



Received: 02 October 2018  
Accepted: 11 March 2019  
First Published: 17 March 2019

\*Corresponding author: Courtney T. Evans, Department of Counselor Education and Family Studies, Liberty University, 1971 University Blvd, Lynchburg, VA 24515, USA  
Email: [cevans75@liberty.edu](mailto:cevans75@liberty.edu)

Reviewing editor:  
Heng Choon (Oliver) Chan,  
Department of Applied Social  
Sciences, City University of Hong  
Kong, Hong Kong

Additional information is available at  
the end of the article

## LAW, CRIMINOLOGY & CRIMINAL JUSTICE | REVIEW ARTICLE

# Counseling sex offenders and the importance of counselor self-care

Courtney T. Evans<sup>1\*</sup> and Courtney Ward<sup>2</sup>

**Abstract:** Sex offender treatment is a process by which offenders learn special strategies for stopping abusive behavior and taking responsibility for harm done. Such mental health treatment is vital for offenders of sexual crimes. Most sex offenders do eventually return to the community. Sex offense counseling is also important in order to reduce recidivism rates. The purpose of this literature review is to discuss possible impacts for counselors working with sex offenders and to highlight the importance of counselor self-care when working with this population.

**Subjects:** Mental Health; Mental Health Research; Counseling Techniques & Intervention; Trauma Counseling - Adult; MentalHealth

**Keywords:** sex offender; mental health; counseling; burn-out; self-care

Sex offenders are individuals who are convicted of a sexual offense. According to the Federal Bureau of Investigation Criminal Justice Information Division, sexual offenses include indecent exposure, incest, statutory rapes, and attempts (U.S. Department of Justice, 2011). Illegal sexual behavior is different from most other illegal behavior in that it may occur in the contact of a strong, biologically mediated drive (Saleh, Grudzinskas, Malin, & Dwyer, 2010). The etiology of sexual offender behaviors is extremely complex and multifaceted (Calley, 2007). Past studies have found histories of childhood sexual abuse and deprivation in the histories of sex offenders (Allen, 1991; Matthews, Matthews, & Speltz, 1989; Strickland, 2008). Most sex offenders assault their victims for reasons that are complicated and hidden behind a facade (Office for Victims of Crime, 2011).

In general, the term sex offender can elicit fear and anxiety from the public. The perceptions, attitudes, and experiences of sex offenders inevitably affect counselors work (Lea, Auburn, & Kibblewhite, 1999). Previous studies have examined the effects of treatment delivery through various methods, such as focus groups, surveys, and anecdotal accounts of counselor experiences



Courtney T. Evans

### ABOUT THE AUTHORS

Courtney T. Evans, PhD, LPC, NCC, ACS, RPT is Assistant Professor of Counseling at Liberty University, in the Department of Counselor Education and Family Studies.

Courtney Ward-Sutton, PhD is a Post-Doctoral Research Fellow at the Advanced Rehabilitation Research and Training (ARRT) Program, situated within the Rehabilitation Research and Training Center (RRTC) on Research and Capacity Building for Minority Entities at Langston University. The research reported in this paper relates to wider research interests concerning counseling best practices and counselor self-care.

### PUBLIC INTEREST STATEMENT

Mental health treatment is vital for offenders of sexual crimes. Sex offense counseling is important in order to reduce recidivism rates. Such treatment is a process by which offenders learn special strategies for stopping abusive behavior and taking responsibility for harm done (Stop It Now, n. d.). Most sex offenders do eventually return to the community (Kersting, 2003). The purpose of this literature review is to discuss possible impacts for counselors working with sex offenders and to highlight the importance of counselor self-care when working with this population.

(McCulloch & Kelly, 2007). The specific effects identified across previous research studies are diverse due to the array of practitioners, working in different roles, contexts, and delivery of treatment in different settings (Lea, Auburn, & Kibblewhite, 1999). Over the years the treatment of sex offenders has become a high priority (Lea, Auburn, & Kibblewhite, 1999). Counseling professionals, who provide treatment to those who have committed a sexual offense, can be considered critical members of the counseling occupation (Barnett, 2011). It has been reported that providing such treatment generally has detrimental effects on counselors (Elias & Haj-Yahia, 2019; Kadambi & Truscott, 2003). Changes to the specific types of thoughts counselors have about themselves, others and the environment, problems in romantic relationships, changes in sexual activity or arousal, and depression are all effects reported by counselors who provide treatment to sexual offenders (Dean & Barnett, 2011). As a result, understanding self-care factors that influence the well-being of counselors while delivering treatment is an important area of research in order to keep counselors safe, resilient, and ultimately satisfied in the valuable work they do. Given the potential consequences of this work, such literary reviews are important in informing the responsible management of counselor self-care while providing treatment for sex offenders.

