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Relationship between Vicarious Trauma and Coping Skills Among Mental Health Professionals Working with Sexual Offenders

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ABSTRACT

The present study investigated vicarious trauma, burnout, and compassion fatigue experienced by mental health clinicians working with a population of sex offenders. The study was conducted using validated measures via an online secure and confidential survey. The study used validated scales measuring coping skills (via the COPE inventory) and assessing Compassion Fatigue, Burnout, and Vicarious Trauma. Sixty-four participants were mental health clinicians working with sex offenders, and 48 were mental health professionals working with other groups. The inclusion criteria for the participants in this study is that they are at least 18 years old and are currently working as licensed mental health clinicians working with the general population or sex offender clients. There was a total of 112 participants in this study. Based on the results collected, the study found no significant difference in levels of vicarious trauma, compassion fatigue, and burnout between mental health professionals working with sex offenders and those working with the general population. On the other hand, the research study showed a significant difference in the utilization of coping skills in the group of mental health workers working with sex offenders, such as higher levels of venting of emotions, mental disengagement, active coping, social support, denial, behavioral disengagement, religion coping, restraint, substance abuse, planning, acceptance, and suppression, as compared to mental health professionals working with the general population.

INTRODUCTION

The concept of vicarious trauma is described as the cumulative psychological impact of working with individuals who have experienced or perpetrated trauma (McCann & Pearlman, 1990). This is relevant to working with sexual offenders because it involves exposure to detailed accounts of violence, defiant behavior, and abuse. As a result of the exposure to graphic accounts of sexual violence, defiant behavior, and abuse, mental health workers working with these sexual offenders in many cases may internalize these stories, which lead to nightmares, intrusive thoughts, or nightmares that may diminish a sense of personal safety in oneself (Bourke & Craun, 2014; Ennis, & Horne, 2003). Therefore, these vivid details would amplify the

risk of vicarious trauma (Moulden & Firestone, 2007). Unlike professionals working with survivors of trauma, those who are working with sexual offenders often face unique ethical dilemmas, such as social stigma, which further complicates their emotional response to their career.

Mental Health Professionals working with sexual offenders or individuals diagnosed with pedophilia are primarily at high risk of experiencing vicarious trauma due to thinking about the gruesome details of the case after assessing the sex offender (Barros, et.al., 2020). Compassion fatigue for clinicians working with sexual offenders is also a part of vicarious trauma, which the clinician often displays through exhaustion, lack of compassion, sorrow, and low empathy toward patients (Barros, et.al. 2020).

This current study investigated if there are differences in the self-reported experience of vicarious trauma, compassion fatigue, burnout, and coping skills among a group of mental health clinicians working with individuals charged with sexual offenses versus a group of mental health clinicians working with individuals from the general population.

This study also assessed whether the degree of coping skills utilized by mental health clinicians is related to lower rates of burnout, compassion fatigue, and vicarious trauma (Adams & Riggs, 2008). The study was conducted using validated questionnaires such as the COPE (Coping Orientation to Problems Experienced) inventory and the Burnout, Compassion Fatigue, and Vicarious Trauma scale, which were administered on a secure, confidential online survey platform for mental health clinicians to complete.

