to answer any question or exit the study at any time during the interview. Participation in the interview was completely confidential; no names were used, and participation was completely voluntary.

Informed Consent and Confidentiality

Informed consent was obtained through one of four means. If the participant was able and willing to be interviewed in person, informed consent was obtained in person prior to the interview. If the interview was conducted via telephone informed consent was obtained through e-mail or by fax. All participants were asked to read through the text explaining the consent process, and accept all items of participation by checking a box (“I agree”) that indicates agreement. They were also be given the choice to exit the study by checking a box that says “I disagree”. If a participant had checked a box marked “I disagree” they would have been automatically excluded from participation in the study. All participants were given a signed informed consent form for their own records. Participation in this study was voluntary, and participants had the right to refuse participation or to answer any questions during the interview process. Participants were able choose to withdraw from the study at any point. After the interviews were completed participants had until May 1st to withdraw their interview from the study. This could have been done by contacting the researcher by phone or e-mail, which was listed on the informed consent form.

Participation and data gathered in the study will remain confidential and will only be accessed by myself and my research advisor. No personal information, such as address, personal information, or other contact information was collected or stored to ensure that the identities of participants could not be traced. Participants were also asked not to disclose any identifiable

information about their clients/patients. If by chance a clinician had offered such information, it would have not been recorded and/or it would have been deleted from the record. All data collected will be stored on a password protected file on my computer. All data will remain password protected for three years as required by Federal regulations, after which it will be destroyed or kept secure as long as needed.

Data Collection Methods

Once participants passed through screening questions (see Appendix E) to assure that the inclusion criteria are met, and provided informed consent to participate, an interview time and place (if the interview is not being held over the phone) was arranged and agreed upon.

Interviews were conducted in person when possible, and were held in an office that provided confidentiality with a “Do Not Disturb” sign on the door. An audio recorder was utilized to ensure that all information is gathered and accounted for in the data analysis. Participants who resided out-of-state were interviewed via telephone. The phone interview was recorded using the Olympus TP-7 telephone recording device. This device worked with cell phones as well as land lines, recorded both sides of the conversation, and recorded directly to a voice recorder. The responses to the questions were then transcribed for the content analysis. To maintain confidentiality within the data, each participant was referred to as P1 (for participant 1), P2, P3, etc.

Survey Design

The interview resembled a spontaneous, informal, conversation while maintaining predetermined goals of the interview. They remained somewhat flexible and had the feel of an unstructured informal conversational interview. However, in order to provide guidelines for the interview an interview guide (See Appendix D) was utilized. The advantage of an interview

guide is that it makes sure that the interviewer has carefully decided how to best use the limited time available in an interview session. The guide helped to make interviewing a number of different people more systematic and comprehensive by delimiting in advance the issues to be explored (Patton, 2002).

The interviewer used language that participants were familiar with and understood. One question was asked at a time, and there were no double-barreled questions (asking for a single answer to a question that really contains multiple questions). Only questions that the participants were capable of answering and that were relevant to the study were asked. Efforts were made to minimize the use of biased terms in the questions asked to participants. A biased term refers to a word that holds an unspoken meaning, is often emotional, philosophical, and cultural. Words such as right/wrong, fair/unfair, should/shouldn't, moral/immoral, appropriate/inappropriate, guilty/not guilty, and predator are biased terms and were not used in the questions for the interview.

The interview allowed participants to express their perspectives in their own words. Due to the semi-structured format of the interview the interviewer had flexibility regarding sequence of the questions. This also allowed for re-wording of a question if the participant misinterpreted the question or asked for clarification. Demographic data such as age, gender identity, ethnic identity, location/setting of practice, credentials, and number of years in practice were collected at the beginning of each interview session. Information in regards to their licensure, years practicing, and setting of practice (private practice, hospital out-patient, community counseling center, etc.) were also collected.

Data Analysis

Inductive data analysis was more likely to find and take into account the multiple realities inherent in exploratory research (Lincoln & Guba, 1985). An inductive method is a process based on inductive logic, in which the researcher begins with observations, seeks patterns in those observations, and generates tentative conclusions from those patterns. This differs from a process based on deductive logic, in which the researcher begins with a theory, then derives hypotheses, and ultimately collects observations to test the hypotheses. An inductive investigation will make the interaction between researcher and participant more explicit. Inductive analysis is therefore more likely to identify and address those mutually shaping influences from the researcher and the participant that arise from the study. The meanings and outcomes of the study are negotiated between the researcher and the participants. Qualitative and exploratory research aims to generate propositions that correspond to real-world phenomena (Patton, 2002).

Data was gathered by careful and thorough note taking and tape recording interviews. It was analyzed by conducting a content-theme analysis that involved looking for common patterns and themes among participants under major categories. The analysis was then organized; comparing themes and concepts that emerged in the process, and noting how frequently participants mentioned certain themes. Interviews were analyzed with the aid of a qualitative software program, MAXQDA.

Ethical Considerations

An informed consent form (see Appendix C) fully described the purpose for collecting the information. It included the provision that any participant is free to withdraw from the study at any time, the nature of participation, risks to participation, and that no financial compensation

will be made. The potential existed for psychologically stressful reactions from participants in this study, as the content that was addressed may have brought up uncomfortable aspects of their work. No undue pressure was exerted upon participants to explore areas of their work which impel them beyond issues they were comfortable disclosing.

Identifying information was coded for transcripts and all other generated records. All identifying information of participants remained confidential and did not appear in any data records or reports. All tape recorded interviews were erased after transcription. All transcribed interviews will remain in my possession for a period of three year after the data analysis is completed, at which time they will also be destroyed. Transcripts will be stored in a locked and secure location during this time.

CHAPTER IV

FINDINGS

This chapter will first review the demographic data of the participants within the study. Second, this chapter will examine the *Key Findings* of the study, and will then review the *Secondary Finding* revealed by the data.

Demographics of the Participants

Ten clinicians who work with sex offenders in a variety of different settings were interviewed. Four of the participants were female and six were male, when asked to identify race, all ten of the participants identified as Caucasian. In terms of educational degree, five participants were licensed social workers, two participants have master's degrees in Psychology, two participants hold a PhD in Psychology, and one of the participants is a Licensed Clinical Professional Counselor. Five of the participants were employed in agencies in Pennsylvania, three were employed in New Jersey, and the remaining participants were employed in Maine and Maryland.

While all of the participants have experience practicing individual or group psychotherapy with sex offenders, only seven of them were currently practicing psychotherapy with sex offenders; while the other three were doing evaluations and assessments with sex offenders. Two of the participants were significantly involved in administrative duties within their agency. Two of the participants had worked with sex offenders for 30 years or more, two had worked with sex offenders for 15 years, one participant had been in the field of sex offender treatment for ten years, and the other five participants ranged between four and eight years in the

field. Participants reported their caseloads of clients who are sex offenders to be between 50-100%.

Key Findings

Implicit in the thesis is the assumption that clinicians who work with sex offenders struggle with job retention and/or turnover intention due to the difficult nature of the work. However, an unexpected finding among the participants in this study was that very few had serious thoughts of leaving the field of sex offender treatment. In fact, only four of the participants admitted to seriously entertaining the idea of leaving the field, whereas three of the participants mentioned fleeting thoughts of leaving the field. More salient in the data are participant's motivations for remaining in the field of sex offender treatment.

Initial findings revealed that the majority of the respondents who participated in this study did not struggle with job retention and did not often have intentions for job turnover. Factors influencing the clinician's thoughts of leaving the field ranged from issues related to the agency they worked within, personal reasons and characteristic specific to the population. Vicarious trauma and burnout were also factors reviewed as influences of job retention and turnover intention. Other findings such as specific characteristics of the clinician, characteristics of the client, external/organizational factors, and specific effects of the work came up throughout the interview process but were not directly related to the clinician's job retention or turnover intention.

The following sections will review factors that participants discussed that directly impacted the clinician's intention for job turnover and motivation for job retention. These factors include aspects related to the participant's work environment, characteristics specific to the sex offender population, and personal choice or characteristics of the clinician. The findings will be

organized into sub-categories of *Turnover Intention*, which will review any thoughts the participants discussed related to job turnover or job retention; *Motivation for Job Retention*, which reviews the participants motivating factors to retain their positions as clinicians who work with sex offenders; and *Vicarious Trauma and Burnout*, which will review how vicarious trauma and burnout, or symptoms thereof can affect job retention or turnover intention.

Turnover Intention

Only four of the participants mentioned having earnest thoughts of leaving the field of sex offender treatment. Of those four participants, three cited difficulties within the system they worked under as factors influencing turnover intention. One of those three also cited a personal reason for leaving the field, and the fourth participant cited factors involving the population as an influence of turnover intention.

When Participant Two was asked whether or not he had ever had thoughts of leaving the field he responded “yes” but explained that those thoughts were “more related to trying to maintain an agency than the work itself.” Explaining that although the work can get “exhausting and frustrating” he said the turnover intention “falls more heavily on the administrative challenges of keeping payroll together and keeping funding, keeping quality sufficiently in place for the agency.” Participants Four and Six mentioned their “work environment” as the catalyst to potentially leaving the field of sex offender treatment. Participant Four saw himself “possibly backing out” of his current position due to his agency taking on a new contract with the state which forced the sex offender program to be redeveloped and would have potentially changed his hours and the shifts he works.

When Participant Six was asked directly about any thoughts she had in regards to leaving the field of sex offender treatment she stated that she did have them and that the thoughts were

“less about the work and more about my work environment. I find the work environment a difficult work environment for me.” She made note of how for her “it’s the system that I work in, the lack of supports.” She described how “most of the people I work with are not experts in sex offender therapy but they have power over me and how I function and so I have to spend a lot of time educating them.”

Although Participant Six cited her workplace environment as the number one influence over any current intentions she had of job turnover, she did at one point leave the field of sex offender treatment for a completely different reason. Participant Six took a short leave of absence while going through a divorce as well as discovered that a family member was a survivor of sexual assault, only to return back to working with sex offenders:

In fact, not last fall, two falls ago, I went to a career counselor because I kind of had a crisis. And of course at the counselors all the testing showed I should be a therapist.