### 1. Statistics

Every 98 seconds, a person experiences sexual assault. Men, women, and children can all be affected by sexual violence. One in 33 American men have experienced or completed rape in their lifetime. One out of every six American women has been the victim of an attempted or completed rape in her lifetime. The majority of child sexual violence victims are between the ages of 12 and 17. Of the childhood victims 34% have experienced sexual assault and rape under the age of 12, and 66% between the ages of 12 and 17.

Research shows that sex offenders differ significantly by race, age, gender, and socioeconomic class (Office for Victims of Crime, 2011). Sex offenders represent a diverse group and cannot be seen to constitute a specific type of person. When exploring sex offender's age demographics 50% are 30 years of age and older, 25% are between 21–29 years old, 9% are 18–20, and 15% are 17 or younger. In regard to race, 57% of sexual offenders are identified as White, 27% as Black, 8% as unknown ethnicity, 1% mixed group, and 6% other. There are 293,066 victims of sexual assault and violence in America per year (Rape, Abuse, & Incest National Network, 2009). The majority of sexual assault victims are under the age of 30.

Sex crimes are unfortunately fairly common across the United States; however, sex offenses represent less than 1% of arrests. Many victims do not report sexual offenses to authorities for a number of reasons which include fear of abuser, fear of blame, feelings of shame, guilt, and embarrassment. Thus, there are a number of victims and offenders in the community who have not come to the attention of authorities. For individuals who choose to report sex offenses courts impose different sentences depending on the offender, the facts of the case, and the state's law. Some offenders are sentenced to prison or jail, while others are sentenced directly to community supervision (e.g. probation). For those sentenced to prison or jail, some are released on parole or probation supervision while others are released with no supervision. Approximately 150,000 adult sex offenders are currently in state and federal prisons throughout the United States. Between 10,000 and 20,000 are released to the community each year (Center of Sex Offender Management).

### 2. Purpose statement

The purpose of this literature review is to discuss possible impacts for counselors working with sex offenders and to highlight the importance of counselor self-care when working with this population. As high priority is given to the treatment of sex offenders within recent years, more and more counselors are becoming involved in the treatment of this group of offenders. To date, there is a small body of literature in this area exploring counselors' self-care when working with sex offenders. We know little about the specific impact of conducting treatment with sex offenders can have on counselors (Dean & Barnett, 2011). In developing the literature review a better

understanding of the effects experienced by counselors can be used in tailoring support systems to protect, maintain, and enhance counselors' self-care. Moreover, understanding such factors can impact upon the effects of crucial treatment that counselors provide for sex offenders, and their responsibility to maintain their own well-being of self-care.

### 3. Counseling for sex offenders

Sex offense counseling can be defined as "providing face-to-face evaluation and counseling to pre-sentence or convicted sex offenders in jails, prisons, or community treatment centers" (Dreir & Wright, 2011, p. 360). Sex offender treatment is a process by which offenders learn special strategies for stopping abusive behavior and taking responsibility for harm done; a central focus of treatment is to help an individual create a better life for him/herself by developing strengths and managing their risks (Stop It Now, n. d.). Such mental health treatment is vital for offenders of sexual crimes. Most sex offenders do eventually return to the community, underscoring the need for efficacious treatment prior to such homecoming (Kersting, 2003). Sex offense counseling is also important in order to reduce recidivism rates.

### 4. Recidivism rates

Statistics shows that the likelihood of sex offenders' recidivism (the re-offense of sexual assault) in general is around five percent (Office for Victims of Crime, 2011). A study by Sample and Bray (2003) found that, at a three-year follow-up, there was a 5.3% sexual recidivism rate among the sample; However, violent and overall arrests were much higher, with 38.6% of sex offenders in the study returning to prison within three years due to a commission of a new crime. The statistical analyses in the study also showed that sex-crime rearrests rates were four times higher for sex offenders than the sex crime rearrests rates for non-sex offenders (five versus one percent) (Sample & Bray, 2006).

For rapists specifically, at a three year follow up, there was an 18.7% recidivism rate for violent crime, and a 46% recidivism rate for the commission of any crime (Harris & Hanson, 2004). Research shows that sexual recidivism was at 14% at a five year follow up, 21% at a ten year follow up, 24% at a 15 year follow up among one sample (Harris & Hanson, 2004), and at 39% at a 25 year follow up among another sample (Prentky, Lee, Knight, & Cerce, 1997). This seemingly indicates that the category of offenders who engaged in "rape" may have higher sexual recidivism rates than sexual offenders in general while also suggesting the sexual recidivism rates increase across the span of time.

A study by Langan, Schmitt, and Durose (2003) also analyzed "child molesters" specifically as a category in their sample; it was reported that child molesters are more likely than any other type of offender (sexual or non-sexual) to be arrested for a sex crime against a child following release from prison. When looking at "child molesters" sexual recidivism rates, it was found that about five percent had committed a new sex crime at a three year follow up (Harris & Hanson, 2004). This is the same as the sexual recidivism rates for sex offenders in general. However, Prentky et al. (1997) reported that the lifetime sexual recidivism rate for child molesters may be as high as 52 percent.