Vicarious trauma is an occupational challenge for people working and volunteering in the helping field, such as the mental health field (Chouliara, et.al., 2009; Clarke, 2011; Evans, et.al., 2019; Izzard, et.al., 2020). Mental health professionals are at risk of suffering from vicarious trauma and burnout when they work with individuals who have experienced or perpetrated traumatic events (Baum & Moyal, 2020). The scope of the current study explored the difference between vicarious trauma, compassion fatigue, burnout, and coping skills among mental health clinicians who worked with sex offenders versus mental health clinicians working with individuals from the general population. This study also assessed whether the degree of coping skills utilized by mental health clinicians who work with sex offenders is related to their selfreported rates of burnout, compassion fatigue, and vicarious trauma (Adams & Riggs, 2008). In examining the content of this study, this research study reviewed the definition of a sex offender, the purpose of diverse types of sexual offenders, the diverse types of sex offenders, the registration of a sex offender, the report of vicarious trauma, in addition to the work settings, work hours, the field of work, childhood trauma of mental health clinicians, and sex offender treatment providers. This study also examined if there are any differences in vicarious trauma, compassion fatigue, burnout, and coping skills among male versus female mental health clinicians who work with sex offenders (Avramut, et.al., 2023; Cholankeril, et.al., 2023). Mental health clinicians listen to people, both victims and perpetrators, talk about alarming events (Baum & Moyal, 2020). Thus, it was insightful to examine if there are gender differences in selfreported vicarious trauma, compassion fatigue, burnout, and coping skills among mental health clinicians who work with sex offenders.

Prior research has shown that there is vicarious trauma, such as burnout and compassion fatigue, among mental health clinicians, specifically clinicians working with individuals convicted of a sexual crime. In fact, research has shown that 82% expressed that their work with individuals convicted of a sexual offense was not rewarding and that they experienced high rates of vicarious trauma and burnout (Yates, 2013).

Also of note, VanDusen & Way (2018) found that mental health professionals who utilize coping skills experience lower rates of vicarious trauma. Therefore, in addition to contributing to the current body of literature, this research study would enable mental health correctional facilities and treatment facilities to use the knowledge gained to improve policy and training and reduce vicarious trauma and burnout rates of mental health clinicians working with individuals convicted of a sexual offense. In summary, the study examined if there are differences in the self-reported experience of vicarious trauma, compassion fatigue, burnout, and coping skills scales among mental health clinicians working with sexual offenders versus a group of mental health clinicians working with the general population. This study also assessed whether the degree of coping skills utilized by mental health clinicians who work with sex offenders is related to their self-reported rates of burnout, compassion fatigue, and vicarious trauma (Adams & Riggs, 2008, Peacock, 2023, Scheela, 2001).

Research Questions and Hypotheses

The current quantitative research study was designed to answer the following research questions with corresponding hypotheses:

Research Question 1: Are there differences in the self-reported experience of vicarious trauma, compassion fatigue, burnout, and coping skills among a group of mental health clinicians working with individuals charged with sexual offenses versus a group of mental health clinicians working with individuals from the general population?

- *H*10: There are no differences in the self-reported experience of vicarious trauma, compassion fatigue, burnout, and coping skills among a group of mental health clinicians working with individuals charged with sexual offenses versus a group of mental health clinicians working with individuals from the general population
- *H*1a: There are differences in the self-reported experience of vicarious trauma, compassion fatigue, burnout, and coping skills among a group of mental health clinicians working with individuals charged with sexual offenses versus a group of mental health clinicians working with individuals from the general population

Research Question 2: Are there gender differences among mental health clinicians working with individuals charged with sexual offenses on their experience of vicarious trauma, compassion fatigue, burnout, and coping skills?

- *H*20: There are no gender differences in the self-reported experience of vicarious trauma, compassion fatigue, burnout, and coping skills among a group of mental health clinicians working with individuals charged with sexual offenses.
- *H*2a: There are gender differences in the self-reported experience of vicarious trauma, compassion fatigue, burnout, and coping skills among a group of mental health clinicians working with individuals charged with sexual offenses.

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Research Question 3: Does the degree of coping skills utilized by mental health clinicians who work with sex offenders relate to their self-reported rates of burnout, compassion fatigue, and vicarious trauma?

- H30: There is no linear relationship between the degree of coping skills utilized by mental health clinicians who work with sex offenders and their self-reported rates of burnout, compassion fatigue, and vicarious trauma.
- H3a: There is a linear relationship between the degree of coping skills utilized by mental health clinicians who work with sex offenders and their self-reported rates of burnout, compassion fatigue, and vicarious trauma.