Either a therapist or prison warden. I could leave it next week, or next year. I took breaks for about a year when I was going through that divorce because I couldn’t be effective to other people and then I went back to it.

Participant Five initially began her work with sex offenders in a private practice setting where her client caseload consisted of 90% sex offenders. She eventually shifted over to doing exclusively assessments of sex offenders. When asked about her reasoning for shifting over to assessments, which is a much more distanced work with sex offenders, she cited two reasons:

Two fold. One is I found that I would have wanted to involve a whole lot more people in the practice to really be a good program and not so much one or two of us doing out-patient work and this kind of thing. And I could have done that but I didn’t and that would have been a thing I would have wanted to do to continue. I think it’s just a

personal choice really because I think for me I didn't want to do psychotherapy any more with anyone. So it's not specific to this group of folks. So it's a personal choice and I prefer doing evaluations. And probably that's reflective of my own personality. So therapy is an extension of my relationship with folks and I enjoy the short time.

Participant Five clearly stated that the reason she decided to take a more distanced role in sex offender treatment was due to a "personal choice." A personal choice of the type of setting she would have preferred to work in as well as a personal choice of the extent of the relationship she would like to have with clients. However, when asked about her thoughts of no longer working with sex offenders specifically, Participant Five noted the "uncertainty" and "complexity" involved in the work as a major factor in her intention of job turnover:

A lot of that has to go back to sort of the uncertainty of testing and what are we doing and coming from this place inside and this is really complex do I still want to be dealing with this level of complexity as an everyday kind of thing.

Three of the participants have had fleeting and somewhat passive thoughts of leaving the field of sex offender treatment. Factors influencing the intention for turnover range from frustrations with the system they work within, to factors specific to sex offenders, to personal life changes and overall thoughts of career change. When Participant One was asked how long he planned on working in the field of sex offender treatment he stated, "I anticipate that I'll be doing this type of work maybe for the rest of my life or as long as I'm able to." But when asked if he had ever had thoughts of leaving the field he described how lack of job retention would not be "of my own accord":

Because of what I do I know that if one of my clients does something heinous and it appears in the newspaper my boss's will offer me up. I'm supported as long as I'm doing

well. But I don't trust that my boss's would be real supportive of hanging through a tough time should there be a client that re-offends and ends up in the paper. I'm thinking of the guy who killed Megan Kanka and we started Megan's Law which is named after her. The guy who killed Megan Kanka was from New Jersey and I've never met him but I know a lot of practitioners who worked with him and a lot of clients who talk about him. They knew him. So I sometimes think that if there's a big disaster like that the entire services that we provide might be de-funded because the state would say 'we're not paying for this no more and we're going to do a punitive kind of response.' If that were the case, than I wouldn't be doing this.

Participant Eight, who worked in private practice with sex offenders for many years and then changed roles and is currently doing evaluations of sex offenders, portrayed some ambivalence around her experience of turnover intention and job retention. Throughout her interview she made a number of negative and somewhat cynical statements regarding her work with sex offenders, such as: "I don't know if this would be something I would do for the rest of my life", "you definitely get burned out", "gets a little old", "You start to say 'Wow can I really do this forever?'". During the interview Participant Eight told a story of how one of her colleagues, who was pregnant, had a client tell her "he was going to stab her and kill her fetus" and then stated "she [colleague] still stayed in the field and didn't want to do anything else. I don't know why."

However, when Participant Eight was asked if she had had any thoughts of leaving the field of sex offender treatment she discussed that she did not have, "leaving thoughts, just thoughts that I needed to do something..... leaving the whole field of psychology in general", but was unable to elaborate: "I can't give you specifics of where or when or why." When asked

about her role change from doing psychotherapy to doing evaluations, a much more distanced role, she stated, “In 2010 I had a baby, I went on maternity leave and I didn’t go back. And now I do evaluations.” She went on to state: “I enjoy talking and figuring people out kind of thing. Which is why I am more of an evaluator at this point and less of a therapist because I do enjoy that initial intake and evaluation and trying to figure out happening and maybe how to direct folks, to start working somebody.”

Participant Nine, similar to Participant Five, cited the complexity of his work as an out-patient provider to sex offenders as a factor that influences his intention for turnover. Although he described his thoughts of job turnover as fleeting, and expressed a desire to continue his work with sex offenders:

My plan is for the long term. I’m in my mid-30s now so I don’t plan on leaving working with people who have sexual addictions, people who have sex offending behaviors, people who have problems with sexual harassment or professional sexual misconduct or professional sexual boundary problems. I don’t see myself leaving the practice. I have had thoughts about “Oh wow this is a really difficult client or sort of really difficult week it would be nice to do something that’s less challenging. Sure, not seriously. The challenge brings me back. The complexity brings me back.

Support and Supervision

During the interviews, all participants were asked how supervision affected their job experience, and if it affected their intention for job turnover or job retention. All ten of the participants spoke to the importance of having either formal or informal support in order to be able to do their work. Only two of the participants mentioned having one-on-one supervision with a clinical supervisor. Participant Six reported having “clinical supervision and I have team

clinical supervision” while Participant Nine noted that he received as well as provided individual and group supervision. Participant Six described the beginning of her career, when she had a “great supervised start”, and how she “learned a lot about the work. I learned a lot about myself. I learned about how to conceptualize a case.” She expressed how that supervision was “invaluable” to her and then compared it to her current form of supervision:

And then right now I have a supervisor. The problem now is, he’s doing this role but he’s also been a consultant to this program and so he’s supervisor signing off on my stuff, I have a non-clinician do that and so when I go to him for supervision this is why, I say certain things. Certain things about the system and he is the keeper of the therapeutic component of the system then he flips out because why don’t those residential people understand what they’re doing and so my supervisor who, finds the violation, is dragged in and then she blames me for kind of snitching on the program. She has a role as the keeper of the therapeutic component of the system and being my clinical supervisor is really getting in the way. And it’s something been pretty well pulled out. It’s untenable for me. You need to be my supervisor and not get in the way of my supervisor employee relationship with my boss.

Participant Three described how she would have informal supervision with colleagues during their lunch hour to “talk about case”, describing the lunches as “wonderful” and that “she couldn’t have done it [the work] without that.” Participant One supported the importance of having a “supportive network of colleagues”, but noted that having a spouse to talk with is a crucial support. He stated: “I think that having a supportive network of colleagues, and maybe most important, having somebody like my spouse is like gold to me because we can talk about this stuff and you know it becomes, we support each other in this.” Participant Seven described

how “doing this work privately” and not having the support of colleagues “would be physically exhausting and just psychologically traumatizing; it would just be overwhelming.” Participant Three discussed how not having support in her work place greatly affected her in a negative way, and although she did not leave her job on her own accord she described feeling “thrilled” after being laid off:

When I worked in a halfway house I can say I was the program I had no support. My supervisor was a drug and alcohol supervisor. I said oh I don't have supervision and she said oh I thought you knew what you were doing. That was very tough because I had nowhere to put it. I think I was much more, well generally kind of miserable. And part of that was not having someone to go over this stuff with. And I when I found out I was getting laid off from there I was thrilled. The guy came in to tell me and I said do I get unemployment. I was thrilled. The funding actually went to the program I worked for later which was part time and good. It was hard and I didn't enjoy going to work. The clients I worked with, it wasn't a safe situation either. It wasn't comfortable, they didn't understand it. I was in the building sometimes by myself. It was icky. After I left there I think it took me a while to kind of regroup. To be ok again.

Motivation for Job Retention

Among the major findings, motivation for job retention was a much more salient topic within the interviews. Though some of the participants could not speak to factors that influenced intentions for job turnover, all of the participants spoke to the motivating factors that influenced job retention. Motivating factors to work in the field of sex offender treatment and remain in the field of sex offender treatment included altruistic drives, past personal experience, personal gain, the excitement of the work and one's values.

For five of the participants the fact that they found the work “difficult”, “interesting”, and/or “fascinating” was a motivator to stay in the field of sex offender treatment, even if they did have thoughts involving job turnover. Participant Three noted that working with sex offenders was not a career she had ever had a “desire” to do but, “It’s interesting work.” Participant Eight also described the work as “never boring” and stated, “I would never come home from work having had a boring day. There’s always something that’s interesting.” Participant Nine enjoys the “clinical challenge” of the sex offender population and finds his work “intellectually very stimulating”. Similarly, Participant Five finds the “people interesting”, but also noted that she receives a “personal gain” from her work because she “enjoys talking and figuring people out.”

Three participants found their feelings of success with clients as a motivating factor for job retention. Participant Three described her work as “rewarding” citing the low recidivism rate for sex offenders. Participant Eight also mentioned success with her clients as a factor that influenced job retention when she stated: “There are a lot of people you like and who you care about and it’s very motivating to see people doing well.” Participant One described the last 30 years of doing sex offender treatment as an “incredibly rewarding trip” because he believed his work was “an actual benefit for certain people.”

While Participant Seven, along with two other participants, cited monetary motivation for job retention, he also made note of the personal gain he received while working with sex offenders when he was able to “to let go of any self-blame” he held about his own sexual assault history. Participant Six also mentioned a personal motivator to working in the field of sex offender treatment:

I have a personal, not my own, but I will say that my ex-husband who fathered my two kids, unbeknownst to me is a survivor, he's the one who got me into this and he never shared any of that with anyone until I said I have to divorce you and that's something that came out and we had to make a lot of adjustments around that because that was shocking if you consider everything, I think about the implications of that on our relationship and how I got into this work. Everyday I've been, unless he's setting me up, somehow it involves him. It's weird, it's very weird. It's very odd. But for me it's also about my kid's father and concern that other kids don't have to go through that.

For many of the participants (n=5) an altruistic drive played a large part in their motivation to work in the field of sex offender treatment as well as influenced job retention.

Participant One described how "making our lives and our world a better place" is a great motivator for him to remain in the field of sex offender treatment:

I transitioned into working with offenders because my boss was smart enough and astute enough, and had enough persuasive power, to get me to do the work that really needs to happen to make this society a safer place for everybody involved. And feel honored that she pushed me in this way and I feel that I have been... that I hopefully have made the world a better place in the programs that I have set up and the direct work that I have also done over these 30 years. But if you want to do this type of work, I highly respect people who do this type of work but I certainly know a lot of them and that it has the eventual benefit of making society a better place. Making our lives and our world a better place for everybody. If you can turn around and you can go through tough times, from whatever circumstance but recognize that when we do things that are in fact making the

world a better place to live you are helping us all. And helping our children and my grandchildren and everybody to live their lives and have a better world for all of us.

