**Who Will Help the Therapist?**

**Personal and Environmental Factors that Reduce Secondary Traumatization among Therapists for Sex Offenders**

**RUNNING HEAD: Secondary Traumatization among Therapists for Sex Offenders**

**Abstract**

This research examined secondary traumatization among 91 therapists for sex offenders in Israel, particularly the relationship between their level of secondary traumatization and their family status (unmarried n = 14 and married n = 66) and social support. The unmarried therapists exhibited higher symptoms of secondary traumatization compared to married therapists, whether with or without children. Among married therapists, a significant negative correlation was found between their satisfaction with their level of social support and their secondary traumatization. However, no correlation was found between family status, social support, and secondary traumatization among unmarried therapists, who reported a high level of secondary traumatization, regardless of the social and family support they received. The findings shed light on the differential needs of therapists for sex offenders, reflecting their family status, in order to maintain their psychological wellbeing and improve the effectiveness of the care they provide to their clients.

**Keywords**: Family status, Social support, Marital support, Secondary traumatization

**Introduction**

 *“Treating a sex offender means refraining from judgement and being careful not to cross red lines. It means being ready to provide treatment to someone who has harmed others and committed horrific acts. It requires being brave. Life before entering the world of treating sex offenders and after entering that world are very different. The traumatic experience occupies every part of my body and mind, my ability to think. The feeling that I have no control over it intruding into my inner world, and my need to be protected, makes me scream inside: what is happening to me? A glance in the mirror shows what is going on in my mind, and I see that I am different. I am gaunt. The figure reflected in the mirror looks different. The feeling that I need to be saved and that this madness could cast me into the abyss causes real anxiety.”*

*--S., social worker, Israel Prison Service*

Secondary traumatic stress (STS) among therapists, also called compassion fatigue or the cost of caring, is defined as an internal experiential process that turns into a negative experience. Its symptoms are similar to those of post-traumatic stress disorder (PTSD) including: hyperarousal (i.e., difficulty sleeping, hypervigilance); avoidance of thoughts, feelings, places or people associated with the traumatic event; and intrusive thoughts such as flashbacks or nightmares related to the trauma. This syndrome develops over time, but symptoms may appear suddenly, and do not necessarily result from a reaction to a specific patient (Farrenkopf, 1992; Figley, 1995; Pearlman & Saakvitne, 1995; Way et al., 2004).

Over the past two decades, research on secondary traumatization has shifted from a focus on those who treat trauma victims to increased attention to those providing care to the populations who cause the trauma, such as sex offenders (Bach & Demuth, 2018; Baum & Moyal, 2018; Idisis & Vered, 2010; Rzeszutek et al., 2015). This shift reflects the growing number of therapists for sex offenders (Severson & Pettus-Davis, 2013), and the recognition that secondary traumatization impacts the effectiveness of the treatment provided and the therapists’ quality of life (Bach & Demuth, 2018; Baum & Moyal, 2020; Ben-Porat, 2013; Idisis & Vered, 2010).

Previous studies have identified three main categories of risk factors for STS among therapists. One category pertains to professional (work-related) factors such as seniority and work experience, sufficiency of training or guidance, caseload, workload, and uncertainty regarding expectations and assessment of their role (Robins et al., 2009; Severson & Pettus-Davis, 2013). The second category relates to therapists’ personal characteristics, such as past traumatic experiences (Figley, 1995), or demographic variables such as age, ethnicity, and gender (Baum & Moyal, 2020). The third category refers to social factors such as level of support in the workplace (Ben-Porat, 2013; Ennis & Horne, 2003) or from family and spouses (Elias & Haj-Yahia, 2016; Ghahramanlou & Brodbeck, 2000; Severson & Pettus-Davis, 2013; Steed & Bicknell, 2001). However, there have been virtually no studies that specifically looked at unmarried therapists. The current study examined whether unmarried therapists are more resistant or more vulnerable to STS, as compared to married therapists (with or without children). It investigated whether there is a relationship between therapists’ family status and the scope and availability of their social support, and whether this social support affects symptoms of STS.