METHODOLOGY

Participants

The inclusion criteria for the participants in this study is that they are at least 18 years old or older and are currently working as licensed mental health clinicians working with the general population or sex offender clients. There was a total of 121 participants in this study. There was a total of 64 participants who were mental health clinicians who worked with sex offender clients and a total of 48 who were mental health clinicians who worked with general population clients. There were 53 male mental health clinicians and 59 female mental health clinicians. As for age distribution, 20.7% of the sample ranged between 25 and 35, 32.3% between 36 and 46 years old, and 47.5% of the sample ranged between 47 and 57 years old. As for education, 13.4% completed their undergraduate degree, 15.2% had some college experience, 41.1% had their master's degree, and 30.4% had their doctoral degree.

Instrumentation

At the beginning of the online survey, participants in the study answered demographic questions on their age, gender, education level, and if they had mental clients charged with sexual offenses versus clients from the general population. The validated assessments used in the current research study were the Burnout, Compassion Fatigue, and Vicarious Trauma Scale and the Coping Orientation to Problems Experienced (COPE) questionnaire. The Burnout, Compassion Fatigue, and Vicarious Trauma Scale assessment is a measurement with 21 Likert questions designed to assess any distressing effects of exposure to unfortunate events. It is important to note that there are three subscales to the Burnout, Compassion fatigue, and Vicarious Trauma scale. The subscales include burnout, compassion satisfaction, and secondary traumatic stress (Crisis & Trauma Resource Institute, 2018). The questions are divided in the following manner: Burnout questions are items 1,4, 7, 10, 13, 16, and 19. Next, Compassion Fatigue questions were items 2, 5, 8, 11, 14, 17, and 20. Finally, Vicarious Trauma questions were represented by items 3, 6, 9, 12, 15, 18, and 21. The assessment is scored into four ranges scores, with scores ranging between 0-14 representing Low Risk, scores ranging between 15-21 representing Moderate Risk, scores ranging between 22-28 representing High Risk, and finally, scores ranging between 29-35 representing Extremely High Risk (Crisis & Trauma Resource Institute, 2018). In a study conducted by Aparicio and colleagues (2013), the researcher examined the psychometric properties of the vicarious trauma scale in a cross-sectional sample of participants. The item response model and the confirmatory factor analysis suggested that the vicarious trauma scale was valid and reliable in detecting exposure to distressing events, along with the measurement of the disclosure and impact on the cognition of the respondents.

The second assessment tool incorporated in the current research study is the Coping Orientation to Problems Experienced (COPE) Inventory. This is a 60-item questionnaire that is considered a self-report measuring effective and ineffective ways to deal with stressful events (Carver, 2013). The subscales of the COPE consist of Positive reinterpretation and growth, Mental disengagement, Focus on and venting of emotions, represented by questions, Use of instrumental social support, Active coping, Denial, Religious coping, Humor, Behavioral disengagement, Restraint, Use of emotional social support, Substance use, Acceptance, Suppression of competing activities, and Planning (Carver, 2013). The recommended range scores for each score on the various subscales suggested by Craver (2013) were that a cumulative rating score between 4 – 13 indicates low resilient coping, and a cumulative rating score between 17 – 20 shows highly resilient coping (Craver, 2013). In addition, a study has provided empirical evidence that across different cultures of the Hispanic population (Latin American population and the Chilean population) and age groups (both children and adults), the COPE Inventory is both reliable and valid in measuring coping mechanisms (Garcia et al., 2018).

Procedure

The researcher reached out to potential participants of the research study via an email invitation. The researcher's email invitation was sent to a sample of licensed mental health professionals on behalf of the primary researcher. The licensed mental health professionals were kindly asked to complete the secure online survey hosted on SurveyMonkey and forward the recruitment email to other licensed mental health professionals who would fit the criteria for the online research study.