Others hold similar sentiments in regards to their motivation to stay in the field.

Participants describe their work as “noble”, “important”, and “honest”. Participant Ten stated, “I think that in teaching new skills to people to learn how to negotiate tough situations you are actually doing something worthwhile. So in that sense doing this type of work is a very noble thing.” Participant Four cited his personal “goal to have no more victims” as an influence on his motivation for job retention. Similarly, Participant Six cites her altruistic drive to reduce pain and suffering in victims as a motivating factor:

I guess one thing that keeps my motivation is that when I was a cop back in the early 80s as a woman I was one of the female officers, believe it or not, they didn’t know what to do with us so they put us on sex crimes. And I always find it interesting when I look back at those dark ages and so I had the opportunity to interact with so many victims. And seeing what that process was like, the whole victimization, I’m very sensitive to that.

Participant Three cites her ability to be able to work with this specific population as a motivator when she states, “because I can do it, because I found that I can work with these guys and I’m not appalled by them and I’m not repelled by them and that I can see the other parts of them.” In the following quote, Participant Eight explains how her enjoyment of the work and her relationships with her clients is a motivating factor in her continued work with the sex offender population:

I do like the collaborative effort of working with offenders and all the different people who you work with. You do develop relationships with your clients the way you would

with other therapy clients. There are a lot of people you like and who you care about and it's very motivating to see people doing well.

Vicarious Trauma and Burnout

Part of the purpose of this study was to examine how vicarious trauma or burnout may affect the clinician's job retention or intention for job turnover. During the interview interview the participants were asked about multiple symptoms that are often tied to Vicarious Trama and Burnout. While all ten participants endorsed having experienced at least one of the symptoms of vicarious trauma and/or burnout, the majority did not link their symptoms directly to job satisfaction or thoughts of leaving the field of sex offender treatment. Only one participant, Participant Eight, directly stated feeling burned out, stating: "Yeah, you definitely get burned out." She then directly associated her feelings of burnout to job retention:

I mean, I get a client or when a probation or parole officer send me a case I can read the file and with very high accuracy tell you what that person's excuse is going to be. That gets a little old. When you have three people and one month saying that the only reason why they gave oral sex to a 12 yo was a case of mistaken identity. You start to say 'wow can I really do this forever.'

The two most frequently noted symptoms were *cynicism* (n=6) and *sensitivity to violence* (n=6), followed closely by *Intrusive imagery* (n=5). Participant Seven described how he remains vigilant to the signs and symptoms of vicarious trauma and burnout: "We're aware of the fact that it can affect us in all kinds of ways. Our sex lives. We check ourselves for the same stuff. are you sleeping well, are you eating well."

Cynicism was a topic discussed again and again during the interviews. Whereas some participants described their cynicism as something that comes and goes: "times when I've

probably been more cynical”, others described it as a more permanent characteristic: “I’m kind of cynical anyways and I think that I have been cynical and suspicious of people. When you see people with kids.... That’s lessened since I first worked with flashers. I would think everyone was a flasher.” Participant One described how he is more cynical in regards to his clients re-offending: “I felt that [cynicism]. That probably is more something that I feel. I don’t know if it’s cynicism about the world in general but I certainly, who you know, the guys are ‘I swear to God I’ll never I do it again!’ and then that’s kind of wasted breath with me. I don’t hold a lot stock in that.”

Sensitivity to violence and intrusive imagery were two other symptoms most commonly endorsed by the participants. Participant Three notes that she has always been sensitive to violence but since working with sex offenders, she is “now more so.” She also made note of how seeing child pornography is “so hard because it stays in my head” and “the images come back a lot”, but that it is “not disturbing in a way that it stops me or interferes with my life but it’s sticky. While discussing symptoms of vicarious trauma, Participant Three also described how she had a specific client for whom she will occasionally experience flashbacks: “And the real hardcore pedophiles. I get flashbacks to one who was just.... He’s back in prison; I worked with him for years.”

Two of the participants, Two and Three, noted that they “pay more attention to news about violence, to national and international stories and things related to violence in the news” and when Participant Three reads the paper she is “looking at the sex offenses mostly because it’s my work and I want to know about it.” When participant Six was asked about intrusive imagery, she denied experiencing intrusive imagery with her clients but endorsed the symptoms of emotional lability and sensitivity to violence:

I don't necessarily get that [intrusive imagery] from my clients or their stories. Somehow, I can cut myself off from that but what I did find was that I would be reading or watching on the couch and during that time would hear about a sex offender or some kind of heinous crime and would read that and get really emotional about that. Or I would see on the television and that's been heightened. And again, it's just sporadic, but how I react to that, I just don't read and I don't watch that. I don't watch any TV.

When asked about social withdrawal, only two participants commented on it being a noticeable symptom in their lives. Participant One stated, "I have experienced that but I don't know if it's directly associated with work." Whereas Participant Two stated, "I think from time to time that has been an issue and an ongoing danger." Although none of the other participants endorsed social withdrawal, a number of them (n=6) brought up potential feelings of isolation or the potential for isolation. Participant Five described how he struggles with feelings of isolation among other clinicians, who do not work with sex offenders because he feels as though he cannot discuss with them the "kinds of things that you're really worried about" because they have no "frame of reference." Participant One, who worked in private practice for many years, discussed the potential for isolation in private practitioners:

I think it's much tougher for people, again, private practitioners who work and whose spouse is not in this field and if they're not connected, it'd be tough because they won't have anybody to process the filthy stuff we have to listen to. If you work privately and you do this kind of work you end up with not having the support network of other people who you can talk to about the difficulty of doing this work.

Most participants (n=8) did not make note of having sexual difficulties. Although, Participant One noted how a colleague, in an anonymous survey, wrote about how they had

never considered “pre-pubescent children sexy“ until they began working in the field of sex offender treatment. Participant One expressed that this was “very disturbing“ but that he could “see how it would happen“. Participant Six described how her work with sex offenders has affected her relationship with her husband and their sex life:

I am kind of, in a way more, hypersexual. Not in the clinical, DSM sense but just in the sense that I need that from my husband. I need that affection from him, that knowing that there is.... I don't know. Sometimes it's not necessarily sex; it's just a need for physical touch and affection. I think again, I don't know still. I don't think I would fall off the bell curve in terms of sexual appetite. I just don't think so. If you would talk to my husband who would say of course you do, it's the work you do but there is something to what he says frankly. They're not difficulties that's just an interesting thing in our lives.

Although all of the participants acknowledged some symptoms of vicarious trauma and burnout, only one directly correlated them with her intention for job turnover. Further, most of the participants (n=9) did not believe that their experiences would qualify as vicarious trauma or burnout, but that they simply had fleeting moments of symptoms related to vicarious trauma and burnout. And of those participants, none of them directly related their symptoms to an intention for job turnover. All of the participants spoke to the importance of self-care to cope with symptoms, which may be why many of them do not attribute vicarious trauma and burnout to thoughts of leaving the field. Participants discussed a number of different ways in which they engaged in self-care; ranging from religion, to using activities such as exercise, going on vacation, and socializing.

Secondary Findings

Key Findings presented the influences that directly impacted the clinician's intention for job turnover and motivation for job retention. However, because of the nature of the open-ended questions used during the interviews, participants brought to light several components ingrained in the work of sex offender treatment. A number of areas of the work that involved in sex offender treatment were explored, revealing data not directly associated with job retention or turnover intention, but data that may indirectly influence the clinician's experience of their work with sex offenders. This section of the *Findings* chapter will review the data brought up by participants that was not directly associated to job retention or turnover intention, but that related to common themes brought up by participants that may be an indirect influence. These themes include *Characteristics of the Clinician*, *Characteristics of the Client*, *External/Organizational Factors*, and *The Effects of the Work*.

Characteristics of the Clinician

Participants made note of a number of characteristics that they believed were necessary for a clinician to have in order to work with sex offenders. These characteristics include clinical abilities, self-awareness, and having respect for humanity. Although, participants did not directly associate these characteristics to job retention or turnover intention, it can be assumed that if a clinician is lacking in these characteristics, their ability to work with the population may be diminished and therefore job retention or turnover intention could potentially be directly influenced.

Clinical Abilities

Many of the participants made note of clinical abilities necessary to work with sex offenders. These abilities ranged from being able to work with complex cases and within

complex systems, the ability to maintain boundaries and work constructively with transference and countertransference, the ability to be able to “look past the offense”, and the clinicians ability to balance an appropriate level of trust with their client.

Participants described the complexity that is involved in working with sex offenders in a therapeutic setting. When directly asked about the qualities necessary to be an effective clinician who works with sex offenders, Participant Five noted, “understanding what it is this person this person has to deal with because it’s just so much in my opinion.” She further explains how as a clinician she attempts to “help people establish some stability” but that sex offenders have to deal with systems like “the registry” that make it difficult for their clients to establish stability. Although Participant Six is not speaking to the registry, she also made note of the importance of understanding and being able to work with the, sometimes many, systems their clients function under:

I will say that the other two therapists I work with, they do not go into the residence at all. They never leave the office. But because I was a part of the system, and I do have this training in system theory, I was pretty grounded in systems theory in grad school and so I appreciate the system and I think that’s what probably makes me more effective than the other two therapists I work with.

The intricacies of the many systems that sex offenders function under/within, was just one complexity that participants noted was important for clinicians to understand. Many of the participants commented on other psychosocial stressors that effect their clients and that must be effectively addressed during treatment. Seven of the participants mentioned how their clients had a history of some form of abuse. Participant Nine and Participant Four discussed how the abuse history is “often times a source of their offending history, their offending behaviors.” Other

participants noted a high rate of unemployment and addiction (substance addiction as well as sexual addiction). Participant Three discussed the importance of the ability of the clinician to “get to the real stuff.” Participant Four also spoke to the importance of the clinician being able to address the complexity of the clients treatment needs:

Some guys, who in addition to being sex offenders, have process addictions or are overly involved in sex, looking for nurturing through sex. I have a guy who likes underage kids, he likes teenagers, but he also has a sexual addiction. So dealing with that too.

