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SECONDARY STIGMA FOR PROFESSIONALS WHO WORK WITH MARGINALIZED GROUPS: A COMPARATIVE STUDY

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ABSTRACT

Catherine Stein, Advisor

Although research has been done on social stigma and its effects on individuals in marginalized groups, relatively little is known about the effects of secondary stigma for those people who are associated with stigmatized individuals, such as mental health professionals. Using a sample of 196 mental health professionals who work with sexual offenders (64 sexual offender counselors), serious mental illness (64 case managers), and college students (68 college counselors), the present research examined mental health professionals' experience of secondary stigma, personal growth, professional burnout, and job choice regret as a function of working with clients. The mixed-method research design includes a qualitative analysis of mental health professionals' descriptions of secondary stigma and the impact of their work on their professional and personal lives. The psychometric properties of the newly developed measure, the Mental Health Professionals Secondary Stigma Scale (MHPSSS) were also evaluated. Findings suggest that sex offender counselors reported experiencing more secondary stigma and depersonalization than case managers and college counselors. Case managers reported higher levels of personal growth followed by college counselors and sexual offender counselors. All three samples of mental health professionals identified positive and negative aspects of their work. Implications of findings for research and clinical practice are discussed.

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INTRODUCTION

Although research has been done on social stigma and its effects on individuals in marginalized groups (Mak & Wu, 2006; Vogel et al., 2006), relatively little is known about the effects of secondary stigma for those people who are associated with stigmatized individuals, such as mental health professionals. Secondary stigma occurs when a negative characteristic is placed on an individual who associates with a member of a stigmatized group (Halter, 2008). Previous research has linked mental health professionals' burnout and high job turnover rates to job factors, such as working in an institutional setting, external job constraints, a lack of personal control over job activities, and individual factors (Dupree & Day, 1995). However, systematically understanding the role of secondary stigma in the lives of mental health practitioners may have implications for the well-being of helping professionals and for the quality of services that helping professionals provide to their clients.

The present study examines mental health professional's experience of secondary stigma as a function of working with clients who have committed sexual offenses as compared to that of counselors working with other client populations. Specifically, the study examines perceptions of secondary stigma in accounting for perceptions of professional burnout, job choice regret, and personal growth as a result of work with clients with serious mental illness for case managers, counselors who work with sex offenders, and counselors who work with college students. To provide a framework for the present study, literature on social stigma, professional burnout, personal growth as a result of working with clients, and associated job activities of mental health professionals who work with sex offenders, people with mental illness and college students is reviewed.

Social Stigma

Goffman (1963) defines social stigma as a personal characteristic that is discrediting. As time has gone by researchers have revised Goffman's definition of stigma. Jones et al. (1984) view social stigma as occurring when a discrediting mark is connected to a person. Elliot, Ziegler, Altman and Scott (1982) contend that as a form of deviance, stigma leads to judgment from others that the individuals are illegitimate for interaction. According to these authors, stigmatized people may be considered illegitimate for interaction because it is felt that they are somehow incompetent or dangerous.

The perception of the stigma for one person may not be as severe as it is for the next person. Jones et al. (1984) describe the six dimensions of social stigma that include concealability, course, disruptiveness, aesthetic quality, origin, and peril. Concealability deals with how obvious the stigmatizing characteristic is and how it varies depending on whether the individual is able to conceal their condition. Jones suggests that more hidden the characteristic, the lesser the social impact of the stigma. A person can have a non-concealable stigma, if he can hide it from others; there is less chance he will be stigmatized for it. The second dimension, course, deals with how the characteristic changes over time or how revisable the condition is over time (i.e. does it get worse or go away with time?). Irreversible conditions often elicit more negative attitudes from others. Disruptiveness depends on the degree to which the characteristic hinders interpersonal interactions. For example, others can often experience interpersonal interaction with individuals with mental illness as disruptive due to fear of unexpected behaviors from the individuals with mental illness. The fourth dimension, aesthetic, deals with how attractive the characteristic is to society's perceptions. In terms of stigma, aesthetic refers to the

extent to which the condition elicits a negative reaction, for example, disgust. Origin is where the characteristic comes from or how it came into being. If an individual is perceived as being responsible for their condition, others are more likely to respond with unfavorable views of the individual. The last dimension, peril, deals with how dangerous or threatening others perceive the characteristic to be. The perceived threat can be either fear of physical danger or contact with uncomfortable feelings of vulnerability (e.g., uneasiness from watching a handicapped person navigate a flight of stairs). These six dimensions have been used to evaluate the stigma of mental illness (Jones et al., 1984).