The participants were asked to review an informed consent document at the beginning of the online study. This informed consent form was used before the participants answered any questionnaires, and they could opt out before the online survey started or during the survey. On the consent document, the participants were informed of the purpose of the study and whom to contact with questions or concerns about the research study. Participants were told there were no repercussions if they chose not to participate in the study. The participants were notified that all their responses were kept confidential and anonymous. In addition, each participant was provided resources for therapy and counseling if triggered at any point in the study, such as the mental health hotline and the suicide hotline. The participants were told that participation would range between 45 to 60 minutes in length. After reviewing and agreeing to participate in the research study, each participant checked the agreement box and completed the online survey's demographic questions and the two validated measures.

RESULTS

Research Question 1: Are there differences in the self-reported experience of vicarious trauma, compassion fatigue, burnout, and coping skills among a group of mental health clinicians working with individuals charged with sexual offenses versus a group of mental health clinicians working with individuals from the general population?

Using the SPSS 25 statistical software, a Multivariate Analysis of Variance (MANOVA) was a test that was used to run a statistical analysis among different dependent variables (vicarious trauma, compassion fatigue, burnout, and coping skills) when comparing mental health professionals working with sex offenders versus mental health professionals with clients from the general population. A multivariate analysis of variance (MANOVA) was conducted

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comparing mental health professionals working with sex offenders versus mental health professionals with clients from the general population (Occupation) on the dependent variables of vicarious trauma, compassion fatigue, burnout, and coping skills (mental disengagement, venting of emotions, social support, active coping, denial, religious coping, behavioral disengagement, humor, restraint, emotional support, substance abuse, acceptance, suppression, and planning) showed a significant multivariate effect for Occupation, Wilks Lambda=.018, F (17,93) =294.075, p=0.01.

For the factor of burnout, mental health clinicians working with sex offenders presented with an average burnout score (M=21.85, SD=8.10), which is not statistically different from an average burnout score of mental health clinicians working with the general population (M=23.60, SD=7.33), p=0.244. For the factor of compassion fatigue, mental health clinicians working with sex offenders presented with an average compassion fatigue score (M=24.49, SD=9.63), which is not statistically different from the average compassion fatigue score of mental health clinicians working with the general population (M=26.35, SD=7.70), p=0.275. For the factor of vicarious trauma, mental health clinicians working with sex offenders presented with an average vicarious trauma score (M=24.95, SD=9.49), which is not statistically different from the average vicarious trauma score of mental health clinicians working with the general population (M=27.04, SD=7.36), p<0.210.

For the factor of mental disengagement, mental health clinicians working with sex offenders presented with an average mental disengagement score (M=13.49, SD=2.19), which is statistically higher than the average compassion mental disengagement score of mental health clinicians working with the general population (M=11.77, SD=2.59), p<0.001. Other findings included the statistically significant difference between individuals working with sex offenders concerning venting (M=6.14, SD=1.83) and individuals working with the general population mental disengagement (M=4.42, SD=1.55), p<0.001.

For the factor of social support, mental health clinicians working with sex offenders presented with an average social support score (M=9.19, SD=2.52), which is statistically higher than the average social support score of mental health clinicians working with the general population (M=6.68, SD=2.04), p<0.001. For the factor of mental disengagement, mental health clinicians working with sex offenders presented with an average active coping score (M=12.60, SD=2.98), which is statistically higher to the average active coping score of mental health clinicians working with the general population (M=9.10, SD=2.68), p<0.001. For the factor of mental disengagement, mental health clinicians working with sex offenders presented with an average denial score (M=6.14, SD=1.83), which is statistically higher than the average compassion denial score of mental health clinicians working with the general population (M=4.42, SD=1.55), p<0.001.

For the factor of religious coping, mental health clinicians working with sex offenders presented with an average religious coping score (M=6.30, SD=1.99), which is statistically higher compared to the average compassion religious coping score of mental health clinicians working with the general population (M=3.25, SD=1.74), p<0.001. For the factor of behavioral disengagement, mental health clinicians working with sex offenders presented with an average religious coping score (M=10.50, SD=2.19), which is statistically higher as compared to the

average compassion behavioral disengagement score of mental health clinicians working with the general population (*M*=7.39, *SD*=3.51), *p*<0.001.