Mental health services such as counseling may decrease recidivism rates. In fact, research shows that failure to develop sound interventions may ensure that the offending behavior will continue (Calley, 2007), thus indicating the importance of efficacious mental health treatment for sexual offenders. It has been suggested that the vast majority of adults and juveniles who have committed a sex offense, treatment significantly reduces the future risk of sexual recidivism (Stop It Now, n. d.). A meta-analysis by Hanson, Gordon, and Harris (2002) reveals a significant difference between recidivism rates for sex offenders who were treated (9.9%) versus those who were not (17.3%). Such research backs up that modern treatment (i.e. professional counseling) lowers recidivism rates. Mental health treatment is also beneficial to the sex offender, in that judges often base release conditions on progress reported from prison psychologists (Kersting, 2013).

## 5. Types of mental health treatment

While traditionally, counseling has been more focused on the victims of sexual abuse (Wolfe, 1990; Russell, 1986), over the years the public has increased spending for rehabilitation of sex offenders, now willing to pay higher taxes for policies calling for civil and regulatory interventions for sex offenders (Easterly, 2014). Such treatment is offered by trained therapist who specialize in working with youth and/or adults with sexual behavior problems (Stop It Now, n. d.). Currently across the nation, there are about 2, 350 therapists whom provide court ordered counseling for sex offenders (TIME, 2018).

Some treatment may exist while the offender is in prison and others may begin or continue once the offender is released or has served time. It is crucial to start therapy for sex offenders as soon after incarceration as possible, as offenders often fail to realize the severity of their crime and attitudes that lead to reoffending can become stronger in prison and explanations for their own actions solidify over time (Kersting, 2003). In regard to treatment effectiveness, most statistics are focused on recidivism rates among sex offenders in treatment, and do not differentiate between what type of counseling took place.

There is no one standard treatment for sex offenders, however, experts do say that this population should receive sex offender counseling and not sex addiction counseling (TIME, 2018). Group therapy tends to be the treatment of “best practice” in the field of sex offender counseling, with group dynamics becoming a focal point of treatment (Hubbard, 2014). Individual therapy can also benefit sex offenders. Whichever the format, therapy for sex offenders is complex, as factors such as co-occurring disorders, addictions, cognitive distortions, and the potential for criminogenic behavior all come into play; the ultimate goal of sex offender treatment is relapse prevention (Hubbard, 2014).

While traditional psychotherapy seeks to reduce feelings of anxiety and inadequacy, sex offender therapy seeks to confront the offender with thinking errors, promoting accountability and acceptance for actions (Hubbard, 2014). Thus, therapy for this population has been, and continues to be, provided from a cognitive behavioral perspective, with an emphasis on containment of the offender and risk management rather than “curing the problem” (Dreir & Wright, 2011). A holistic cognitive behavioral therapy approach for sex offenders would include cognitive restructuring, attention to victim empathy, social skills development/improving social competence, accepting responsibility and modifying cognitive distortions, controlling sexual arousal, developing relapse-prevention strategies, and establishing supervision conditions and networks (Center for Sex Offender Management, 2017; Saleh et al., 2010).

A holistic approach to therapy based on Adlerian theory may also be applicable to working with sex offenders, as it emphasizes social interest, responsibility, and feelings of inferiority and superiority (Garrett, Oliver, Wilcox, & Middleton, 2003; Jennings & Sawyer, 2003; Levenson & Macgowan, 2004). Furthermore, Adler believed sex offenders lack social interest and suggested that when someone is not prepared to confront their problems, they will try to gain distance from them by developing safeguarding behaviors and private goals of wanting superiority over victims to make up for feelings of inferiority (Adler, 1976, 2007). This allows for the discovery of mistaken beliefs sex offenders may possess (Adler, 2007) as well as the opportunity to explore how and why sex offenders’ behaviors are developed (Johnson & Lokey, 2007). Lifestyle assessment can aid in identifying the ways sex offenders’ can change distorted beliefs and deviant sexual behaviors to live a healthier lifestyle (Adler, 2007; Johnson & Lokey, 2007).

Many other theories can be used to guide sex offender treatment, depending on the theoretical orientation of the therapist; However, it should be highlighted that the client-therapist relationship is an integral part of therapy (Levenson & Macgowan, 2004). Researchers have also found that the relationship with the therapist and group members promotes successful treatment for sex offenders (Garrett et al., 2003; Jennings & Sawyer, 2003; Levenson & Macgowan, 2004). Engagement in

the therapy process is also positively correlated with treatment progress while denial is negatively correlated with achieving therapy goals (Levenson, Brannon, Fortney, & Baker, 2007; Levenson & Macgowan, 2004). Such correlations underscore the importance of client engagement through rapport building.