Other participants mentioned the importance of the clinician being able to be “persistent” as well as “patient”. Participants discussed using these qualities as skills to “deal with a certain lack of respect “as well as keeping clients focused on treatment goals. Participant Three described this when she stated, “he just gets so into it and it controls the therapy session and you’re out of it and I think that’s where it takes skill to get them back and ok that’s not what we need to talk about.” Persistence was noted as a needed quality of the clinician especially in the context of dealing with denial among clients. Participant Nine described how “directing denial and confrontation of denial” is a crucial quality the clinician must demonstrate while working with the sex offender population

Boundaries and Self-Awareness

Another characteristic that was noted as important piece of working with sex offenders was the clinician’s awareness and maintenance of boundaries with their clients. When Participant Six was asked about qualities necessary to be an affective clinician who works with sex offenders she stated:” You have to have very good boundaries, number one.” Participant Seven described how he believes rapport with the client is crucial while also acknowledging concrete boundaries as an important quality for the clinician to embody:

The most important characteristic is a warm relationship with your client but at the same time being directional and just not put up with BS. It's the same thing that makes a good teacher, makes a good boss, whatever. It's like; I can get along with you but don't step over my bounds. Listen, I bite. I have three guys who are in jail right now and they know I bite.

Qualities of self-awareness, especially in regards to countertransference and transference, were discussed by almost all of the participants (n=9) as a characteristic necessary for clinicians who work with sex offenders. Self-awareness of “what makes you tick”, self-awareness around keeping “your own prejudices, issues in check”, and self-awareness of “transference of reactions” were all qualities brought up by participants when asked about characteristics of a clinician that are essential when working with sex offenders. Participant Six, who works with intellectually and developmentally disabled sex offenders, discussed how she needed to have awareness around not giving her clients “breaks” because of their disability.

Self-awareness in term of noticing and dealing with transference and countertransference while working with sex offenders was a topic brought up by a number of the participants (n=8). One participant, Participant Seven, discussed his countertransference in relation to his own sexual assault history and being confronted with a client that was a “dead ringer” for the man the sexually offended him. He noted the difficulty he had in “keep my countertransference and all that stuff intact.”

Of the participants who were women (n=4), three of them spoke specifically about countertransference and transference as women working with this population. One of the female participants, Participant Three, spoke to the issue of countertransference specifically as a woman:

As a woman, when somebody goes in a brutally beats a person and blah, blah, blah and she was living alone, that touches a whole different thing for me. That depends too. It depends on the offenses for one. Sometimes it's a little different with an adult rapist. It's because that's who I am, a potential victim let's say.

Participant Three explained that as a female clinician working with sex offenders one must be able to "establish yourself" and "be able to deal with the transference thing, the love thing with guys." Participant Eight indicated that as a woman she is often treated differently by clients compared to her male colleagues. She described seeing a "different side" to the clients; "more manipulation and more bullshit that men would see" and a "certain lack of respect." However, she viewed this transference as tool in treatment: "In some ways it's really positive because a lot of the men we worked with never had a relationship with emotional experience with a woman before and being able to develop that could be really positive."

The above findings speak to the difficulties of countertransference and transference faced by clinicians who work with sex offenders. It is a challenge they face every day and have to work very hard at noticing and dealing with it in supervision. Participant Nine discussed how the clinician must have the ability to be aware of and to "appropriately use countertransference in terms of confrontation" as well as be "open with colleagues and group and in supervision about how you're feeling about working with the clients and your activity and your reactions. It's very important "

Clinician's Ability to Look Past the Offense

Participant Six expressed the importance of being "non-judgmental" and "trying to find the good in everybody", as did Participant Eight when she stated, "You need to be a person who, as cynical as you might be, also has the ability to see positive things in people who nobody else

can see that in.” Another characteristic brought up by participants was the ability to be “able to see past the offense to see the whole person” and “not be appalled by, repelled by them, and see the other parts of them.” Participant Five supported this notion of being able to look beyond the offense as a paramount characteristic needed for clinicians working with sex offenders:

Not that the past is not important either, I’m not saying that either but not having that color your ability to work a person towards something productive. And I think people who cannot get past what it is a person did, and that would apply to anybody, a murderer, no different, if you really can’t get past the fact that this person in front of you committed murder I don’t know how you can be at all helpful.

Trust in the Client

Another ability necessary for clinicians who work with sex offenders is the challenge of balancing trust and skepticism with clients. Many of the participants discussed a lack of trust in their clients as a significant challenge of working with sex offenders. Participant Eight expressed the challenge of “being able to trust your clients enough” while also being cautious of their success because “maybe they’re doing too well, maybe there’s something to hide, maybe that person has a dungeon in the basement.” She goes on to describe how these feelings of distrust can keep her up at night if she does not handle them appropriately through supervision or talking with colleagues.

Characteristics of the Client

Participants revealed a number of characteristics about their clients that had an effect on their work. Participants discussed the difficulties faced in treating a population that is often mandated to treatment and is often not voluntary. The data also revealed that participants found that there were certain behaviors and personality traits within the sex offender population that

made the work particularly difficult. The fact that clinicians who work with sex offenders are often treating mandated, involuntary clients who struggle with a number of personality disturbances, affects how they experience their job, and in turn may indirectly affect their intention for job turnover or job retention

The In-Voluntary Client and Denial

Participants discussed that most, if not all of the clients for whom they provided treatment, were forced into treatment by an outside power. Participant Eight mentioned the possibility of a voluntary client while also expressing the unlikelihood of the event of seeing a sex offender who presented for treatment voluntarily; stating, “There would be one or two who came in on their own accord but I would say 99.9% were mandated.” Although participants noted that working with clients who are not voluntary is a common challenge of working with the sex offender population, four of the participants noted denial as the more challenging aspect of working with mandated clients. Participant Two states, “Clinically I think it’s frustrating working with clients who are not volunteers in the true sense of the word; working through denial.” Participant Nine explains how he handles the challenge of denial, and how it is an ongoing challenge even if it has been thought to be worked through with a client:

If someone’s in denial we confront the denial with some specific kind of restructuring work with them where we do some specific confrontation with them individually and then group. But if a client is in denial we don’t leverage too much motivational interviewing given that these guys are at risk of offending if they don’t take responsibility for the impact of their behavior. Take responsibility for their offenses then we just, I can’t effectively treat them as an outpatient so we refer. Biggest challenge is how the population denies their behaviors or the impact on others or how they may not want to or resist my treatment recommendations. Effectively

working on denial throughout the course of treatment because just because the denial lifts in the first day of treatment doesn't mean it doesn't come back later on and so the clinician has to be very good at staying on top of that.

Client Personality Traits

During the interviews, participants used a number of different words, adjectives, and phrases to describe their clients who were sex offenders. Participants described them as having “emotional disturbances”, “behavior problem”, and “social skills deficits.” Some used adjectives such as “disturbed” and “dangerous” and explained how they “have done horrific things and abused others.” Others, like Participant Three, described their clients who were sex offenders as “controlling” and “fixated” and exhibiting rigidity in their thought process:

I'm not very technical and I don't listen to the intellectuals. They're really in love with children. They are not sexually interested in anyone else. Can't even try that. It just doesn't work at all and fixated and in love. The NAMBLA. I had one guy talk to me all about NAMBLA and I had never known about that. Yeah, he got molested from 8 until 16 years. Yeah, I don't know what to call them [pedophiles], they're just very fixated on the kids. Because you have ones who are just opportunistic and then the other basic child molesters who it's the step daughter but that dynamic... And that's all they're really interested in. They're [pedophiles] almost obsessed but not necessarily but their whole life is about kids. They can't really communicate with adults at all.

Other participants noted certain personality traits among the sex offender population as being a challenge to this work. In fact, when describing their clients; words, adjectives, and phrases that characterized the sex offender's personality where the most commonly used. Participants used descriptions such as: “antisocial”, “psychopaths”, “good at manipulating”,

“charming and sophisticated”, and “personality traits that are very difficult to work with.”

Participant Seven described how he can get “sucked in” when “clients lie to us at least initially even when they’re real psychopaths and real charming.” Participant Ten also made note of the challenges that come along with this population in regard to personality and behavior, specifically around control and the lack of emotion:

I had one guy who used to talk a lot. He was a serial rapist. And he would talk about his offenses like he was reading a book. There was no emotion and that was a way of controlling in that he wasn’t getting into the emotional stuff at all but he wasn’t getting off on it I don’t think.... It may be different with a pedophile talking about, I was here and doing this, it gets... he just gets so into it and it controls the therapy session and you’re out of it and I think that’s where it takes skill to get them back and ok that’s not what we need to talk about.

When asked about specific challenges of the work, Participant Nine stated:

They are very sophisticated. They are very complex. They often times look and sound good and they’re very good at manipulating. And many of the guys have had personality disorders or personality traits that are very difficult to work with and they act out in session or in group sessions being mindful of that and confronting that appropriately is a challenge, very difficult work. Often times we have very exhibitionistic behavior or sexual harassment issues or issues of professional exploitation of a patient but that is the tip of the iceberg so to speak. And there are other issues they have along with that including difficult personality and so forth and so on. Challenging them on a personality disturbance and how they act out in session or group or how they act out with their colleagues, their wives, their children.

External/Organizational Factors

As noted in the *Key Findings* section of this chapter, some of the participants directly cited organizational factors as having an influence on their intention for job turnover and job retention. Even though other participants did not directly relate external/organizational factors to intention of job turnover or job retention, all participants spoke to how they influence their work. These factors include organizational influences, State/Federal Policy, support of the clinician, and perceived pressure put onto the clinician. Most of the participants (n=9), with the exception of Participant Nine, referenced a “system” to be a more challenging part of her work rather than the actual client. Participant Five expressed that she finds the “system” the more challenging part of her work rather than the client. Participant One referred to multiple systems when he used the phrase “embedded systems” in the following remark:

It is hard at times to tease out the effects of working specifically with offenders doing clinical work versus the effects of working within difficult, embedded systems, like the criminal justice system; even the university of medicine and dentistry of new jersey is an incredibly difficult administrative system I work in.