For the factor of humor, mental health clinicians working with sex offenders presented with an average humor score (*M*=12.09, *SD*=3.79), which is statistically higher as compared to the average compassion humor score of mental health clinicians working with the general population (*M*=9.33, *SD*=3.62), *p*<0.001. For the factor of restraint, mental health clinicians working with sex offenders presented with an average restraint score (*M*=6.65, *SD*=1.30), which is statistically higher as compared to the average restraint score of mental health clinicians working with the general population (*M*=9.58, *SD*=1.42), *p*<0.001.

For the factor of emotional support, mental health clinicians working with sex offenders presented with an average emotional restraint score (M=13.24, SD=2.93), which is statistically higher as compared to the average emotional restraint score of mental health clinicians working with the general population (*M*=10.60, *SD*=2.87), *p*<0.001. For the factor of substance abuse, mental health clinicians working with sex offenders presented with an average substance abuse score (*M*=11.42, *SD*=4.47), which is statistically higher as compared to the average substance abuse score of mental health clinicians working with the general population (*M*=6.20, *SD*=3.52), *p*<0.001.

For the factor of acceptance, mental health clinicians working with sex offenders presented with an average acceptance score (*M*=10.14, *SD*=1.63), which is statistically higher as compared to the average acceptance score of mental health clinicians working with the general population (*M*=8.62, *SD*=1.83), p<0.001.

For the factor of suppression, mental health clinicians working with sex offenders presented with an average suppression score (*M*=13.20, *SD*=2.54), which is statistically higher as compared to the average suppression score of mental health clinicians working with the general population (*M*=10.04, *SD*=2.29), p<0.001. For the factor of planning, mental health clinicians working with sex offenders presented with an average planning score (*M*=10.07, *SD*=1.68), which is statistically higher as compared to the average planning score of mental health clinicians working with the general population (*M*=8.91, *SD*=2.05), p<0.001.

Research Question 2: Are there gender differences among mental health clinicians working with individuals charged with sexual offenses on their experience of vicarious trauma, compassion fatigue, burnout, and coping skills.

Using the SPSS 25 statistical software, a Multivariate Analysis of Variance (MANOVA) was a test that was used to run a statistical analysis among different dependent variables (vicarious trauma, compassion fatigue, burnout, and coping skills) when comparing male versus female mental health professionals working with sex offenders. A multivariate analysis of variance (MANOVA) was conducted comparing male and female mental health professionals working with sex offenders (Gender) on the dependent variables of vicarious trauma, compassion fatigue, burnout, and coping skills (mental disengagement, venting of emotions, social support, active coping, denial, religious coping, behavioral disengagement, humor, restraint, emotional support, substance abuse, acceptance, suppression, and planning) showed a significant multivariate effect for Gender, Wilks Lambda=0.018, *F* (17,62) =294.075, *p*=0.01.

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For the factor of burnout, female mental health clinicians working with sex offenders presented with an average burnout score (*M*=23.64, *SD*=7.68), which is statistically similar to an average burnout score among male mental health clinicians working with sex offenders (*M*=19.90, *SD*=8.24), *p*=0.067. For the factor of compassion fatigue, female mental health clinicians working with sex offenders presented with an average compassion fatigue score (*M*=26.48, *SD*=8.91), which is statistically similar to the average compassion fatigue score among male mental health clinicians working with sex offenders (*M*=22.30, *SD*=10.70), *p*=0.085. For the factor of vicarious trauma, female mental health clinicians working with sex offenders presented with an average vicarious trauma score (*M*=27.27, *SD*=9.07) which is statistically higher than the average vicarious trauma score among male mental health clinicians working with sex offenders (*M*=22.40, *SD*=9.43), *p*=0.041.