## 6. Counselors working with sex offenders

Sexual offender treatment is a specialized area of counseling with various subspecialties within the specialty (i.e. private practice, mental institutions, post-prison supervision, etc.) (Hubbard, 2014). A great deal of counselors elect not to work with this population and many professionals have left the field of sex offender treatment and management because the impact working with sexual abuse cases has had on their own lives (Anechiarico, n.d.). Working with sex offenders can be challenging, one reason being that they may oftentimes not disclose all of their crimes and/or sexually deviant thoughts (Kersting, 2003).

Several states have passed legislative measures to limit sex offender treatment to mental health professionals who are specifically licensed to work with sex offenders, sometimes even making it illegal for other mental health professionals to work with sex offenders (Jensen & Jewell-Jensen, 1998; Texas House of Representatives, n.d.). Any counselor working with sex offenders should take part in education and training that will help them become more trained and skilled in working with this population. Certification is an important part of becoming credentialed to work with this population and ensures competence. Certification validates an individual's qualifications and knowledge to practice in a defined area and creates an identifiable workforce to which the criminal justice system can refer (National Association of Forensic Counselors, 2017).

The Association for Treatment of Sexual Abusers (ATSA) is an international, multidisciplinary association with an overarching goal of making society safer by preventing sexual abuse (Association for Treatment of Sexual Abusers, 2017a). This association was founded to identify a competent workforce to counsel, evaluate, supervise, and manage criminal offenders in the areas of addiction, criminal justice, mental health, and corrections; the association also promotes competency, training, and improved communication between the clinician and the criminal justice system (National Association of Forensic Counselors, 2017). The organization promotes effective assessment, treatment, and management of those who have participated in sexually abusive behaviors or are at risk for such (ATSA, 2017a). The National Association of Forensic Counselors (NAFC) also exists, in which certifications for a Certified Sex Offender Treatment Specialist (CSOTS) and a Certified Juvenile Sex Offender Treatment Specialists (CJSOTS) are offered for those professionals who have completed at least 270 hours of formal training and 6000 hours of supervised experience in the area which they are applying for certification (National Association of Forensic Counselors, 2017). Obtaining such training is integral in that it provides specialized knowledge to the counselor which can aid in effective treatment.

For sex offenders, receiving treatment may not be an easy task. Long waiting lists and shortages of providers with this specialized knowledge have been reported. For example, reports by Montana State Prison report that although sex offender treatment there has been shown to cut the offender's risk to reoffend in half, has an extremely long waiting list, sometimes with hundreds at a time on it (Bermes, 2016). Shortages have also been identified from other sources (Evans, 2014; Texas Juvenile Probation Commission, 2011). The Association for Treatment of Sexual Abusers provides a portal on their website to submit referral requests in order to find treatment providers by specialization and location (ATSA, 2017b).

It is important to understand that clients tend to have better outcomes when counselor case-loads are low (McCaughrin & Price, 1992; Woodward, Das, Raskin, & Morgan-Lopez, 2006), possibly suggesting that overworked counselors are less effective. Due to complex factors often associated with sex offender treatment such as co-occurring disorders, addictions, cognitive distortions, and the potential for criminogenic (Hubbard, 2014), counselors working with this population may

should consider maintaining a caseload of clients that they feel comfortable with. This will help to monitor against feeling overwhelmed which can quickly lead to burnout.

### **7. Possible impact on counselors**

Few client populations present as many personal and professional challenges to therapists as sex offenders (Kadambi & Truscott, 2003). This can be because oftentimes, counselors are required to engage in traumatic material in graphic detail while maintaining an empathic relationship with the client (Moulden & Firestone, 2007). Oftentimes, perpetrators/offenders of sexual abuse are in denial or demonstrate little or no remorse for their abusive behavior, which may exacerbate the impact on the counselor (Ennis & Horne, 2003; Roseman, Ritchie, & Laux, 2009). There has been discussion and increased awareness regarding the potential psychological harm caused by exposure to the trauma of others (Anechiarico, n.d.). Research has shown that counselors working with victims or offenders of sexual abuse are likely to experience vicarious trauma or burnout at some point during their careers (Hatcher & Noakes, 2009; Kadambi & Truscott, 2003; Levenson, 2014; Moulden & Firestone, 2007).

Professionals working with victims or offenders of trauma have the potential to be deeply affected by the stories and images to which they are exposed; longer, more severe exposure, personalities, and personal issues (when left unresolved), can greatly increase this risk (Catanese, 2010; Chassman, Kottler, & Madison, 2010; Dreir & Wright, 2011). Compassion fatigue is a term that encompasses burnout and secondary traumatic stress. To explain further, “when experiencing burnout, you may feel exhausted and overwhelmed, like nothing you do will help make the situation better” (SAMSHA, 2014, p. 1). Secondary traumatic stress occurs when the negative effects of helping make individuals feel like the trauma of the people they are helping is happening to them or their loved ones (SAMSHA, 2014, p. 1). Vicarious trauma takes this a step further; when secondary traumatic stress symptoms go on for long periods of time, they can develop into vicarious trauma (SAMSHA, 2014).

