Who Cares for the Therapist? Family Status, Social Support and Secondary Traumatization among Therapists for Sex Offenders

**Abstract**

Although there is a considerable literature about the distress of therapists who work with sex offenders, little, if anything, is known about whether differences in family status may affect their distress. Using online questionnaires, this research examined the levels of social support and secondary traumatization stress (STS) among 91 married and unmarried therapists of sex offenders in Israel. The findings indicate that unmarried therapists exhibit higher symptoms of secondary traumatization compared to married therapists, whether with or without children. A two-way ANOVA showed that the STS level among married therapists was high when their level of satisfaction with their social support was low. However, the STS level among unmarried therapists was high regardless of their level of satisfaction with their social support. These findings indicate the differential needs of therapists of sex offenders in the context of maintaining their psychological well-being according to their family status.

**Keywords**: Therapists for sex offenders, family status, social support, secondary traumatization

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**Introduction**

 *“Treating a sex offender 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 termed compassion fatigue or the cost of caring, is defined as an internal experiential process that becomes 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 not necessarily in 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 trauma 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 pertains to professional (work-related) factors, such as seniority and work experience, adequate training or guidance, caseload, workload, and uncertainty regarding expectations and role assessments (Raymond et al., 2023; 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 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, scarce studies have specifically examined unmarried therapists. The current study investigated three questions regarding: 1. whether unmarried therapists are more resistant or more vulnerable to STS compared to married therapists; 2. whether there is a relationship between therapists’ family status and the scope and availability of their social support; and 3. whether this social support affects STS symptoms.

**Literature Review**

Therapists treating sex offenders face higher risks of STS. Repeated exposure to graphic descriptions of sexual violence and delving into details of events that caused suffering and pain to victims, especially children, makes therapists vulnerable to STS and burnout (Catanese, 2010; Elias, 2013; Ennis & Horne, 2003; Sharim, 2018).

Sex offenders often exhibit self-centeredness, lack of empathy, manipulation, minimization or externalization of personal responsibility, and lack of internal change motivation), making it difficult for therapists to see their patients’ human side and possibly causing distrust and raising doubts regarding the offenders’ ability to change (Farrenkopf, 1992; Jennings & Deming, 2017).

The risk that the offensive behavior will recur requires that authorities intervene, supervise, and monitor sex offenders. This heavy responsibility rests mainly on therapist working with offenders who must 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 contribute to burnout (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, there is evidence of psychosomatic reactions such as fatigue, difficulty sleeping, or headaches (Elias & Haj-Yahia, 2016). Long-term cumulative responses include emotional flooding and difficulty disconnecting from work, nightmares, and intrusive thoughts related to the treatment or to incidents of sexual abuse (Pearlman & MacIan, 1995; Sharim, A. (2018).).

Therapists report symptoms of hyperarousal and hypervigilance due to fears that their patients will continue their abusive behavior (Raymond et al., 2023), suspicion and vigilance regarding other people’s behavior, and reluctance to enter potentially dangerous situations (Cunningham, 2003). They also 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 distorted 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., 2010; 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). Degrees of social support, particularly marital and family support, significantly affects 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 can be tangible or abstract, including helping others, shielding them from the negative effects of stressful life events and providing them 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. The former refers to helpful actions performed by others (Barrera, 1986), while the latter 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 important in reducing loneliness and anxiety and in increasing feelings of belonging and self-esteem (Heany & Israel, 2002; Schönenberg et al., 2014;).

Perceived support does not always correspond with the actual support received. Even if support does meet expectations, the recipient might consider it insufficient. A study from Poland among 80 trauma therapists found a negative correlation between STS and perceived social support, while received social support had no impact on STS levels (Rzeszutek et al., 2015). These findings are consistent with Robinaugh et al.’s (2011) claim that poor perceived social support, not received support, correlates with the PTSD symptoms’ severity.

In any event, it seems apparent that stronger social support is more beneficial to individuals in stressful situations (Goodwin et al., 2004). As earlier described, it has been found that therapists with a poor social support system are at significantly greater risk for developing STS. Some studies indicate that sex offender therapists experience exclusion and isolation in the public, marital, and professional spheres due to their work (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 Israel’s adult probation services, subjects reported experiencing criticism, disdain, and rejection due to their work, as well avoiding sharing, even with their spouses, the complex reality of treating this population (Sharim, 2018). Another qualitative study conducted in Israel interviewed 15 youth probation officers who work with sexually abusive minors (Rosenblum-Gitlis, 2016). Some said they prefer not to share what goes on in the therapy with their spouses, while others described their marital relationship as a significant source of support and reinforcement. Another quantitative study found that marital support mitigated the negative consequences of working with sex offenders (Kadambi & Truscott, 2003). These findings about spouses and family members’ supportive role 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 stress (STS) among therapists for sex offenders in Israel. The three research hypotheses were: 1) There will be differences between the level of STS among married vs. unmarried therapists; 2) There will be differences between therapists’ family status and their reported level of social support; and 3) Social support reduces symptoms of STS differently among unmarried and married therapists.