**Literature Review**

People working in therapeutic professions must have not only knowledge and intelligence, but also personal and interpersonal skills; without these, there is little chance that the therapist-patient encounter will succeed. The qualities required for therapists include sensitivity to others and to themselves, the ability to put themselves in the patient’s shoes, ability to impartially observe the interpersonal interaction while being an active part of it, patience, perseverance, courage, and willingness to evoke and absorb negative emotions (Elias, 2013; Youssef, 2017). The expectation that therapists will help their patients who are suffering from trauma, and the tools at their disposal, are precisely what puts them at greater risk for developing STS (Levy, 2018). Therapists must constantly listen to patients describing traumatic experiences and expressing negative emotions such as fear, grief, rage, terror, pain, suffering, injustice, cruelty, and hopelessness. This may lead to therapists developing symptoms similar to those of PTSD, such as intrusion, avoidance, and arousal (Bride et al., 2004; Gil, 2015; Hurrell et al., 2018). There is an even greater risk of STS for therapists who treat sex offenders. Repeatedly listening to graphic descriptions of sexual violence, and the need to delve into details of events that caused suffering and pain to the victims, especially to children, makes therapists vulnerable to STS and burnout (Catanese, 2010; Elias, 2013; Ennis & Horne, 2003; Sharim, 2018).

In addition, sex offenders often exhibit self-centeredness, lack of empathy, manipulation, minimization or externalization of personal responsibility, and lack of internal change motivation (Jennings & Deming, 2017; Strasburger, 1986). When these characteristics and behaviors are exhibited by sex offenders during treatment, it becomes difficult for therapists to see the human side of their patients alongside their inhumane traits, and may cause distrust and raise doubts regarding the offenders’ ability to change (Jennings & Deming, 2017; Shechory et al., 2010).

The risk that the abusive behavior will recur requires the authorities to intervene, supervise, and monitor sex offenders. This heavy responsibility rests mainly on social workers, who must both try to change the criminal behavior and serve as agents representing the authorities. This responsibility, and the dual role of providing care as well as supervision, contributes to burnout (Bride, 2007; Farrenkopf, 1992; Hurrell et al., 2018; Severson & Pettus-Davis, 2013).

Studies have found that therapists treating sex offenders exhibit a range of short-term and long-term physiological, emotional, cognitive and behavioral symptoms of STS. In the short term, at the level of initial reaction, there is evidence of psychosomatic reactions such as fatigue, difficulty sleeping, or headaches [REF]. Long-term cumulative responses include emotional flooding and difficulty disconnecting from work (Elias & Haj-Yahia, 2016; Sharim, 2018), nightmares, and intrusive thoughts related to the treatment or to incidents of sexual abuse (Severson & Pettus-Davis, 2013).

Therapists report symptoms of hyperarousal and hypervigilance due to fears that their patients will repeat their abusive behavior, suspicion and vigilance regarding other people’s behavior, and reluctance to enter potentially dangerous situations (Cunningham, 2003). Therapists report anxiety regarding their own safety and that of their relatives, which manifests in avoiding going out at night, fear, and overprotectiveness of their children (Elias & Haj-Yahia, 2016; Severson & Pettus-Davis, 2013). They have difficulties in emotional regulation, increased anger, frustration and irritability (Elias & Haj-Yahia, 2016; Severson & Pettus-Davis, 2013). Therapists may develop disruptive thought patterns regarding themselves and the world, such as cynicism, heightened awareness of others’ ability to cause harm, and an undermined sense of professional security (Boscarino et al., 2004; Catanese, 2010). Additionally, Idisis and Vered (2010) found that therapists of sex offenders experience isolation and sometimes feel that they must apologize for their choice of profession. Various symptoms of STS have been found in between 46-80% of mental health professionals treating sex offenders (Bengis, 1997; Steed & Bicknell, 2001). Degree of social support, particularly marital and family support, significantly impacts the intensity of these symptoms (Ben-Porat 2013; Ennis & Horne, 2003; Ghahramanlou & Brodbeck, 2000; Steed & Bicknell, 2001).

**Social, Marital, and Family Support and Secondary Traumatization**

Social support is defined as an exchange of resources between at least two people, perceived by both the giver and the recipient as a resource intended to increase the recipient’s wellbeing and quality of life (Hobfoll, 2002). Social support can be tangible or abstract. It includes helping others and shielding them from the negative effects of stressful life events (Shirey, 2004). It provides people with a positive, stable self-concept that helps them organize their experiences and plan for their future (Sarason et al., 1990).