The term vicarious trauma is associated with the “cost of caring” (American Counseling Association, n.d.; Cosden, Sanford, Koch, & Lepore, 2016). Vicarious trauma a state in which the individual becomes tense and absorbed with the traumatic stories/experiences described by clients; counselors may experience such tension in several ways including being in a continued state of arousal and/or becoming numb and avoiding talking or thinking about the stories/experience their clients’ shared (American Counseling Association, n.d.). Vicarious trauma can include an array of symptoms including: having difficulty talking about feelings, worried that they are not doing enough for their clients, diminished interest in things enjoyed previously, diminished feelings of satisfaction/personal accomplishment, low motivation, blaming others, feelings of hopelessness associated with work and/or client, changes in appetite, hypervigilance, depression, anxiety, suspiciousness, anger/irritability, intrusive thoughts, nightmares, and isolation (Adams & Riggs, 2008; Moulden & Firestone, 2007). Vicarious trauma can also affect behavior, interpersonal relationships, personal values/beliefs, and job performance of counselors (American Counseling Association, n.d.). Professional experience, treatment setting and coping strategies employed by the counselor are also associated with symptoms of vicarious traumatization when working with sex offenders (Moulden & Firestone, 2007).

### **8. Discussion and conclusions**

It is important for counselors to be self-reflective regarding signs and symptoms of burnout and to engage in self-care activities for prevention and alleviation. Counselor self-care can be defined as the actions that a counselor may take in order to teach optimal physical and mental health (Goodtherapy.org., 2017). For counselors, such self-care can refer to engaging in activities that promote emotional well-being and alleviate feelings of burnout (e.g. meditating, mindfulness, journaling, counseling, and self-compassion) (Hall et al., 2017). Counselors’ extended failure in engaging in self-care can result in emotional exhaustion, stress, and burnout (Thompson, Frick, & Trice-Black, 2011).

Due to the fact the counselors face unique challenges in sex offender treatment (Prescott & Wilson, 2012), it is important for counselors to engage in self-reflection, supervision, and processing/debriefing when engaging with this population (Catanese, 2010; Chassman et al., 2010). Increased self-awareness, self-reflection, and self-care is essential (Moulden & Firestone, 2010). It is necessary to develop such protective protocols in order to protect health professionals from being harmed by the work they do (Anechiarico, n.d.). It has been recommended that counselors receive quality supervision in an environment that facilitates closeness and support (Dreir & Wright, 2011).

Also, appropriate self-care strategies are important in order to combat possibilities of burnout and vicarious trauma. Keeping a sense of balance and implementing coping strategies such as diversifying work roles, avoiding media content involving sex abuse, appropriate humor, and exercise are important to prevent burnout (Dreir & Wright, 2011). Wellness can be achieved and maintained by recognizing warning signs and not being ashamed of them; warning signs include feeling irritated about clients, experiencing a low level of energy, having problems develop at home, viewing the world and the people in it as unsafe and losing your sense of humor (Shallcross, 2011). Tips for coping with compassion fatigue (burnout and secondary traumatic stress) and vicarious trauma include: getting adequate sleep; good nutrition; regular physical activity; active relaxation (e.g. yoga or meditation); staying hydrated; basic hygiene; washing up to “wash away your workday” (symbolic “washing away” of hardness of the day); consultation; supervision; spirituality; religion; taking time away from work; creating individual ceremonies or rituals (e.g. writing down things that bother you and getting rid of them as a symbolic goodbye); spending time with family, friends, and loved ones; trying to find things to look forward to; etc. (SAMSHA, 2014).

Mental health treatment is imperative for the offenders of sexual crimes, although a great number of counselors elect not to work with this population, for reasons including the impact it has on their own lives (Anechiarico, n.d.). As such, discussing counselor self-care, for all counselors...but specifically for this group of counselors, it an important conversation to have. Counselors should gauge their own personal symptoms that could point to counselor burnout. A variety of self-care strategies (e.g. self-reflection, supervision, processing/debriefing (Catanese, 2010; Chassman et al., 2010) and specific coping strategies (SAMSHA, 2014) were highlighted that can be implemented to reduce chances of emotional exhaustion, overwhelming stress, and burnout. Such protective protocols are vital to continue the growth and to continue the services provided in this field. It is also important to note that although research reveals many challenges for therapists when working with sex offenders, this is not to undermine the statistics that also report the rewards and professional fulfillment reported among counselors working in this field (Slater & Lambie, 2011).

#### Funding

The authors received no direct funding for this research.

#### Author details

Courtney T. Evans<sup>1</sup>

E-mail: [cevens75@liberty.edu](mailto:cevens75@liberty.edu)

ORCID ID: <http://orcid.org/0000-0002-9479-9030>

Courtney Ward<sup>2</sup>

E-mail: [courwar@langston.edu](mailto:courwar@langston.edu)

ORCID ID: <http://orcid.org/0000-0002-9479-9030>

<sup>1</sup> Department of Counselor Education and Family Studies, Liberty University, Lynchburg, VA, 24515, USA.