Bos and colleagues (2009) found that individuals with mental illness are selective when disclosing about their mental illness due to fear of stigma and losing social support. Individuals with mental illness reported a higher likelihood of disclosing to close family members or friends than disclosing to acquaintances or colleagues. Cooper et al. (2003) presents two empirically supported models of stigma associated with mental illness. The first view is that individuals with mental illness are perceived as being responsible for their illness. The second model suggests that the public views individuals with mental illness as being dangerous, which leads to the stigma. Some mental illnesses may be easier to conceal, less chronic, and less disruptive than others, therefore they would be less stigmatized. Mental illnesses usually do not alter the appearance of the person, unless it is a severe mental illness. The origin of mental illness is misunderstood by many, which leads to stigmatization of the person. With the required community notification, or Megan’s Law, sex offenders have a hard time concealing their stigmatizing mark and society views them as highly likely to reoffend (Levenson et al., 2007). Following Jones et al.’s dimension of stigma it would be expected that both individuals with mental illness and sexual offenders would experience stigma as a result of their condition.

Secondary Stigma

Secondary stigma occurs when a negative characteristic is placed on an individual who associates with a member of a stigmatized group (Halter, 2008). Goffman (1963) described individuals who experience secondary stigma as being a “wise person,” or someone who has an understanding of and sympathizes with a stigmatized individual. Mental health professionals who work with individuals with mental illness or sexual offenders would experience secondary stigma due to being a wise person who provides services to these individuals. Society views a wise person as being one with the stigmatized individual and places the stigma from the stigmatized individual to the wise person (Goffman).

A study done by Halter (2008) sampled 122 licensed practical nurses to examine the secondary stigma associated with working as a psychiatric nurse. Nurses were asked to rank, in order of most preferable in their own perspective and society’s perspective, ten specialty areas in nursing (e.g., pediatrics, psychiatry, intensive care unit, or emergency department). Nurses ranked psychiatric nursing as the least preferred specialty in both their own and society’s perspective. Nurses also attributed negative characteristics (e.g. unskilled, idle, illogical, and disrespected) to psychiatric nurses. Findings from this study demonstrate that even professionals in the health field apply secondary stigma to other professionals who work in the mental health field.

Mental Health Professionals

Individuals with mental illness face a variety of problems and are often marginalized by society. The social stigma and marginalization by society that individuals with mental illness face have contributed to them being reluctant to seek professional treatment (Gilchrist & Sullivan, 2006; Vogel, Wester, & Larson, 2007; Stefl and Prosperi, 1985). Although mental

health professionals work with a variety of clients, many often specialize and train to work with specific populations. The job activities and client population of three types of mental health professionals: sex offender counselors, case managers, and college counselors, are reviewed to provide a background for the present research. Literature regarding the degree of social stigmatization of clients seen by these three types of practitioners is also reviewed.

Sex Offender Counselors

A person convicted of a sexual offense is known as a sex offender. According to the Sex Offender Registration and Notification Act (SORNA; 2013) a sexual offense is a criminal offense that involves any type of genital, oral, or anal penetration or sexual touching of another person. Victims of a sexual offense can be either an adult or minor under the age of 18. According to the National Center of Missing and Exploited Children (2015), there are 843,260 registered sex offenders. Sex offenders are frequently mandated to receive mental health treatment by the court system. Sex offender counselors are the counselors who work towards the rehabilitation of sex offenders.