The literature distinguishes between actual or received social support and perceived social support. Received social support refers to helpful actions performed by others (Barrera, 1986). In contrast, perceived support is the assumption that help will be available when needed, and that one’s needs for emotional and practical support will be met (Goodwin et al., 2004; Pines & Zaidman, 2003; Rzeszutek et. al., 2015). Received and perceived social support are both important in reducing loneliness and anxiety and in increasing feelings of belonging and self-esteem (Heany & Israel, 2002; Schönenberg et al., 2014; Wenzel et al., 2002).

Perceived support is not always consistent with the actual support received. Even if support does meet the expectations, the recipient might consider it ineffective. A study conducted in Poland among 80 trauma therapists found that their level of STS was negatively correlated with perceived social support, while received social support had no impact on the level of STS (Rzeszutek et al., 2015). These findings are in line with the assertion of Robinaugh et al. (2011) that poor perceived social support, as opposed to received support, is associated with the severity of symptoms of PTSD.

In any case, it seems apparent that stronger social support is more beneficial to individuals in stressful situations (Dunkel-Schetter, & Bennett, 1990; Goodwin et al., 2004). It has been found that therapists with a poor social support system are at significantly greater risk for developing STS [REF]. Therapists’ social support system includes the family members, friends, professional colleagues, and mentors they rely on to feel cared for and to cope with the demands of work. Social support has a moderating effect on the development of STS among therapists (Ben-Porat & Itzhaky, 2009; Carmel & Friedlander, 2009; Ellerby, 1998; Ennis & Horne, 2003; Kadambi & Truscott, 2003).

Some studies indicate that therapists for sex offenders experience exclusion and isolation due to their field of work, not only in the professional sphere, but also in the public and marital sphere (Ennis & Horne, 2003; Sharim, 2018; Way et al., 2004). In a qualitative study conducted among nine female and nine male therapists for sex offenders in the adult probation services in Israel, the subjects said that they experience criticism, disdain, and rejection due to their work, and that they avoid sharing, even with their spouses, the complex reality involved with treating this population (Sharim, 2018). In another qualitative study conducted in Israel, 15 youth probation officers who work with sexually abusive minors were interviewed (Rosenblum-Gitlis, 2016). Some said they prefer not to share with their spouses what goes on in the therapy, while others described their marital relationship as a significant source of support and reinforcement, and that they allow themselves to openly share and discuss their challenges. Another quantitative study found that marital support mitigated the negative consequences of working with sex offenders (Kadambi & Truscott, 2003). These findings regarding the important supportive role played by spouses and family members for therapists treating sex offenders raise the question of social support for unmarried therapists for sex offenders.

The current study examined the relationship between family status and perceived and actual social support and the level of secondary traumatization among therapists for sex offenders in Israel. The three research questions examined were: 1) Is the level of secondary traumatization among unmarried therapists higher than that of married therapists? 2) Is there a correlation between therapists’ family status and their reported level of social support? 3) Does social support make a similar contribution in reducing symptoms of STS for unmarried and married therapists?

**Methods**

**Sample and Procedure**

In the State of Israel, minors under the age of criminal responsibility (12-18) are referred for diagnosis and treatment to youth probation officers – social workers in training as part of the community juvenile probation service. Minors who require supervision are treated in out-of-home settings operated by the Youth Protection Authority, under the supervision of the Ministry of Welfare. Adults (over the age of 18) are treated, according to the law, in ambulatory/ comprehensive legal frameworks in the community, based on their assessed level of dangerousness. As part of their sentence, sex offenders receive treatment in prison and after their release in preventive rehabilitation centers in the community.

The population for the current study included 91 social workers, psychologists and criminologists involved in the diagnosis and treatment of juvenile and adult sex offenders. Of these, 74 (80%) were social workers and 11 (12%) were clinical criminologists. 60 of them were women and 40% were men. Their ages ranged from 25 to 89 (mean 42.6, SD 11.5). 73% were married, 15% unmarried, and 12% divorced. 75% of the participants were parents, with an average of two children (SD 0.56). 31% of those surveyed hold a bachelor’s degree, 64% hold a master’s degree and 5.5% hold a PhD. Those investigated had between one and 55 years of experience in the profession (mean 14.4, SD 11.2). 60% treated sex offenders in community settings and 40% in institutional settings such as closed dormitories for juveniles, prisons, and probation hostels for adults. 48% treated only sexually abusive minors, 42% only treated adults and 10% treated both minors and adults.