<sup>2</sup> Rehabilitation Counseling, Langston University, Langston, OK 73050, USA.

#### Citation information

Cite this article as: Counseling sex offenders and the importance of counselor self-care, Courtney T. Evans & Courtney Ward, *Cogent Social Sciences* (2019), 5: 1595878.

#### References

- Adams, S. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology, 2*, 26–34. doi:10.1037/1931-3918.2.1.26
- Adler, A. (1976). Individual psychology and crime. *Journal of Individual Psychology, 32*(2), 131–145.
- Adler, K. A. (2007). *Walking in your shoes: Therapeutic strategies for teaching empathy to sex offenders*. Unpublished doctoral dissertation, Winona State University, Minnesota. Retrieved from <http://www.winona.edu/counseloreducation>
- Allen, C. M. (1991). *Women and men who sexually abuse children: A comparative analysis*. Brandon, VT: Safer Society Press.
- American Counseling Association. (n.d.). *Vicarious trauma*. Retrieved from <https://www.counseling.org/docs/trauma-disaster/fact-sheet-9—vicarious-trauma.pdf?sfvrsn=2>

- Anechiarico, B. (n.d.). Vicarious trauma: What are the protective measures? Retrieved from <https://ccoso.org/sites/default/files/vicarious%20trauma.doc>
- Association for Treatment of Sexual Abusers. (2017a). *What we do*. Retrieved from <http://www.atsa.com/>
- Association for Treatment of Sexual Abusers. (2017b). *Find a treatment provider: Referral request*. Retrieved from <http://www.atsa.com/referral>
- Barnett, G. D. (2011). *What is grievance thinking and how can we measure this in Sexual Offenders? Legal and criminological psychology*, 16, 37–61.
- Bermes, W. (2016). *Waiting list for sex offender treatment impacts justice system*. Retrieved from [http://www.boze-mandailychronicle.com/news/crime/waiting-list-for-sex-offender-treatment-impacts-justice-system/article\\_fb50ea68-bd70-5564-8581-c1228748c258.html](http://www.boze-mandailychronicle.com/news/crime/waiting-list-for-sex-offender-treatment-impacts-justice-system/article_fb50ea68-bd70-5564-8581-c1228748c258.html)
- Calley, N. G. (2007). Integrating theory and research: The development of research-based treatment program for juvenile male sex offenders. *Journal of Counseling and Development*, 85(2), 131–142. doi:10.1002/j.1556-6678.2007.tb00455.x
- Catanese, S. A. (2010). Traumatized by association: The risk of working sex crimes. *Federal Probation*, 74(2), 36–38.
- Center for Sex Offender Management. (2017). *Sex offender specific treatment in the context of supervision*. Retrieved from [http://www.csom.org/train/supervision/long/04\\_02\\_03.html](http://www.csom.org/train/supervision/long/04_02_03.html)
- Chassman, L., Kottler, J., & Madison, J. (2010). An exploration of counselor experiences of adolescents with sexual behavior problems. *Journal of Counseling & Development*, 88(3), 269–276. doi:10.1002/j.1556-6678.2010.tb00022.x
- Cosden, M., Sanford, A., Koch, L. M., & Lepore, C. E. (2016). Vicarious trauma and vicarious post-traumatic growth among substance abuse treatment providers. *Substance Abuse Journal*, 37, 619–624. doi:10.1080/08897077.2016.1181695
- Dreir, A. S., & Wright, S. (2011). Helping society's outcasts: The impact of counseling sex offenders. *Journal of Mental Health Counseling*, 33, 359–376. doi:10.17744/mehc.33.4.214t56448430872x
- Easterly, B. (2014). Playing politics with sex offender laws: An event history analysis of the initial community notification laws across American states. *Policy Studies*, 43(3), 355–378. doi:10.1111/psj.12084
- Elias, H., & Haj-Yahia, M. M. (2019). On the lived experience of sex offenders' therapists: Their perceptions of intrapersonal and interpersonal consequences and patterns of coping. *Journal of Interpersonal Violence*, 34(4), 848–872. doi: 10.1177/0886260516646090