**Methods**

**Participants**

The study population included a sample of 91 social workers, psychologists, and criminologists involved in the diagnosis and treatment of juvenile and adult sex offenders. Of these, 80% were social workers and 12% were clinical criminologists. Sixty percent of them were women and 40% were men. Their ages ranged from 25 to 89 (mean 42.6, SD 11.5). Seventy-three percent were married, 15% unmarried, and 12% divorced. Seventy-five percent of the participants were parents, with an average of two children (SD 0.56). About one-third (31%) held a bachelor’s degree, two-thirds (64%) held a master’s degree and 5 % held a PhD. Participants had between one and 55 years of experience in the profession (M =14.4, SD = 11.2). Sixty percent (60%) treated sex offenders in community settings and forty percent (40%) in institutional settings, such as closed dormitories for juveniles, prisons, and probation hostels for adults. Forty-eight percent (48%) treated only sexually abusive minors, forty-two percent (42%) treated only adults, and ten percent (10%) treated both minors and adults.

**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 regarding educational level, profession, place of work, seniority, years of experience in diagnosing/treating 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.

According to Bride et al. (2004), two approaches are recommended for interpreting individuals’ responses on an instrument of this sort. The first involves creating categories based on the following levels of STS: no or low STS (less than 28); mild STS (28 to 37); moderate STS (38 to 43); high STS (44 to 48) and severe STS (49 and above). Another approach is establishing a cutoff value whereby individuals scoring at or above the cutoff score of 38, which represents the lower threshold of the moderate range, are considered to have STS-induced PTSD. Our study demonstrated a Cronbach’s alpha internal consistency reliability of .87, indicating strong internal reliability.

***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). To calculate the index for each subscale and the general index of Perceived Social Support, we calculated the average of the relevant items. Our study demonstrated a high Cronbach’s alpha internal consistency reliability (α = 0.91).

***Social Support Questionnaire – Short Version***

The Social Support Questionnaire short version (SSQ6) developed by Sarason et al. (1983) examines two conceptually distinct aspects of perceived support: availability and satisfaction. Availability is the estimated number of people the respondents feel they can turn to when assistance is needed. 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 express their level of satisfaction regarding 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). N ranges from 0 to 54 and S ranges from 6 to 36. Priel and Shamai (1995) translated SSQ6 into Hebrew. The internal consistency reliability of Cronbach’s alpha in the current study for the number of supporters was .88, and for satisfaction with support, .92.

**Procedure**

The study sample was recruited by a convenience sampling. Requests for participation were submitted to Israel’s probation services , the Youth Protection Authority, the Prisoner Rehabilitation Authority, and the Israel Prison Service’s sex offender treatment department. Those who agreed to participate signed a consent form and received an online questionnaire. The participants did not receive compensation for taking part in the study. Confidentiality and anonymity were guaranteed. The research was approved by the ethics committee of Zefat Academic College (No. 3/2020) and the Ministry of Welfare and Social Security.

**Data Analysis**

Data Analysis was conducted using SPSS version 28. Analyses included Chi-Square correlation, independent sample T-test, and two-way ANOVA.

**Results**

**Secondary Traumatization among Therapists for Sex Offenders**

The total score of STS in the sample (n=91), showed a normal distribution, with an average score of 38.56 (SD = 10.4). According to the data, about one-half (50.5%) of the therapists reported a mild level of secondary traumatization (up to 37) and nearly one-half (49.5%), a moderate-high level of secondary traumatization (38 and above). 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).

Analysis of the symptoms according to these scales revealed that the most prominent symptoms among those who experienced a moderate to high level of secondary traumatization (up to 38) 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 Stress (STS) and Family Status**

In the second stage of the data analysis, we examined the total score of STS among unmarried (n = 14) and married (n = 66) therapists. Divorced therapists were not included, as the study examined differences between single and married therapists. No significant difference was found between therapists with or without children. Married therapists exhibited fewer symptoms of STS (M = 37.6) than did unmarried therapists (M = 44.79), which is statistically significant (t(89) = 2.286, p < 0.05), thus supporting H1. See Table 1.

[Table 1 about here]

Additionally, an analysis of STS level was conducted according to two levels: low-mild vs. moderate-high, and married vs. unmarried subjects. Moderate-high levels of STS, 85.7%, were found among the unmarried therapists, compared to 43.9% among the married therapists. These differences were found statistically significant in a chi-square test comparing variance between groups ($χ\_{(1)}^{2}$= 8.06, p < 0.01).