The subjects were located through requests made to the administrations for the adult and juvenile probation services and the Youth Protection Authority, the sex offender treatment program center at the Prisoner Rehabilitation Authority, the sex offender treatment department at the Israel Prison Service, selected private centers, and the ELEM nonprofit association, which operates groups for the treatment of sexually abusive minors.

Online questionnaires were sent to individuals who agreed to participate in the research either directly or through the manager of their framework/service. The research was approved by the ethics committee of the Safed Academic College prior to its execution, and was conducted in accordance with its requirements.

**Research Tools**

*Personal and Professional Background Questionnaires*

The personal background questionnaire included items related to gender, age, family status, religion, level of religiosity, country of birth, and (for immigrants) year of immigration. The professional background questionnaire included items related to educational level, profession, place of work, seniority, years of experience in the diagnosis/treatment of sex offenders, the treatment framework, the treatment target population, and the district where they work.

*Secondary Traumatization Questionnaire*

We used the final version of the Secondary Traumatic Stress Scale (STSS) (Bride et al., 2004), a 17-item, self-report instrument designed to assess the frequency of symptoms of intrusion, avoidance, and arousal associated with STS. Respondents are instructed to read each item and indicate how frequently the item was true for them in the previous seven days using a 5-point Likert-type response format ranging from 1 (never) to 5 (very often). The STSS is comprised of three subscales: Intrusion (items 2, 3, 6, 10, 13), Avoidance (items 1, 5, 7, 9, 12, 14, 17), and Arousal (items 4, 8, 11, 15, 16). Scores for the full STSS and for each subscale are obtained by summing the items assigned to each. The STSS differs from the many available PTSD measures in the wording of the instructions and in that in the stressor-specific items (items 2, 3, 6, 10, 12, 13, 14, 17) the traumatic stressor was identified as exposure to clients. Consistent with the DSM-IV criteria for PTSD, other items are not stressor-specific (items 1, 4, 5, 7, 8, 9, 11, 15, 16) but indicate the negative effects of traumatic stress.

Two approaches are recommended for interpreting individuals’ responses on an instrument of this sort. The first is categories based on percentiles, such that scores at or below the 50th percentile (less than 28) are interpreted as no or low STS, scores at the 51st to the 75th percentile (28 to 37) are interpreted as mild STS, scores at the 76th to the 90th percentile (38 to 43) are interpreted as moderate STS, scores at the 91st to the 95th percentile (44 to 48) are interpreted as high STS, and scores above the 95th percentile (49 and above) are interpreted as severe STS. Another approach is establishing a cutoff value whereby individuals who obtain a score at or above the cutoff value are considered to have PTSD due to STS. Given the proposed score ranges presented earlier, a cutoff score of 38, which is at the lower threshold of the moderate range, is recommended. In a reliability test carried out by the authors of the questionnaire, Cronbach’s alpha was found to be α = 0.93. In an internal reliability test for the current study, the entire questionnaire was found to have a Cronbach’s alpha of α = 0.87.

*Multidimensional Scale of Perceived Social Support*

The Multidimensional Scale of Perceived Social Support (MSPSS) developed by Zimet et al. (1988) tests respondents’ subjective perception of the degree of social support available to them from three sources: family, friends, and significant others. The questionnaire includes 12 statements. For each, respondents indicate the extent to which it corresponds to their feeling on a scale from 1 (not appropriate at all) to 7 (extremely appropriate). Cronbach’s alpha reliability is α = 0.88. The internal reliability of the scale for the present study is high with α = 0.91.

*Social Support Questionnaire*

The Social Support Questionnaire (SSQ) developed by Sarason et al. (1983) examines perceived and received social support. There is a long version with 27 statements and a short version with six statements (SSQ6). In SSQ6, each statement has two parts, addressing two conceptually distinct aspects of perceived support: availability and satisfaction. Availability refers to the estimated number of people the respondents feel they can turn to when assistance is needed in a given situation. Satisfaction is the perceived adequacy of support, in relation to expectations and needs.