- Ennis, L., & Horne, S. (2003). Predicting psychological distress in sex offenders therapists. *Sex Abuse: A Journal of Research and Treatment*, 15, 149–157. doi:10.1177/107906320301500205
- Evans, R. (2014). *Sex offenders released from prison without treatment*. Retrieved from <http://www.bbc.com/news/uk-26078124>
- Garrett, T., Oliver, C., Wilcox, D. T., & Middleton, D. (2003). Who cares? The views of sexual offenders about the group treatment they receive. *Sexual Abuse: A Journal of Research and Treatment*, 15, 323–338. doi:10.1177/107906320301500408
- Goodtherapy.org. (2017). *Self-care*. Retrieved from <http://www.goodtherapy.org/learn-about-therapy/issues/self-care>
- Hanson, K. R., Gordon, A., & Harris, A. J. R. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 14(2), 169–194. doi:10.1177/107906320201400207
- Harris, A. J. R., & Hanson, R. K. (2004). *Sex offender recidivism: A simple question*. Ottawa, Ontario, Canada: Public Safety and Emergency Preparedness Canada.
- Hatcher, R., & Noakes, S. (2009). Working with sex offenders: The impact on Australian treatment providers. *Psychology, Crime, & Law*, 16(1), 145–167. doi:10.1080/10683160802622030
- Hubbard, M. (2014). Sex offender therapy: A battle on multiple fronts. American Counseling Association. Retrieved from <https://ct.counseling.org/2014/03/sex-offender-therapy-a-battle-on-multiple-fronts/>
- Jennings, J. L., & Sawyer, S. (2003). Principle techniques for maximizing the effectiveness of group therapy with sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 15, 251–267. doi:10.1177/107906320301500403
- Jensen, S., & Jewell-Jensen, C. (1998). Why license sex offender treatment providers? Because it's the responsible thing to do!. *Sexual Abuse: A Journal of Research and Treatment*, 10, 263–266.
- Johnson, D. A., & Lokey, J. P. (2007). Individual psychology approaches to group sex offender treatment. Retrieved from <http://www.shsu.edu/~piic/summer2007/lokey.htm>
- Kadambi, M., & Truscott. (2003). Vicarious traumatization and burnout among therapists working with sex offenders. *Traumatology*, 9(4), 215–229. doi:10.1177/153476560300900404
- Kersting, K. (2003). *New hope for sex offender treatment: Research suggests psychological treatment helps reduce recidivism among convicted sex offenders*. Washington, DC: American Psychological Association. Retrieved from <https://www.apa.org/monitor/julaug03/newhope.aspx>
- Langan, P., Schmitt, E., & Durose, M. (2003). *Recidivism of sex offenders released from prison in 1994*. Washington, DC: U.S. Department of Justice Office of Justice Programs, Bureau of Justice Statistics.
- Lea, S., Auburn, T., & Kibblewhite, K. (1999). Working with sex offenders: The perceptions and experiences of professionals and paraprofessionals. *International Journal of Offender Therapy and Comparative Criminology*, 43(1), 103–119. doi: 10.1177/0306624X99431010
- Levenson, J. (2014). Incorporating trauma-informed care into evidence-based sex offender treatment. *Journal of Sexual Aggression*, 20(1), 9–22. doi:10.1080/13552600.2013.861523
- Levenson, J., Brannon, Y. N., Fortney, T., & Baker, D. B. (2007). Public perceptions about sex offenders and community protection policies. *Analyses of Social Issues & Public Policy*, 7(1), 137–161.
- Levenson, J., & Macgowan, M. (2004). Engagement, denial, treatment progress among sex offenders in group therapy. *A Journal of Research and Treatment*, 16(1), 49–63.
- Matthews, R., Matthews, J., & Speltz, K. (1989). *Female sex offenders: An exploratory study*. Orwell, VT: Safer Society Press.
- McCaughrin, W., & Price, R. (1992). Effective outpatient drug treatment organizations: Program features and selection effects. *International Journal of the Addictions*, 27(11), 1335–1358. doi:10.3109/10826089209047355
- McCulloch, T., & Kelly, L. (2007). Working with Sex Offenders in context: Which way forward? *Probation Journal*, 54(1), 7–21. doi: 10.1177/0264550507073324