When participant Two was asked to describe how his work with sex offenders has affected him, he disclosed that he felt he was more cynical. However, he did not attribute the cynicism to the direct clinical work with sex offenders but rather to external factors that attempt to “control” his clients:

Cynicism is more towards the legislative responses to try to control and contain offenders and offender behavior. There are a lot of poorly conceived and thought out legislative responses. It’s easy to get cynical about that process.

External Pressure

Many of the participants (n=5) discussed the challenge of dealing with the pressure put on them by external forces. Some of the external pressures come from the community, the media, the state, or the participant's supervisors. Participant Four described how she feels a "big sense of responsibility" around preventing recidivism among her clients. Participant Five described the challenge of dealing with the pressure and the uncertainty, as well as the multiple other external factors that come along with working with sex offenders:

Just this huge level of uncertainty that goes into thing. And then you put onto that the pressure, the external pressure and everybody's like oh gosh what do we do. I mean the pressures and the community and the media attention, sort of what's going on in your state, what's going on nationally. So there can be a lot of extraneous things going on that I think create pressure so it's sort of this added pressure that you might not have say, working with someone who's just dealing with general depression and doesn't have the registry and the PO and all these other things that are part and parcel of working with that person.

Effects of the Work

Effects of the Work on the Clinician

Throughout the interviews participants discussed multiple ways in which their work has affected them professionally as well as personally. Although none of them directly associated these effects to job retention or intention for turnover, the frequency at which they discussed these effects is worth noting in this section. Participants reported a number of ways in which their work with sex offenders has affected them as a clinician. For some participants, like Participant Four, their work with sex offenders has affected how they interact with their clients:

“I’m more thoughtful at what I do and realize that...just be more conscientious about what I do with the men, more mindful; because these are dangerous people.” Whereas Participant Ten noted a change in how he interacts with his clients who are sex offenders; stating how he has “toughened up to people that aren’t cooperative.” Similarly, a protective instinct for staff and an increased attunement to aggression while working with sex offenders were effects Participant One has noted:

Yesterday I set up these new groups. I acted as a ... hall monitor with a bunch of guys coming in for groups. One guy started giving the therapist a hard time and I pulled him out, I felt like a school principal, that’s what I felt like. So I pulled out, this rowdy guy who was giving the therapist a hard time and I yelled at him I told him to get the hell out and that he could come back when he calmed down and wasn’t going to give the therapist a hard time. He was being very aggressive towards a female therapist and I felt like at that point I needed to step in to kind of put him in his place. I think that being with this population of folks who don’t have a lot of interpersonal skills are prone to when they get upset become loud and aggressive and I’m very attune to that and I’m a little frightened for all of my staff and I want to make sure that they’re safe so I feel kind of this protective thing but I’m very attune to people who are aggressive and potentially, who could act out in a potentially violent way towards any of my staff.

Participant Four noted that he is “more sensitive to people who have been hurt sexually”. He also discussed how he has not only developed “more empathy for people that have been hurt sexually”, but also become more empathetic to sex offenders, stating: “It’s probably more empathy for the offender and how this didn’t just happen out of a vacuum. I think I have more empathy for them.” Participant Eight also mentioned the empathy that she has developed while

working with sex offenders as well as how “in some ways it makes you a better therapist, or it made me a better therapist with other clients based on the reality of the situation.” She described how when a clinician is working with sex offenders they “have to find some way to relate to people that nobody else wants to relate to.” Although she does not directly tie this ability to relate to or empathize with sex offenders as a factor that effects turnover intention or job retention, it could be an indirect affect.

Personal Effects of the Work

Many of the participants discussed how their work affected their personal lives, but again, did not directly relate these affects to job retention or turnover intention. Many of these effects surrounded how participant’s experienced others and interacted with others. They described how their work changed their relationships with friends and family as well as how they generally perceived human interactions.

Participant Ten noted, “I’ve had my life threatened enough times doing this kind of work that I’m very cautious about my safety and my wife’s safety.” Some participants, like Participant One, acknowledged the increased awareness of the complexities of relationships and the “difficulties in establishing, maintaining, and having healthy relationships”, referring to both sexual and non-sexual relationships. Other participants expressed being more “cynical and suspicious” when it came to relationships and interactions with others. Participant Three and Participant Eight both described how they made overarching generalizations that “everyone” was a sex offender. Participant Eight described how when she would go to the grocery store she would “assume that everyone I see at the grocery store must be beating or molesting their children.” However, she also noted how having that awareness that “anybody can be a sex offender” has not made her over protective of her children; describing how if something does

happen to her children she hopes that she has the “skills” to handle it, and hoped that her children are “resilient and they’re able to cope with anything that might happen to them.”

For those participants that had children or grandchildren, most of them noted being thoughtful about the protection of the children. However the thoughtfulness played out differently among participants. Participant Six discussed how she made an effort to not be “over protective” with her children and “not to think that everybody is an offender” because of the work she does. Conversely, Participant Four described how he is “more protective and more suspicious of things and people” and more “mindful of situations that could be potentially dangerous” when he is with his family.

Many of the participants (n=8) noted their heightened attunement to human connections and interactions. Some, like Participant Ten noted how he “appreciates genuine human connections more”; while Participant Three noted that she is “more cautious about relationships and their background.” Participant Five makes note of how her friends interact with her differently because of her work with offenders and her views on the effects of pornography:

Sometimes, my friends get together and they’re talking about things that they consider sexual jokes or porn and I suppose they probably think of me as kind of a stick in the mud when it comes to some of that stuff because some if it, quite frankly, is not funny when you have worked with some who are victims and offenders, there are some really inappropriate things! And I’m not trying to influence their behavior but... So on that level yeah, probably in that sense it has affected me. Don’t talk about porn in front of her because she’s going to go off. Or something like that. And I don’t think I’m like the most concerned person ever. It’s just the perception that maybe even that what they have because they think that I’m thinking something. And I may or may not be.

Five of the participants discussed the discomfort they feel in disclosing their profession with others. The discomfort comes from the clinician's fear of the other's response. Participant Five described how sometimes people can become sensationalized and make statements like, "Oh my god, you work with what?" Whereas Participant Three related a story of her trying to buy cat food at a pet store when a stranger, who recognized the emblem on her work jacket, began to tell her his own sexual assault story of his father molesting him and his brother. Participant Three also recounted how "people get angry" when she is "understanding in any way" towards sex offenders. Participant Three expressed "I think that not being able to talk about it [working with sex offenders] at cocktail hour" as one of the biggest challenges to working with sex offenders.

This chapter presents and summarizes the findings of ten interviews with clinicians who work with sex offenders. Participants were asked a series of 14 questions, in addition to probe questions. The questions were designed to elicit the perspectives of the clinicians on factors that affect job retention and turnover intention in the field of sex offender treatment. Participant's insights have been categorized into two sections: *Key Findings* and *Secondary Findings*. *Key Findings* represents the themes of *Turnover Intention*, *Motivations for job Retention*, and *Vicarious Trauma and Burnout*. *Secondary Findings* embodies the themes of *Characteristics of the Clinician*, *Characteristics of the Client*, *External/Organizational Factors*, and *Effects of the Work*. The following chapter will provide a more in-depth look at these themes and how they relate to current research on sex offender treatment.

CHAPTER V

DISCUSSION

The objective of this qualitative study is to explore factors in the area of sex offender treatment that influence the clinician's job retention and turnover intention. The study focused on several factors that could influence job retention and turnover intention, such as characteristics of the clinician, characteristics of the client, organizational/external factor, and vicarious trauma and burnout. The complexities of the challenges clinicians experience in the field of sex offender treatment were explored through narratives of ten clinical professionals. This chapter discusses the findings in the following order: *Key Findings*, *Findings through the Lens of Constructive Self-Development Theory*, *Conclusion*, *Limitations*, and *Implications for Future Study*.

Key Findings

The central questions of this study explored clinician's perspectives on the factors that they perceived influenced their intention for job turnover or job retention. Information was collected from the study participants through questions that focused on the clinician's experience working specifically with sex offenders. Specific questions were asked with regards to effects of the work, symptoms of vicarious trauma or burnout, coping strategies used by the participant, motivations of the participant to continue their work with sex offenders, organizational supports in the field, and specific thoughts regarding leaving the field of sex offender treatment. In addition, the participants of this study highlighted specific characteristics of the population as well as characteristics of the clinician that may affect the clinician's turnover intention or job retention.

Motivation for Job Retention

Initial findings revealed that the majority of the respondents who participated in this study did not struggle with job retention and did not often have intentions for job turnover. Few participants could directly speak to having intention for job turnover while all of the participants spoke to motivation for job retention. Scheela's (2001) research on clinicians who work with sex offenders reports that those clinicians feel honored and privileged to work with the population. They felt "rewarded" knowing that they "made a difference in someone's life", and enjoyed being able to witness their client's change and growth; producing the feeling that their work is constructive and offers a contribution to the safety of the community. Participants in this study further supported Scheela's (2001) research by citing "for the betterment of society" as one of their motivations for job retention. Other's also cited the work as "rewarding", and found motivation when they saw clients doing well. Participants also cited the work as "noble", "honest", and "meaningful". Whereas Scheela's (2001) study did not link these feelings directly to motivation for job retention, the participants in this study spoke of their positive feelings regarding the work as a direct motivation to job retention.

Turnover Intention

Again, initial findings contradicted the study's assumption that clinicians who work with sex offenders struggle with job turnover intention. Of those participants in the study who did mention having thoughts of leaving their job or the field of sex offender treatment, the majority cited factors related to their work environment as the biggest influence over job retention and/or turnover intention. This supports Dressel's (1984) writings when she maintained that for social workers, no matter the setting, services provided, or the needs addressed, the difficulties that they are experiencing are with the larger system.