For each item, respondents list the people (maximum of nine persons) on whom they can count in the situation described and expresses level of satisfaction with regard to this support on a 6-point rating from 1 (very unsatisfied) to 6 (very satisfied). Two total scores are calculated: the average number of persons on whom they can rely for support (N), and the average score for satisfaction with support (S). For the short-form, N ranges from 0 to 54 and S ranges from 6 to 36. An individual may be satisfied despite having few friends and relations, or may be dissatisfied despite having a large social network. In a study of 182 university students, the dimensions N and S had a moderate positive correlation (r = 33, p < .O01) (Sarason et al. (1983). Reliability for the items related to the number of supporters was Cronbach’s alpha α = 0.90 and for the level of satisfaction with support α = 0.93.

The short version was translated into Hebrew by Priel and Shamai (1995), which was used in the current study. Its reliability in this study was very high, with α = 0.88 for number of supporters and α = 0.92 for satisfaction with support. Coefficients (c) were 0.95 and 0.96 for N and S, respectively.

**Results**

**Secondary Traumatization among Therapists for Sex Offenders**

In the first stage of data analysis, the level of STS among the subjects (N = 91) was tested according to three operational definitions 1) the total score obtained from the average of all questionnaire items; 2) based on division into levels of STS: low/moderate (0-37) or medium/high (38-100); and 3) according to the scales assessing symptoms of STS: arousal, invasion and avoidance.

The level of STS in the sample, according to the total score, showed a normal distribution, with an average score of 38.56 (SD = 10.4). According to the data, 50.5% of the therapists reported a relatively low level of secondary traumatization (up to 38) and 49.5% a medium-high level of secondary traumatization (38 and above) (see Table 1).

[Table 1 about here]

Examining the frequency of symptoms according to the intrusiveness, arousal, and avoidance scales, showed that avoidance had the highest frequency with an average of 15.14 (SD = 4.41) while arousal was the lowest with an average of 12.08 (SD = 3.8) (Table 2).

[Table 2 about here]

Analysis of the symptoms according to these scales revealed among those who experienced a moderate to high level of secondary traumatization (up to 28) the most prominent symptoms were feeling numb (avoidance), feeling sad when thinking about work and thinking about work when they don’t want to (intrusiveness) and difficulty concentrating (arousal).

**Secondary Traumatization and Family Status**

In the second stage of the data analysis, we examined the frequency of STS among unmarried (N = 14) and married (N = 66) therapists according to the total score. Figure 1 shows the prevalence of the variable.

[Figure 1 about here]

The average score among married therapists in the full STSS was 37.6 (SD = 11.06) and among the unmarried therapists it was 44.79 (SD = 8.16). In the t-test for independent samples, these differences were found to be statistically significant (t = 2.286, p < 0.05), as shown in Table 3.

[Table 3 about here]

Additionally, in accordance with the operational definitions of the variable, an analysis of STS level was conducted according to two levels, low/moderate and medium/high for the married and unmarried subjects. Among the unmarried therapists, 85.7% showed medium-high levels of STS, compared to 43.9% of the married therapists. These differences were found to be significant in a chi-square test to compare variance between groups (rc = 0.318, p < 0.01) (Table 4).

[Table 4 about here]

**Social Support**

Two tools were used to measure social support. The first, the MSPSS (Zimet et al., 1988) measures perceived social support available from family, friends, and significant others. In accordance with the current study’s hypotheses, we referred only to family support. To test the relationship between perceived family support and the level of STS among subjects, a total score of perceived support and a score of perceived support from family members of the researched were calculated. In order to test the relationship between perceived family support and the level of secondary traumatization among therapists, a total score of perceived support and a score for perceived support of family members were calculated. It was found that the total perceived support reported is relatively high (M = 6.08, SD = 0.73) as is perceived support from family members (M = 6.08, SD = 1.01) (see Table 5).

[Table 5 about here]

Using the second tool, the SSQ (Sarason et al., 1983), family support was found to be very high (M = 7.5, SD = 3.8), as was the therapists’ reported degree of satisfaction with the received support (M = 5.33, SD = 0.63). No statistically significant correlation was found between the average number of supporters and the degree of satisfaction with the support received, (r = .06, p > 0.05).

**Social Support and STS**

The next step of data analysis investigated the relationship between perceived overall social support, perceived family support, and STS. No statistically significant correlation was found between these variables. However, a low and significant negative correlation was found between satisfaction with received social support and the level of STS (p < 0.05). That is, those who reported high satisfaction with the amount of received support experienced less secondary traumatization (see Table 5).