**Social 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. It was found that the total perceived support reported is relatively high (M = 6.08, SD = 0.73), as is the perceived support from family members (M = 6.08, SD = 1.01); additionally, the therapists’ reported degree of satisfaction with the received support was also high (M = 5.33, SD = 0.63). See Table 1. No significant differences were found between married and unmarried therapists in family support, friend support, significant others support, social support, or number of supporters. Married therapists exhibited greater satisfaction with support (M=5.40) than did unmarried therapists (M=5.13), which is marginally significant (t(89) = 1.876, p < 0.06), thus partially supporting H2.

**Family Status, Social Support and Secondary Traumatization Stress (STS)**

To examine the hypothesis that social support reduces symptoms of STS differently for unmarried and married therapists, we conducted a two-way ANOVA on two independent variables: family status and social support, with the dependent variable being STS. As shown in Figure 1, no differences were 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), F (1,76) = 1.01, P>0.05. In contrast, among married therapists, the degree of STS changes is such that when the degree of satisfaction with received support is low, the level of STS is high (around 42), F (1,76) = 3.69, P<0.05. No interaction was found between family status and satisfaction, (F (3,76) = 0.63, P>0.05), thus partially supporting H3.

[Figure 1 about here]

**Discussion**

**Secondary Traumatization**

The present study found that about half (50.5%) of the surveyed therapists of sex offenders in Israel reported mild secondary traumatization (a score of up to 38 on the STSS) and nearly half (49.5%) reported moderate/high traumatization (38 and above). These findings indicate a more serious level of STS among this population than has been indicated by previous quantitative studies conducted among therapists who treat sexually abusive people that have found that a low percentage, if any, suffer STS symptoms (Hatcher & Noakes, 2010; Sheehy et al., 2009; Steed & Bicknell, 2001).

The present study focused on the therapists’ family status and compared the level of STS among unmarried and married therapists (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%.

Two possible explanations for these findings relate to married and unmarried therapists. In the context of social support, specifically from spouses and family members, some studies have indicated that the marital relationship can be a significant source of inclusion, support, and reinforcement, and that therapists for sex offenders openly share their work-related difficulties with their partners (Kadambi & Truscott, 2003; Rosenblum-Gitlis, 2016; Rzeszutek et al., 2015). Thus, 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 this study’s finding that among married therapists, there is a negative correlation between satisfaction with support and the STS level, whereas among unmarried therapists, satisfaction with social support had no correlation with the STS level.

In the context of “dating,” people seeking partners want an emotionally and sexually intimate relationship; however, this can cause worries and insecurity, and feelings of lack of control and vulnerability (Ismail et al., 2007; Paynter & Leaper, 2016; Schoon et al., 2005). An example of this can be seen in how two unmarried female therapists participating in Rosenblum-Gitlis (2016)’s study 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?”

Among the current study’s 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 thus harm their attempts to find a long-term romantic partner. Lacking 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 (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 therapists’ level of STS. These findings are consistent with those of previous studies in which sex offender therapists said they worry about reactions of disgust and rejection toward their occupation from people in their social environment, which make them feel a need to 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 applied to married therapists only, whose STS level 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. Only a limited number of qualitative studies refer to therapists’ family status. Therefore, we identified the variable of the population of unmarried therapists as requiring special attention for several reasons. For example, 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. Therapists working in these settings often have no choice about treating sex offenders. Therefore, 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 sex offender therapists, the demand for which is increasing over the years (Dreier & Wright, 2011; Severson & Pettus-Davis, 2013).

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 affect the level of STS among various types of therapists.

**Study Limitations and Recommendations for Application in Practice**

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 unmarried were women (ten women and four men). This sample is too small to examine in-depth the gender differences with respect to the effect of working with sex offenders on family status. Therefore, we recommended that future studies will include a larger sample of unmarried women and a higher representation of men. It is also recommended to test this variable on samples in other countries to examine whether these findings are replicated in cultures with different emphases on family values and importance. 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. 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 unmarried and the lack of correlation with the level of social support.

 The current study has important implications for the training processes of therapists. The finding indicate that training processes should increase awareness of the phenomenon of secondary traumatization, its symptoms, and the factors that may exacerbate or mitigate them. Ongoing individual and group training is needed to provide peer support and support to the individual therapists based on their distinct developmental needs. This recommendation is consistent with the suggestions made by Branson (2019). Providing multidimensional support is especially significant for unmarried therapists in view of the research findings.

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 to protect themselves, thereby enhancing the usefulness of the therapeutic process for this complex population.

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