Organizational Factors

One of the participants highlighted the stress of his administrative role in the agency as the biggest factor that influenced his intention for job turnover. The catalyst for thoughts of leaving the field of sex offender treatment fell more heavily on administrative challenges; for example, keeping payroll together, finding and maintaining funding, and ensuring quality within the agency while also being an effective clinician. These findings were supported in the writings of Um & Harrison (1998) and Mor Barak et al. (2001), who reported that role stress is an antecedent to burnout and turnover intention. Soderfeldt, Solderfeldt & Warg (1995) suggested that therapists are more likely to feel burned out when they perceive high levels of role-related stress; characterized by a worker's high role conflict, role ambiguity, and role overload.

Kim and Stoner (2008), who studied the effects of role stress, job autonomy, and social support on burnout and turnover intention among social workers, found that social workers with higher role stress experience higher burnout, which in turn increases the likelihood of turnover intention. They also found that job autonomy and social support have a direct negative effect on turnover intention, which was another finding supported by the participants in this study. For two of the participants, the lack of job autonomy, especially around their work hours, were cited as factors that directly influenced their intention for job turnover. For two other participants the lack of support within their agency directly affected their intention for job turnover.

Social Support

Study participants supported the theory found in the literature by Um & Harrison (1998); Houkes et al. (2003); Mor Barak et al. (2001); Nissly, Mor Barak & Levin (2005); Karasek and Theorell (1990); that social support, or perceived social support in the work place is an important part of their work and can have an effect on job stress, burnout, and turnover intention. It was

cited that support within their work place was an essential part of being able to work with sex offenders and that without it, clinicians can become “overwhelmed” and “isolated”. This was recounted a number of times as an important and an “invaluable” factor to their work in order for them to process the difficult subject matter they were often listening to, discuss issues around transference and countertransference, and to be able to conceptualize cases. The findings of this study reinforce the theory that social support in the work place is negatively correlated with turnover intention among therapists who work with sex offenders.

Supervision

A number of the participants spoke to how having good supervision can positively impact their satisfaction with their job, a finding that supports the literature of Robinson et al. (2005). Four of the participants spoke to the effects of having no supervision or poor supervision as having an impact on their turnover intention. This directly supports the writings of Gleason-Wynn (1995), who reflected that quality/good supervision maybe associated with job satisfaction and is in turn associated with job retention.

Participant’s spoke to the many gains of good/quality supervision while working with sex offenders, many of these gains very similar to those represented in Henley’s (2002) study of the experiences of supervision among social workers. Hensley (2002) spoke to how social workers gain skills, often related to theory; professional growth and support; role modeling of professional and personal qualities; and mutuality through an interactive supervisory relationship. However, Hensley’s study did not speak to how supervision affected job retention or turnover intention.

For the participants in this study, “good/quality” supervision was defined as someone who was an expert, or at least trained in the field of sex offender treatment and was

knowledgeable about treatment approaches; someone who was able to conceptualize cases; was able to point out blind spots of the clinician as well as the client; someone who could help with the stages of change with the sex offender population; and someone who was able to offer guidance, especially around issues regarding transference and countertransference. These qualities mirrored the qualities that Bango and McKnight (2005) found in their study that make a supervisor more “prized”.

Participants also supported Ellerby’s (1998) results that indicated clinicians viewed supervision as a supportive and beneficial because it gave the clinician an opportunity to vent and provided a place in which they could receive clinical guidance and direction as well as a means of confirmation and validation. Multiple participants spoke of how supervision, formal and informal, offered them a space to open up about the things they have listened to as well as offered a place for them to review any doubts they may have been having about clients in regards to treatment. One of the participants directly supported the theory presented by Boud et al., (1985) as supervision as a way to turn experiences into learning when he commented on supervision being an important lifelong practice to improve on your work.

Participants discussed how having a team, which consisted of fellow colleagues as well as parole officers, often helped to process treatment issues. This was another theme that supports Scheela’s (2001) theory that clinicians who work with sex offenders used colleagues as a coping strategy to process issues and concerns as well as using them to make decisions as team so that responsibilities do not fall on one individual. Many of the participants in this study experienced the weight of responsibility put on them around concerns of recidivism among their clients; feelings that were often comforted with supervision or reassurance from others. This was another theme that supported the literature. Craissati (1998) also speaks to the importance of supervision

while working with sex offenders, as a means to potentially provide quality assurance and possibly thwart feelings of isolation.

Kearns (1995) reiterated how essential it is to have quality supervision while working with sex offenders. He suggested that therapists who work with sex offenders have the potential to become increasingly isolated from other clinicians and that their work climates often discourage therapists from discussing the negative aspects of their work. Although participants in this study did not support the theory that their work climate discouraged them discussing the negative aspects of their work, they did support the former idea of his theory. A number of participants noted potential feelings of isolation. However, most of the participants warned of isolation when working in private practice, whereas if the clinician works in an agency with other clinicians who treat sex offenders, isolation is much less of a threat. Participants in this study even mentioned feeling isolated among other therapists, who did not treat sex offenders. This was mostly because they believed others did not want to hear about sex offenders, they were worried of what others would say to them, or they did not think that the other clinician would understand their dilemma.

Effects of the Work

Participants in this current study described their work as complex, and at times exhausting and frustrating; similar to the results found in Maletzky's (1991) study of clinicians who work with sex offenders. Participants discussed the feelings of burden due to the weight of responsibility put on them to prevent re-offence; frustrations around dealing with a difficult population as well as dealing with difficult, often times embedded systems; and feelings of isolation among fellow clinicians and the community due to the discomfort they feel in regards to talking about their work. The feelings reported by the participants in this study of being

burdened, frustrated and alone emulate those of participants in a study by Hanson and Scott (1995).

Farrenkopf (1992) reported that therapists who experience emotional hardening, defined as “dulling of emotions” or “emotional distancing”, are more likely to have difficulty feeling and exhibiting empathy for their clients. This literature was not exactly supported by the findings in this study. Some of the participants explained how they had to distance themselves from their client’s offense in order to not let their client’s past effect how they worked together. Participants in this study spoke to needing some way of distancing from their clients in order to look past their offense and be able to be empathetic. In fact one of the participants used the phrase “tough exterior” and referenced “hardening skin” to explain how he is able to cope with the difficult subject matter he listens to from his clients. It would appear that for the participants in this study, some level of emotional hardening is necessary for the work in order to stay empathetic towards their clients.

A common theme among the participants in this study was a loss of trust, an increased awareness of danger and how unsafe the world can be; another theme supported by the literature (Freeman-Longo, 1997; Jackson et al., 1997). Many of the participants in this study noted being more vigilant and suspicious of others, generalizing everyone as a potential sex offender, feeling more protective of family, and more mindful of potentially dangerous situations. These findings were supported in the writings of Bengis (1997); Ellerby (1998); Jackson et al. (1997); Rich (1997); and Farrenkopf (1992); who reported that therapists who work with sex offenders also tend to feel more vulnerable to violence for themselves and their families and in turn increase their vigilance and safety precautions.

Another theory in the literature that was reinforced by the participants in this study, was that of Bengis (1992); who wrote that clinicians who work with sex offenders experience considerable anxiety provoked by a natural question of whether they too could be an aggressor or a victim, leading them to misgivings about their self-image. One of the participants in this study reported that a colleague of his experienced anxiety around finding pre-pubescent children sexy since working in the field of sex offender treatment. While another participant in the study expressed anxiety and discomfort at times when clients tell a story of one of their victims who is similar to herself.

A study by Guy and Liaboe (1986) found that many therapists have increased negative experiences in their ability to relate meaningfully with friends and family. Similarly, Faber (1983) found that more than half of those conducting therapy reported a decrease in their emotional investment in their own families. Both of these theories were not supported by the findings of this study. In fact, participants in this study reported an increased investment in their families, an appreciation for the connection they had with their friends, spouses and children, and for some participants their work is a means of connecting with their spouse. Only one participant noted having difficulty around connecting with friends, but it was in the context of discussing sexual jokes or pornography.

Several of the participants in this study reported multiple ways in which their work with sex offenders has influenced them emotionally and physically. While only two participants noted physical exhaustion a number of participants noted more emotional and cognitive changes. The accumulation of these changes within clinicians who work with sex offenders were discussed in writing by Ellerby (1998); Jackson, Holzman, Barnard, & Paradis (1997); Layton (1988); and Polson & McCullom (1995); who point out the fact that therapists who work with sex offenders

are significantly influenced by their work in ways that produce multiple emotional and physical ailments manifesting cognitively and/or in the workplace; which jeopardizes both the therapist's well-being and treatment efficacy. However, Participants in this study did not attest to these cognitive changes being a detriment to their own well-being or to treatment efficacy. Furthermore, they did not directly link these cognitive changes to factors that have influenced their intention for job turnover.

Findings through the Lens of Constructive Self-Development Theory

Each of the ten participants was able to recall at least one way in which they have been affected by the work they do with this population. The changes noted by study participants often involved a change in their world view or a change in their self or their identity. These findings fit with the Constructivist Self-Development Theory presented by McCann, Sakheim, and Abrahamson (1988); which outlines the development of vicarious traumatization. They postulated that exposure to trauma can cause one's schemas about the self and the world to be more vulnerable to disruption; with schemas related to each individual's most central need areas being the most likely to be affected. They believed that adaptation to trauma is the result of an interaction between an individual's life experiences and the developing self. These developmental issues include psychological needs, ego resources, identity, and schemas about self and the world.

Participants in this study reported that they were often exposed to difficult and traumatic subject matter during the course of their careers while working with sex offenders. Participants described their work as overwhelming, emotional, exhausting, psychologically traumatizing and physically exhausting. For two of the participants in this study, the constant exposure to emotive, and often traumatic and sexually violent subject matter has affected their ego-resources,

especially affect regulation. However, participants noted using “down time” when they began feeling overwhelmed, suggesting the use of the ego function: stimulus barrier.

Participants also explained how seeing stimulus pertaining to violent crimes or sex offender crimes at home can at times cause her to become very emotional. Although participants in this study support the theory of McCann, Sakheim, and Abrahamson (1988) that exposure to trauma can cause a disruption in the clinician’s ego-resources, many of the participants displayed a great deal of ego strength and stability. For example, a number of participants in this study spoke about the importance of looking past their client’s offense and viewing them as a human being and an individual who has good and bad parts to them. They were able to see the positive aspects of their clients as well as the negative, viewing them as a whole person. This shows a tremendous strength in the ego function of object relations, positively affecting the clinician’s ability to work productively with this population and potentially, indirectly influencing turnover intention and job retention.