**Family Status, Social Support and STS**

To assess the relationship between family status, social support, and the level of STS, we conducted a two-way ANOVA on two independent variables: family status and social support for the dependent variable STS. As shown in Figure 2, no correlation was found between these variables among unmarried therapists; their level of STS was high regardless of their degree of satisfaction with the amount of support they receive (around 45). In contrast, among married therapists, the degree STS changes such that when the degree of satisfaction with received support is low, the level of STS is high (around 42), and vice versa.

[Figure 2 about here]

**Discussion**

The purpose of this study was to examine the relationship between family status, social support, and the level of STS among therapists for sex offenders in Israel. Despite increased research over the past two decades on the impact that treating sex offenders has on therapists, with emphasis on the importance of marital and family support to reduce symptoms of STS, there has been virtually no reference to unmarried therapists of sex offenders. Family status is relevant to family-based social support, a resource that has been found to mitigate burnout and deterioration of the emotional state to the point of developing symptoms of STS (Elias & Haj-Yahia, 2016; Ennis & Horne, 2003; Severson & Pettus-Davis, 2013).

**Secondary Traumatization**

The present study found that 50.5% of the surveyed therapists of sex offenders in Israel reported low/moderate secondary traumatization (a score of up to 38 on the STSS) and 49.5% reported medium/high traumatization (38 and above). The most prominent symptoms among those who reported a medium/high level of STS were emotional numbness (Avoidance scale), sadness when thinking about work and thinking about patients when they don’t want to (Intrusion scale) and difficulty concentrating (Arousal scale). These findings indicate a more serious level of STS among this population than has been indicated by previous quantitative studies conducted among professionals who treat sexually abusive people, according to which a low percentage, if any, suffer from symptoms of STS (Hatcher & Noakes, 2010; Sheehy et al., 2009; Steed & Bicknell, 2001). This study verifies findings from qualitative studies that reported clear symptoms of STS among therapists in this field (Baum & Moyal, 2018; Moulden & Firestone, 2007; Youssef, 2017).

The present study focused on the therapists’ family status and compared the level of STS among therapists who are unmarried and married (with or without children). The findings show that the married therapists are less susceptible to STS than are the unmarried therapists (SD = 11.0637.6 vs. SD = 8.16 44.79, respectively). Moreover, among the unmarried therapists, medium/high levels of STS were found with a frequency of 85.7% (higher than the upper limit reported in the literature) compared to the married, among whom secondary traumatization was found with a moderate frequency of 43.9%.

These findings can be explained through the social support variable assessed in this study, with reference to the dating world. In the context of social support, and specifically support from spouses and family members, previous studies conducted in Israel found that therapists who said they refrain from “bringing their work home “ and sharing their work experiences with their partner, whether to protect their partners or to avoid criticism from them, experience greater isolation in their marriage (Rosenblum-Gitlis, 2016; Sharim, 2018). In contrast, other studies indicated that the marital relationship can be a significant source of inclusion, support, and reinforcement, and that therapists for sex offenders allow themselves to share openly and share their work-related difficulties with their partners (Kadambi & Truscott, 2003; Rosenblum-Gitlis, 2016; Rzeszutek et al., 2015). From this, it can be deduced that being unmarried makes therapists more vulnerable to STS due to the lack of a regular and safe response to their emotional needs (Argyle, 1999; Schoon et al., 2005). This is consistent with the current study’s finding that for married therapists there is a negative correlation between satisfaction with support and the level of STS, whereas among unmarried therapists, satisfaction with social support had no correlation with the level of STS.

In the context of “dating”, a review of research shows that consequences of treating sex offenders include the undermining of therapists’ thought schemes in relation to themselves and the world are undermined, and symptoms of arousal expressed in suspicion and vigilance in relation to the behavior of others (Baum & Moyal, 2020; Farrenkopf, 1992; Hatcher & Noakes, 2010). People looking for partners want an emotionally and sexually intimate relationship, however this can raise concerns and cause insecurity, feeling lack of control, and vulnerability (Ismail et al., 2007; Paynter & Leaper, 2016; Schoon et al., 2005). An example of this can be seen in the ways that two unmarried female therapists who participated in the study by Rosenblum-Gitlis (2016) described how their work with abusers affected their personal lives, how they relate to the men they know, and their inner fears: “I go on dates, people say something to me on a date and I am constantly checking -- are they really telling me the truth? Or are they manipulating me?”