For the factor of various coping styles, female mental health clinicians working with sex offenders showed statistically similar average scores as compared to their male counterparts on various coping styles of mental disengagement (*p*=0.054), venting of emotions (*p*=0.398), social support (*p*=0.206), active coping (*p*=0.188), denial (*p*=0.414), religious coping (*p*=0.378), behavioral disengagement (*p*=0.631), humor (*p*=0.749), restraint (*p*=0.502), emotional support (*p*=0.069), substance abuse (*p*=0.267), and suppression (*p*=0.316).

In contrast, it was found that female mental health clinicians working with sex offenders presented with an average acceptance score (*M*=10.61, *SD*=1.64) which is statistically higher than the average acceptance score among male mental health clinicians working with sex offenders (*M*=9.63, *SD*=1.50), *p*=0.017. Moreover, female mental health clinicians working with sex offenders presented with an average planning score (*M*=10.64, *SD*=1.62) which is statistically higher than the average planning score among male mental health clinicians working with sex offenders (*M*=9.47, *SD*=1.57), *p*=0.005.

Research Question 3: Does the degree of coping skills utilized by mental health clinicians who work with sex offenders is related to their self-reported rates of burnout, compassion fatigue, and vicarious trauma?

Using the SPSS 25 statistical software, a series of Multiple Linear Regression analyses were conducted with the independent/predictor variables of the various coping styles (mental disengagement, venting of emotions, social support, active coping, denial, religious coping, behavioral disengagement, humor, restraint, emotional support, substance abuse, acceptance, suppression, and planning) and the three dependent variables (burnout, compassion fatigue, and vicarious trauma).

The multiple linear regression analysis showed that there was no statistically significant linear relationship between the independent variables of the self-reported mental disengagement, venting of emotions, social support, active coping, denial, religious coping, behavioral disengagement, humor, restraint, emotional support, substance abuse, acceptance, suppression, and planning upon the dependent variable of burnout among all the mental health professionals who work with sex offenders, *F*(14, 62)= 0.96, *p*=0.508.

The multiple linear regression analysis showed that there was no statistically significant linear relationship between the independent variables of the self-reported mental disengagement, venting of emotions, social support, active coping, denial, religious coping, behavioral

disengagement, humor, restraint, emotional support, substance abuse, acceptance, suppression, and planning upon the dependent variable of compassion fatigue among all the mental health professionals who work with sex offenders, $F(14, 62)= 0.98$, $p=0.490$.

The multiple linear regression analysis showed that there was no statistically significant linear relationship between the independent variables of the self-reported mental disengagement, venting of emotions, social support, active coping, denial, religious coping, behavioral disengagement, humor, restraint, emotional support, substance abuse, acceptance, suppression, and planning upon the dependent variable of vicarious trauma among all the mental health professionals who work with sex offenders, $F(14, 62)= 1.05$, $p=0.427$. Overall, these statistical research findings show that the various coping skills among the sample of mental health professionals who work with sex offenders do not predict their experience of burnout, compassion fatigue, or vicarious trauma.

DISCUSSION

This study's primary purpose was to investigate the psychological impact and coping mechanisms of mental health professionals who are working with sex offenders compared to mental health professionals working with the general population. Additionally, the study also explored gender differences within mental health professionals working with sex offenders, along with examining the relationship between various coping skills, the experience of burnout, compassion fatigue, and vicarious trauma.

Based on the results collected, the study found no significant difference in levels of vicarious trauma, compassion fatigue, and burnout between mental health professionals working with sex offenders and those working with the general population. The results suggest that the experience of adverse psychological outcomes is not exclusively heightened in mental health professionals working with sex offenders. This implies that factors contributing to this issue, such as emotional demands, organizational support, and workload, are prevalent across different mental health workers.