The participants in this study also displayed other ego resources that allowed them to continue their work with sex offenders. One participant noted numerous times her ability to use humor to cope with the difficult subject matter she deals with at work. She described using the mature ego defense of humor to discuss “totally inappropriate things in a somewhat humorous way.”

Participants in this study also offered rationalizations in regards to pleasant feelings they had toward their clients. Many of the participants reported having good rapport with their clients, a characteristic needed to work productively with clients (Dunkle & Friedlander, 1996). They described how they developed relationships with their clients, and enjoyed and cared about them. Because of the horrific acts their clients have committed and the negative stigma put on them by

society, the affection the clinician feels may be confusing. The clinician's ability to use reasoning to justify an emotion, feeling, or thought that feels unreasonable or in the case of the participants in this study, against societal norms, is an ego defense used by the majority of the participants in this study. Many of the participants described their clients who were sex offenders as "good guys", "good people and they do something wrong", "just like you or I".

Only one of the participants in the study spoke to a change in her psychological needs since working with sex offenders. Her comments supported the Theory of Constructive Self-Development (McCann, Sakheim, and Abrahamson, 1988) when she discussed how she has noticed an increased need for physical affection, a central need area which the theory states is the most likely to be affected. She noted that she desired more affection from her husband, not necessarily sex. She described needing to know that affection was available and there for her. Her desire to "know" that the affection is there for her represented an increased psychological need for support and affection from a loved one.

All participants described a change in their schemas about either themselves or their world view since working in the field of sex offender treatment. One participant described how working with sex offenders can, "skew your view of normal", precisely supporting McCann, Sakheim, and Abrahamson's (1988) belief that exposure to trauma can change a clinician's schema in regards to their world view. Participants in this study also noted how their world view changed in the sense that they view the world as more dangerous, children as more vulnerable, and saw others as more suspicious as less trustworthy. Participants also noted a change in how they viewed laws and policies, once viewing them as efficient tools to better the world, whereas now they view them more skeptically.

A number of participants reported changing their view or schema of offenders over time to a view opposed to that of the general population. A number of participants described how their view of sex offenders had changed over time, in a positive way. On the other hand, some of the participants in this study also made note of how they had become more cynical regarding trust in their clients and recidivism; describing their clients promises to not re-offend as “wasted breath”.

Another participant described how his overall schema of whom he believed the sex offenders were in the community changed when he began this work. This participant described how before he began in his private practice he theoretically understood that psychopathology could present in individuals from all socioeconomic statuses. However, when he began working in a private practice that serves majority professionals, who are prominent members of the community, he was forced to change his schema of sex offenders as being individuals from a lower socioeconomic status. This participant’s dilemma and the anxiety provoked by the testing of his schema of who is a sex offender and who is not a sex offender is supported by the Constructivist Self-Development Theory; which holds that exposure to trauma can cause one’s schemas about the world to be more vulnerable to disruption.

McCann, Sakheim, and Abrahamson’s (1988) belief that adaptation to trauma is the result of an interaction between an individual’s life experiences and the developing self was also supported by many of the participants in this study. A number of the participants spoke to how they have developed as parents based on their experiences as a clinician who works with sex offenders and the traumatic stories they hear. Whereas all of the participants who were parents noted how they acknowledged their increased awareness of danger in the world and how anyone could be a sex offender, they took different approaches on how they adapted to that knowledge. The male participants, who were fathers or grandfathers, took on a more protective role for the

families; while the female participants, who were mothers, made an effort to not be overprotective and saw themselves as being capable of handling whatever trauma might ensue on their families. These participants adaptation of themselves and how they viewed themselves is directly supported by the Constructivist Self-Development Theory as well as by the findings of Piaget & Inhelder (1967) who theorized that when information that is presented cannot be assimilated into one's existing schema, new or modified schemas are developed.

There were other changes in schema around self-identity that participants in this study noted as well. While one participant explained how he adapted his view of self-identity in relation to his role in his own sexual abuse, another participant noted his colleagues change in self-identity around sexuality, noting that he had never before found pre-pubescent children "sexy" until working with sex offenders. Similarly, another participant in the study noted the anxiety he felt around being excited by his client's stories. This anxiety is a result of the clinician's schema of self-identity overlapping with their client's schema as a sex offender. It can potentially be very confusing and disturbing to share or identify with the parts of your client's schema that are viewed as deviant and have caused other's pain as well as caused a good amount of suffering in them. Another, female participant also shared how she experienced some anxiety when she realized that she was similar to one of her client's victims. This was upsetting to the participant because it challenged the schema she had of herself, and all of the sudden she viewed herself as a victim rather than a clinician; a phenomena also supported by the works of Bengis (1992).

The participants in this study revealed a number of ways in which they adapt and protect themselves from the emotionally traumatic experience of being exposed to traumatic and difficult subject matter, which leads to burnout, vicarious trauma and possibly turnover .

Pearlman & Saakvitne (1995) postulated that according to the Constructivist Self-Development Theory, therapist's vicarious traumatization is an adaptive response to traumatic content disclosed by clients. The development of issues around identity, psychological needs, schemas about self and the world and ego resources are very much evident among participants in this study, but it is not clear whether or not these developments are related to vicarious trauma.

Although some of the participant's developments are a direct response to exposure to trauma, such as increased psychological needs and a change in how safe they viewed the world; other developments evolved as a means to protect the clinician from vicarious trauma. For example, as reviewed earlier, some of the participants spoke to how their view of sex offenders changed over time; holding a more whole schema of the sex offender as not just someone who has done horrific things to other people, but as a good person who has done bad things. This schema change may be a result of hearing about the horrific things their clients have done, but the adaption that was made allowed the clinician to work with the client without become too traumatized or horrified by what their clients told them. In a sense this schema adaptation protects the clinician from vicarious traumatization and subsequently turnover.

Similar to McCann, Sakheim, and Abrahamson's (1988); Curtois (1993) and McCann & Pearlman (1992) identified seven schemata that are especially susceptible to trauma-induced alterations: The individual's personal frame of reference about self and others; safety; dependency and trust; power; esteem; independence; and intimacy. Five of these schemas were noted as altered among the participants in this study; supporting the writings of Curtois (1993) and McCann & Pearlman (1992). However, the argument made by McCann and Pearlman (1990) that these cognitive shifts that result from exposure to traumatic client material may create a general emotional distress in therapists, including heightened anger, guilt, fear, grief,

shame and inability to contain intense emotions was not fully supported by the participants in this study. Only one participant noted times when she was unable to contain intense emotions; and in regards to heightened anger, guilt, fear, grief, and shame, only two of the participants mentioned a possibility of increased anger which arose when they felt a client was not be cooperative or had the potential to become aggressive. Herman (1997) believed it was very likely that these types of cognitive shifts may interfere with effective functioning in the therapeutic role. Conversely, many of the participants in this study noted certain changes in schema as an aid in the effective functioning in the therapeutic role; especially those adaptations in the schema of their clients who are sex offenders.

In the literature that reviews the effects of vicarious trauma on clinicians, McCann & Pearlman (1992) and Farber (1983) discuss how when trauma and exposure to another's traumatic content present a challenge to the clinician's individual schemas, painful identity and emotional and interpersonal changes occur. Clinicians develop adaptations as a form of self-protection against the emotionally traumatic experiences; adaptations that are cumulative and pervasive and can affect every area of the clinician's life. Although the participants in this study spoke to how their work has affected them in multiple areas of their lives they did not speak to the effects as "pervasive". In fact, of the participants who experienced the effects of their work with sex offenders in terms of disruption of schemas, psychological needs, ego resources, identity, or change in their world views, none of them described these effects/adaptations as being extensive or detrimental symptoms of vicarious trauma. Further, none of the participants described the effects as having a having a direct positive correlation with turnover intention or job retention.

Conclusion

Although the participants in this study work with a population that is generally thought of as difficult and deal with topics that are emotively loaded, the therapists do not have strong intentions for turnover. This is important because the majority of the research on turnover is directly linked to burnout and vicarious trauma but not on other factors that may be directly influencing turnover or turnover intention. This study fills the gap in the literature by suggesting organizational factors as having more of a direct influence on turnover and turnover intentions among therapists who work with sex offenders. These findings point to things that can be done to support therapists who work with sex offenders in the context of social policy and organizational policy rather than focusing solely on the clinician themselves or the population they serve.

Limitations

The findings from this study must be viewed within the light of its limitations. While the qualitative interview design allowed for open, flexible and rich exploration, of the study question, it carries the inherent threats to validity and reliability including sample selection, reactivity, researcher bias, and respondent bias (Padgett, 2008). For example, those who were happier with their jobs may have been more likely to participate in the study. Also, sample selection came from the ATSA list, which does not include a comprehensive list of all therapists who work with sex offenders. Efforts to support rigor and validity of the study were employed but these cannot render mute the impact of bias. In addition, the interview questions were designed by the researcher and in retrospect could have been more precisely aimed at how multiple factors influenced job retention and turnover intention. Because of the broadness of most questions, which is often innate in qualitative research, participant's interpretations varied in some cases, as did length and depth of their responses.

Due to the limited amount of time to conduct the research, the study only included interviews from ten participants. A sample size of ten is small; therefore it limits the generalizability of the findings. The sample was also racially homogenous, with all of the participants identifying as Caucasian. There was a variance in gender, clinical experience, and setting, but all of the participants were currently working in the field of sex offender treatment. Because the focus of this study was to attempt to reveal factors that influence job retention and turnover intention among clinicians who work with sex offenders, it would have been advantageous to include the input of clinicians who are no longer working with sex offenders. This may have broadened the findings in regard to direct impacts on job retention and turnover intention. Future research would benefit from a larger, more diverse sample size, in addition to the crucial insights of clinicians who have actually left the field of sex offender treatment.