In the current study, among the unmarried respondents, ten were women and four were men. It is likely that for unmarried female therapists, clinical practice with sex offenders (the overwhelming majority of whom are men) will undermine or impair their trust in “strange” men as a source of security and protection, and therefore harm their attempts to find a long-term romantic partner. Lack a permanent, stable relationship can diminish feelings of personal competence and being cared for (Ismail et al., 2007; Schoon et al., 2005).

**Social Support**

The present study did not find a correlation between the family status of therapists for sex offenders and the extent of their social support. Similarly, no correlation was found between their perceived support and level of STS. The literature review shows the importance of social support for therapists dealing with the consequences of their encounter with traumatic content (Ellerby, 1998; Levy, 2018; Pearlman & Saakvitne, 1995; Yassen, 1995). The present study found that the surveyed therapists reported a high level of perceived and received social support (including from spouses), regardless of family status. However, the findings also indicated a significant but weak negative correlation between satisfaction with received support and the level of STS among the therapists. These findings are consistent with the findings of previous studies in which therapists for sex offenders said they worry about reactions of disgust and rejection regarding their occupation from people in their social environment, which make them feel they must apologize for their professional choice and refrain from talking about their work (Elias, 2013; Idisis & Vered, 2010, Rosenblum-Gitlis, 2016). It is important to note that this finding was valid for married therapists only. Their level of STS remained high regardless of their satisfaction with social support.

**Strengths and Limitations of the Study and Suggestions for Further Research**

This was the first empirical study conducted in Israel – and to the best of our knowledge in the world – that quantitatively assessed the contribution of family status and social support to the level of STS among therapists for sex offenders. Its main contribution is in expanding the research field and knowledge regarding the specific population of unmarried therapists for sex offenders. The few references in the research literature to therapists’ family status has been in a limited number of qualitative studies. Therefore, we identified the population of unmarried therapists as requiring special attention variable for several reasons. First, in Israel, most therapists in this field are women, while the vast majority of sex offenders referred to correctional facilities and prison services are men. Professionals working in these settings often do not have a choice whether or not to treat the population of sex offenders. Therefore, in order to reduce the harmful consequences of treatment in this field, it is important to identify subgroups of therapists who may be particularly vulnerable to secondary traumatization. Appropriately directing support resources can help prevent attrition and dropout among therapists in the field of sex offender treatment, the demand for which is increasing over the years [REF].

A major strength of the study is the diversity in the population of therapists surveyed, which supports the ecological validity of the study. Data were collected from therapists for adult and juvenile sex offenders in public and private community and out-of-home settings. This differs from previously published quantitative studies on secondary traumatization among therapists, most of which focused on specific populations of therapists or services. This research therefore, enriches knowledge about the personal and environmental factors that impact on the level of STS among various types of therapists.

However, the study has several limitations. One is the sample composition and size. The sample was based on volunteers and contained few unmarried men and women (14 out of 91, approximately 16%). Additionally, most of those who were single were women (ten women and four men). This sample is too small to examine in-depth the gender differences regarding the impact of working with sex offenders on family status. Therefore, we recommended that future studies include a larger sample of single women, and a higher representation of men. It is also recommended to test this variable on samples in other countries to examine whether or not these findings are replicated in cultures with different emphases on the values and importance of the family.

A second limitation in assessing the variable of family status is related to the research design, a cross-sectional study which cannot answer the direction of the effect; that is whether family status affects or is affected by the work with sex offenders. A third limitation of this study is that the data was collected in 2020, during the Covid-19 pandemic. The social distancing and restrictions may have affected the findings with regard to the relationship between social support and secondary traumatization.

A fourth limitation pertains to the scope of the research variables. We did not take into account the influence of variables at the organizational level, such as peer support and training, which may shed light on the nature of the support therapists receive. Also, regarding family status, the nature of the marital relationship was not examined: there may be unmarried people who are in a strong intimate relationship, while some married people may be unsatisfied with the marital relationship. In future studies, it is recommended to specifically examine the existence of an intimate relationship and its nature, beyond the status of being unmarried or married. In addition, it is possible that the status of being “unmarried” was a proxy for the variables of age and seniority at work, which can explain the high levels of traumatization among singles and the lack of correlation with the level of social support.