On the other hand, the research study showed a significant difference in the utilization of coping skills in the group of mental health workers working with sex offenders, such as higher levels of venting of emotions, mental disengagement, active coping, social support, denial, behavioral disengagement, religion coping, restraint, substance abuse, planning, acceptance, and suppression. The current findings suggest that being a mental health worker who works with sex offenders requires more intensive and diverse coping skills to manage stressors that are associated with that specific population due to the use of both maladaptive and adaptive coping skills. On the one hand, this increased reliance on adaptive strategies may reflect proactive skills to cope with stress and maintain effectiveness. On the other hand, the use of maladaptive strategies raises much concern about the long-term well-being of the mental health professional working with sex offenders. This dual process suggests the need for targeted support systems and training programs that promote practical coping skills while mental health professionals working with sex offenders.

The multiple linear regression revealed no significant linear relationship between the different coping skills and levels of burnout, compassion fatigue, and vicarious trauma among mental health workers working with sex offenders. Since coping is not a factor of vicarious trauma,

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burnout, and compassion fatigue, there may be other factors beyond coping skills that impact vicarious trauma, compassion fatigue, and burnout. Psychological outcomes might be influenced by interactions with other variables that are not considered, such as personal resilience (Figley, 2002; Maslach & Leiter, 2016). Organizational support (Figley, 2002; Maslach & Leiter, 2016) or the severity of the cases (Figley, 2002; Maslach & Leiter, 2016). The coping skills utilized may not capture how an individual manages stress in a specific context. Further research would be recommended to explore the impact of alternative coping skills that were not covered in the BRIEF COPE assessment on vicarious trauma, compassion fatigue, and burnout among mental health workers working with sex offenders. Other factors not explored in this study that may affect the impact of vicarious trauma, compassion fatigue, and burnout among mental health workers working with sex offenders may include personal experiences (Figley, 2002; Maslach & Leiter, 2016) and personality traits (Figley, 2002; Maslach & Leiter, 2016).

In addition to contributing to the current body of literature, the information gained from this research study may enable mental health correctional and treatment facilities to use the knowledge gained to improve policy and training and reduce vicarious trauma and burnout rates of individuals working within the defined mental health field. Based on the study, specialized training is needed to prepare mental health professionals who will work with sex offenders with specialized adaptive coping skills such as venting emotions, social support, active coping, religious coping, humor, emotional support, acceptance, and planning.

The proposed specialized training would emphasize the development of adaptive coping mechanisms, which may enhance the mental health worker's resilience. Another recommendation to take into consideration for improving coping skills among mental health workers working with sex offenders involves organizational interventions. These recommendations can include implementing support systems such as access to mental health resources, peer support groups, supervision, and support groups that would specifically help clinicians manage specific stressors that are associated with working with sex offenders.

One limitation was gathering the responses. It was challenging to find individuals within the mental health field who work with sex offenders who are willing to answer the survey. One possible reason for the challenge of recruiting the mental health workers working with sex offenders to complete the survey is due to limitations of the total number of clinicians working with sex offenders within the profession, or it could have been difficult for these individuals to answer questions about their coping skills.

Future recommendations for other researchers and scientists who explore the topic further would be to explore more in-depth the other factors that may contribute towards vicarious trauma, burnout, and compassion fatigue that individuals who work in the mental health field with sex offenders experience. It is also recommended to look at different factors that may shape the coping skills of individuals working with sex offenders over the span of their careers. In conclusion, this study highlights the complex interplay between coping skills and psychological well-being among mental health professionals working with sex offenders and mental health professionals working with the general population. While no differences were found in compassion fatigue, burnout, and vicarious trauma between mental health professionals working with sex offenders and those with the general population, significant

variations in coping skills suggest that mental health professionals working with sex offenders face distinct stress management challenges compared to those working with the general population. Further differences also emphasize the imperative need for different support mechanisms. Future research would benefit from building on these findings to develop targeted interventions that improve mental health professionals' resilience and enhance the sustainability of the professionals within this field.

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