Implications for Future Study

The study opens the door for many new areas of research, as well as for practice and policy. Findings in this study point to the many factors, such as characteristics of the clinician and/or the client, that effect not only the clinician but also the treatment process. Further exploration into these factors and the effects they have could influence practice and treatment within the field of working with sex offenders. In terms of future research, a continuation of research and expanded sampling is needed in order to further understand the complexities and impact of vicarious trauma on clinicians who work with sex offenders, the needs of those clinicians, and in turn an understanding of factors that reduce job turnover and increase job retention. In regards to policy, research that focuses on how social policy as well as organizational policy effects job retention and turnover intention could help shape future policy regarding sex offenders and sex offender treatment. Future studies should examine supervision,

peer supervision, worker autonomy, and worker inputs into program management, as these areas hold hope for concrete interventions to address worker turnover.

Future Research

An important issue that should be explored in the next stage of this research is the difference among male and female clinicians who work with sex offenders. This study revealed a slight difference among male and female participants when it came to the personal and professional effects of their work. Further research that teases out these differences may help to address specific issues regarding burnout or vicarious trauma, and may even impact theories of practice with sex offenders.

Finally, looking at the differences in job retention and turnover intention among clinicians who work with sex offenders in different settings would be a rich addition not only to research regarding vicarious trauma, burnout, and job satisfaction, but also an invaluable addition to the research that looks at treatment efficacy for sex offenders. One of the participants in this study worked in a setting that treated primarily professional, affluent individuals who were solely private pay that had been convicted of a sexual offense or sent to treatment due to professional, sexual misconduct. This participant was very blunt in expressing his observation that his clients receive “better” treatment. He lacked the frustration all other participants felt in regards to working with or within multiple, complex, sometimes “embedded” systems. Further research into the factors that influence this deviation in treatment among different setting, as well as among different sub-groups of the sex offender population may offer insight into ways sex offender treatment could be improved; as well as insight into how to limit the frustrations clinicians feel towards the many organizational/external factors that influence the clinician, the treatment and the client.

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Appendix A

HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 15, 2013

Abigail Kirschbaum

Dear Abigail,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads 'Marsha Kline Pruett / khp'.

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Acting Chair, Human Subjects Review Committee

CC: Will Lusenhop, Research Advisor

Appendix B

Recruitment Letter to Potential Participants

Dear ATSA Members,

My name is Abigail Kirschbaum, and I am a graduate student at the Smith College School for Social Work, currently doing my final clinical internship in Portland, ME. I am writing to ask for your help in completing my Master's thesis by participating in a brief (30-60 minute) interview on the topic of the experience of therapists who work with sex offenders. You are receiving this letter because you are a member of ATSA, an organization dedicated to the assessment and treatment of those who have sexually abused or are at risk to sexually abuse.

I am sending you this letter to ask for your help with recruiting participants for my research study, which is a brief, in person or via telephone interview; if you meet eligibility criteria.

My research study focuses on identifying personal and professional experiences of psychotherapists associated with their staying in the field of working with sex offenders as well as their personal and professional experiences associated with their moving away from the field of working with sex offenders. This study will not ask any questions that would require the clinician to disclose any identifying information of their clients or themselves. Potential participants will be presented with an informed consent form prior to the interview. Participants will be asked for their signatures, but only if they agree to participate.

Clinicians are eligible to participate in my study if they are currently working with or have experience working with registered sex offenders, or individuals who identify as sex offenders and/or pedophiles. They must have a Master's, Doctorate, or MD in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Clinical Psychology, or Psychiatry. Any individuals who do not meet the aforementioned criteria will be excluded from participating in the study. Participating in the study is very easy. Participating in a 30-60 minute interview is the only requirement. Below is a link to the website containing my thesis questionnaire.

If you meet criteria for participating, I encourage you to take part in my study. Participation will be kept confidential, other than myself, others will have no way of knowing whether or not you participated. If you do not meet criteria, I encourage you to please forward this letter to any acquaintances or colleagues you know of who may be eligible to participate.

Responses could provide insight into the needs for the future development of education regarding sex offender treatment and the experience of the sex offender therapist in clinical work.

If you have any questions about my research or the nature of participation, please feel free to reply to this email (akirschb@smith.edu) or contact me at a later date.

Thank you for your time, assistance, and interest in my research topic!

Sincerely,

Abigail Kirschbaum
MSW Candidate, Smith College School for Social Work

Appendix C

Informed Consent Letter

Dear Participant,

My name is Abigail Kirschbaum, and I am a graduate student at Smith College School for Social Work. I am conducting research for my Master's thesis, which explores factors associated with turnover intention and job retention among therapists who work with sex offenders. To participate you must be currently working with or have experience working with registered sex offenders, or individuals who identify as sex offenders, and/or pedophiles. They must have been practicing/practiced with sex offenders for at least one year. They must have a Master's, Doctorate, or MD in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Clinical Psychology, or Psychiatry. Interviews for this study will begin immediately and cease at the end of March.

This study will be conducted through interviews that can be completed in person or via telephone. All interviews will be audio recorded. You will be asked multiple open-ended questions regarding your experience as a sex offender therapist. Because the questions deal with sensitive subject matter, there is a small risk that participation in the study could cause negative or uncomfortable emotions to arise. Possible benefits from participating in the study include experiencing participation as informative and having the opportunity to reflect upon your practice. Unfortunately, no monetary or material compensation for your participation can be provided.

This interview will remain completely confidential. Also, in the interest of confidentiality, you are asked not to provide any names or identifying information about clients in any of your responses. Any identifying information you include about yourself or your client will be treated confidentially and then deleted. All data from the interview will be kept in a secure, password protected location for a period of three years, as required by Federal guidelines, and data stored electronically will be fully protected. If the material is needed beyond a three year period, it will continue to be kept in a secure location and will be destroyed when it is no longer needed. All Informed Consent will be stored in a secure location separate from other study materials.

Initial data will only be viewed by myself, my research advisor, and an employed transcriptionist who will have signed an Assurance of Research Confidentiality. Data will be presented in aggregate format and illustrative quotes will be presented in such a way that they will not identify any individual. When material from this study is used for future presentation and possible publication, any possible identifying information will be removed.

Your participation in this study is voluntary. You have the right to refuse to answer any question during the interview. You may also withdraw from the study at any time. If you do this, any answers you provided to any previous questions will be deleted and not used if that is what you wish. Once you have completed the interview, if you wish to withdraw from the study, you must do so before April 1st after which data will be in aggregate form. Researcher will provide a copy of the interview for the participant's records.

If you do wish to rescind your interview please contact the researcher immediately. Contact information is below.

If you have any additional questions, please feel free to contact me directly at akirschb@smith.edu or by phone: (XXX) XXX-XXXX. Should you have any concerns about your rights or any aspect of the study, you are encouraged to contact me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. **BY CHECKING THE BOX BELOW THAT SAYS "I AGREE," YOU ARE INDICATING THAT YOU HAVE READ AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS; AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

____ I disagree ____ I agree

Participant Signature _____ Date _____

Researcher Signature _____ Date _____

Appendix D

Interview Guide

1. How did you initially decide to become a therapist who works with sex offenders?
2. Describe the type of sex offender you work with? (i.e. voluntary, involuntary, continuum of offense?)
3. What effect has this (referring to question #2 – type of offender) had on you as a therapist?
4. Describe your work as a clinician who works with sex offenders.
5. Have you experienced any of the following symptoms while working with sex offenders: Social withdrawal, emotional lability, aggression, greater sensitivity to violence, somatic symptoms, sleep difficulties, intrusive imagery, cynicism, sexual difficulties, difficulty managing boundaries with clients, and/or a change in your core beliefs? If yes, how long did you experience these symptoms?
6. Did you use any coping strategies to combat these symptoms? If so, what were they?
7. What are some of the downfalls of being a therapist who works with sex offenders?
8. What motivates you to continue working with sex offenders?
9. What qualities are necessary to be a good therapist while working with sex offenders?
10. How long do you think you will work in the field?
11. Any thoughts of leaving the field?
12. Are there organizational supports/lack of supports that have helped/hindered your work?
13. Upon what theory and/or theories do you base your approach to sex offender treatment?
14. Any additional comments?

Appendix E

Demographic Questions

Screening Questions

1. Do you hold a Master's degree, Doctorate degree, or MD in one of the following disciplines: Clinical Social Work, Psychiatry, Psychology, Psychiatric Nursing, Marriage and Family Therapy, or Mental Health Counseling?

Yes No

2. Have you completed graduate or postgraduate training to practice psychotherapy?

Yes No

3. Have you completed postgraduate training to practice psychotherapy?

Yes No

4. Are you currently practicing psychotherapy with sex offenders in the United States?

Yes No

5. Have you received any training for working with sex offenders?

Yes No

DEMOGRAPHIC QUESTIONS

1. What is your discipline?

MD/DO (Medical Doctor/Doctor of Osteopathic Medicine)

Clinical Social Worker

Mental Health Counselor Psychologist

Marriage and Family Therapist Psychiatrist

Psychiatric Nurse Specialist

Psychiatrist

LCPC

Other:

6. How many years have you been practicing psychotherapy? Please round to the nearest year.

7. How many years have you been practicing as a sex offender therapist? Please round to the nearest year. _____

8. How do you identify racially/ethnically?

Black or African American

Hispanic, Latino, or Spanish origin

Asian

Middle Eastern

Native American or Alaskan Native

Pacific Islander

Mixed Race or Biracial

White or Caucasian

Other (please specify) _____

9. Please select the gender you most identify with.

Woman

Man

Transgender

Other (please specify) _____

10. If you are still practicing with sex offenders, approximately what percentage of your caseload, are sex offenders?

None (0%)

Less than 50%

About 50%

More than 50%

All (100%)

11. In which type of geographical area do you primarily practice outpatient psychotherapy?

Urban

Suburban

Rural

12. In which of the following outpatient settings do you primarily practice?

Agency or community mental health center

Hospital outpatient clinic

Court setting

School setting

Office space outside my home

Office space inside my home

Clients' homes

Other (please specify) _____

Appendix F

Professional Transcriber's Assurance of research Confidentiality

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.
- A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.
- The researcher for this project, Abigail Kirschbaum, shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, Abigail Kirschbaum, for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

Signature
Date
Abigail Kirschbaum
Date