**Recommendations for Application in Practice**

 The current study found high levels of secondary traumatization among about half of the sample subjects. This has critical implications for the training processes of social workers. The training processes must not be limited to mastering the knowledge and tools in the assessment and treatment of the population of sex offenders. It must also include exposure to and increased awareness of the phenomenon of secondary traumatization, its symptoms, and the factors that may exacerbate or mitigate them. There is a need for ongoing individual and group training to provide peer support and support to the individual therapists based on their distinct developmental needs.

The finding of a correlation between social support and levels of secondary traumatization among married therapists reinforces the need to increase the scope of their social and emotional support. The lack of correlation between the extent and availability of social support for unmarried male and female therapists and the extent of STS symptoms is also significant. It is possible that for this group of therapists, the difficulties related to this complex type of treatment are so great that support alone is not enough to prevent or minimize secondary traumatization. In this case, various comprehensive systemic and personal support measures must be offered to unmarried therapists in order to make it easier for them to treat the population of sex offenders. This recommendation is consistent with the suggestions made by Branson (2019) to reduce the development of vicarious trauma. First, Branson emphasized the importance of adhering to a regular and ongoing training process for therapists, veterans and novices alike. with time between treatments dedicated to reflection on the material covered in the session. In addition, Branson proposed holding dedicated training sessions that deal with vicarious trauma and vicarious traumatic growth (VTG) in order to increase awareness of the phenomenon and give therapists tools to cope. Branson called on supervisors to support to therapists in multiple ways such as giving them adequate vacations and mental health days, offering opportunities for promotion and development in various fields, helping them maintain a balanced workload, ensuring diversity in the type and severity of cases, and more.

The findings of the present study show that in addition to Branson’s recommendations for all therapists, special attention should be given to unmarried therapists. The research findings also show the significant power of support in reducing STS symptoms among married therapists. Providing multidimensional support is especially significant for single therapists in view of the research findings in relation to the avoidance scale. Avoidance and especially emotional numbness were found to be the most common symptoms among subjects who reported a moderate to high level of STS. In addition to the clear burden to the therapist, emotional numbness can interfere with a beneficial therapeutic process. Providing support can alleviate symptoms of avoidance as well as REF arousal, hence its importance.

In conclusion, we hope that our focus on unmarried therapists, recognizing the importance of giving therapists emotional support, developing supportive interventions, and increased awareness of symptoms of STS, will help therapists for sex offenders protect themselves and contribute to the usefulness of the therapeutic process for this complex population.

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**Table 1**

*Distribution of Secondary Traumatization Level (N = 91)*

|  |
| --- |
|  |
|  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid | 0-37 | 46 | 50.5 | 50.5 | 50.5 |
| 38-100 | 45 | 49.5 | 49.5 | 100.0 |
| Total | 91 | 100.0 | 100.0 |  |

**Table 2**

*Prevalence of the Total Score and Full Secondary Traumatization Stress Scale Among Therapists for Sex Offenders (N = 91)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SD | Mean | Maximum | Minimum | Variable |
| 4.4 | 15.1 | 28 | 7 | Avoidance |
| 3.5 | 11.3 | 20 | 5 | Arousal |
| 3.8 | 12.1 | 24 | 5 | Intrusion |

**Table 3**

*Differences in STS Level between Unmarried and Married Subjects (N = 91)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Unmarried N = 14** | **Married N = 66** | **Difference** |
| **Variable** | M | SD | M | SD | *t* |
| **STS** | 44.79 | 8.16 | 37.6 | 11.06 | 2.286\* |

\* p < 0.05

**Table 4**

*Correlation Between Level of STS and Family Status (N = 91)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | STS low/moderate | STS medium/high | X2 test |
| Family status |  |  |  |
| Unmarried N = 14 | 14.3% | 85.7% | X2 = 10.703, p < 0.01 |
| Married N = 66 | 56.1% | 43.9% |  |

**Table 5**

*Correlation Between Family Support and STS (Sarason et al.)*

|  |  |  |
| --- | --- | --- |
| Variable | Full STSS | STS level |
| Perceived support (number of supporters) | 0.029 | 0.028 |
| Perceived support from spouses and family members | 0.168 | 0.071 |
| Satisfaction with support | -0.216\* | -0.221\* |

\*p < 0.05

**Figure 1**

*Simple Bar Graph of Full STSS by Family Status*



**Figure 2**

*Average Difference of Satisfaction with Support Between Unmarried and Married Therapists*