- Moulden, H. M., & Firestone, P. (2007). Vicarious traumatization: The impact on therapists who work with sex offenders. *Trauma, Violence, and Abuse*, 8, 67–83. doi:10.1177/1524838006297729
- Moulden, H. M., & Firestone, P. (2010). Therapist awareness and responsibility in working with sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 22(4), 374–386. doi:10.1177/1079063210382047
- National Association of Forensic Counselors. (2017). *A few facts about the National Association of Forensic Counselors (NAFC)*. Retrieved from [http://www.forensiccounselor.org/images/file/Grandfathering%20WEB%20RVSD%202017\\_05\\_16\(1\).pdf](http://www.forensiccounselor.org/images/file/Grandfathering%20WEB%20RVSD%202017_05_16(1).pdf)
- Office for Victims of Crime. (2011). *Resources for sexual assault response teams*. Retrieved from <http://ovc.ncjrs.gov/sartkit/about/about-sa-so-b.html>
- Prentky, R., Lee, A., Knight, R., & Cerce, D. (1997). Recidivism rates among child molesters and rapists: A methodological analysis. *Law and Human Behavior*, 21, 635–659.
- Prescott, D., & Wilson, R. J. (2012). Paradoxical and double-bind communication in treatment for people who sexually offend. *Journal of Sexual Aggression*, 18, 233–246. doi:10.1080/13552600.2011.595515
- Rape, Abuse, & Incest National Network. (2009). *Occurrence of sexual assault*. Retrieved from <https://rainn.org/get-information/statistics/frequency-of-sexual-assault>
- Roseman, C. P., Ritchie, M., & Laux, J. M. (2009). A restorative justice approach to empathy development in sex offenders: An exploratory study. *Journal of Addictions & Offender Counseling*, 29(2), 96–109. doi:10.1002/(ISSN)2161-1874
- Russell, D. E. (1986). *The secret trauma: Incest in the lives of young girls*. New York: Basic Books.
- Saleh, F., Grudzinskas, A., Malin, M., & Dwyer, G. (2010). The management of sex offenders: Perspectives for psychiatry. *Harvard Review of Psychiatry*, 18(6), 359–368. doi:10.3109/10673229.2010.533003
- Sample, L., & Bray, T. (2003). Are sex offenders dangerous? *Criminology and Public Policy*, 3, 59–82. doi:10.1111/cpp.2003.3.issue-1
- Sample, L., & Bray, T. (2006). Are sex offenders different? *Criminal Justice Policy Review*, 17(1), 83–102. doi:10.1177/0887403405282916
- SAMSHA. (2014). *Tips for disaster responders: Understanding compassion fatigue*. Retrieved from <https://store.samhsa.gov/shin/content/SMA14-4869/SMA14-4869.pdf>
- Shallcross, L. (2011). Taking care of yourself as a counselor. *Counseling Today: A Publication of the American Counseling Association*. Retrieved from <https://ct.counseling.org/2011/01/taking-care-of-yourself-as-a-counselor/>
- Slater, C., & Lambie, I. (2011). The highs and lows of working with sexual offenders: A new zealand perspective. *Journal of Sexual Aggression*, 17(3), 320–334. doi:10.1080/13552600.2010.519056
- Stop It Now. (n.d.). FAQ's on sex offender treatment. Retrieved from <https://www.stopitnow.org/help-guidance/faqs/faqs-on-sex-offender-treatment>
- Strickland, S. (2008). Female sex offenders. exploring issues of personality, trauma, and cognitive distortions. *Journal of Interpersonal Violence*, 23(4), 474–489. doi:10.1177/0886260507312944
- Texas House of Representatives (n.d.). *Texas State house bill 2036*. Retrieved from <http://www.house.state.tx.us/about-us/bill/>
- Texas Juvenile Probation Commission. (2011). *Identifying the shortage of licensed professionals available to serve juvenile offenders*. Retrieved from <http://www.tjpd.texas.gov/publications/reports/RPTOTH201201.pdf>
- Thompson, E. H., Frick, M. H., & Trice-Black, S. (2011). Counselor in training perceptions of supervision practices related to self-care and burnout. *The Professional Counselor*, 1, 152–162. doi:10.15241/eht.1.3.152
- TIME. (2018). *Can bad men change? What it is like inside sex offender therapy*. Retrieved from <http://time.com/5272337/sex-offenders-therapy-treatment/>
- U.S. Department of Justice. (2011). *Crime in the United States*. Retrieved from <https://ucr.fbi.gov/crime-in-the-u.s/2011/crime-in-the-u.s.-2011/offense-definitions>
- Wolfe, V.V. (1990). Sexual Abuse of Children. In: Bellack A. S., Hersen M., Kazdin A.E. (eds) *International Handbook of Behavior Modification and Therapy*. Springer, Boston, MA.
- Woodward, A., Das, A., Raskin, I. E., & Morgan-Lopez, A. (2006). An exploratory analysis of treatment completion and client and organizational factors using hierarchical linear modeling. *Evaluation and Program Planning*, 29, 335–351. doi:10.1016/j.evalprogplan.2006.08.005



© 2019 The Author(s). This open access article is distributed under a Creative Commons Attribution (CC-BY) 4.0 license.

You are free to:

Share — copy and redistribute the material in any medium or format.

Adapt — remix, transform, and build upon the material for any purpose, even commercially.

The licensor cannot revoke these freedoms as long as you follow the license terms.

Under the following terms:

Attribution — You must give appropriate credit, provide a link to the license, and indicate if changes were made.

You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use.

No additional restrictions

You may not apply legal terms or technological measures that legally restrict others from doing anything the license permits.



**Cogent Social Sciences (ISSN: 2331-1886) is published by Cogent OA, part of Taylor & Francis Group.**

**Publishing with Cogent OA ensures:**

- Immediate, universal access to your article on publication
- High visibility and discoverability via the Cogent OA website as well as Taylor & Francis Online
- Download and citation statistics for your article
- Rapid online publication
- Input from, and dialog with, expert editors and editorial boards
- Retention of full copyright of your article
- Guaranteed legacy preservation of your article
- Discounts and waivers for authors in developing regions

**Submit your manuscript to a Cogent OA journal at [www.CogentOA.com](http://www.CogentOA.com)**