Due to the nature of their offense, sex offenders are a highly stigmatized population (Levenson et al., 2007). In a study of stigma experienced due to registering as a sex offender, a sample of 239 sex offenders reported that they have experienced threats and harassment, job loss, and damage to their property as negative consequences (Levenson et al.). Offenders also reported experiencing psychological distress (isolation, embarrassment, shame, and hopelessness) due to the stigma and being forced to move from their home once the community became aware of their offense. Almost half of the sample of sex offenders voiced concern for the safety once the community became aware of their offense, with some of the sample reporting they have been physically assaulted as a result of the community being made aware. The

damaging effects of the stigma may hinder the offender's progress in treatment and successful reintegration into the community (Levenson et al.).

A common and successful approach to the treatment of sex offenders is the containment approach. The containment approach is a multidisciplinary approach in which the criminal justice system (often probation and parole officers) and sex offender treatment providers work together in the community to hold the offender accountable for their offense and risk to the community (English, 1998). The purpose of the containment approach is threefold. The first purpose is to help offenders gain internal, or personal, control over their deviant sexual behaviors, thoughts, and impulses. Second, external control is gained through supervision from probation and parole officers. Offenders are educated on what is expected from them and the consequences of violating these expectations. Lastly, polygraph examinations are used as way of monitoring compliance with the external expectations (English, et al., 1997). The success of the containment approach is due to the offenders working closely with their counselors and the criminal justice system.

Case Managers

According to the National Alliance on Mental Illness (NAMI, 2013), mental illnesses are a medical condition that causes a disturbance in an individual's thinking, feeling, mood, daily functioning, and ability to relate to others. Individuals of all ages, race, and backgrounds can be impacted by a mental illness. One in 17 Americans, about 6%, live with a serious mental illness with 1 in 4 adult Americans experiencing a mental health disorder in a given year (NAMI, 2013). Ten percent of American children and adolescents live with serious emotional and mental disorders that interrupt their daily functioning. Individuals with mental illness often seek treatment voluntarily, however can at times be court mandated for treatment.

Individuals with mental illness face considerable social stigma that impacts their everyday lives. The public often reacts with stigmatizing attitudes and fear toward individuals they perceive to have mental illness (Corrigan, Green, Lundin, Kubaik, & Penn, 2001). These stigmatizing attitudes contribute to people distancing themselves socially from individuals with mental illness. The public holds many misconceptions toward individuals with mental illness that may lead to this social stigma. A study done by Arboleda-Florez (2003) found that most common misconception held by the public about individuals with mental illness was that they were violent and dangerous. Other common misconceptions of individuals with mental illness are that they cannot function, are of lower intelligence, are weak and lazy, and unpredictable. The misconceptions held by the public are detrimental to the recovery process of individuals coping with mental illness.

Case management is used to coordinate the integration and provision of care to individuals with mental illness with the limited resources available (Thornicroft, 1991; Rapp & Goscha, 2004). The use of case management has increased as an attempt to overcome deficiencies, such as lack of continuity of care in community care (Stuart, 2000). Similar to sex offender counselors, case managers work in a community setting alongside their clients. The clinical case management framework allows for the case manager to offer direct clinical services and have more hands on involvement in the client's life (King et al., 2000). Case managers perform a wide range of tasks in order to coordinate the care of clients who are in need of multiple services: identify patients, assess needs, design care packages, coordinate service delivery, monitor service delivery, evaluate effectiveness of services, modify care package, and repeat the cycle until services are no longer needed (Thornicroft, 1991). Patient identification refers to the process of defining the target group of case management services (e.g., individuals

who require psychiatric care). Once the target group has been identified the case manager then assesses the client's clinical, social, occupational, residential and health needs. Case managers work alongside other mental health professionals to gain a better understanding of each client's needs. Once the client's needs are understood, using what resources are available the case manager determines what services would be helpful. Although the client is receiving services, the case manager evaluates the effectiveness of the services and makes modifications in order to ensure quality of care. Case managers have the difficult task of providing the best quality of services with a limited amount of funding and resources.

College Counseling Center Providers

Counselors in a college setting are not commonly perceived as working with individuals with serious mental illness but instead with school-related stress or relationship problems. However, as the college student population becomes more diverse, so do the problems for which students seek help (Lucas & Berkel, 2005). College students are facing more prevalent and severe psychological problems (Hunt & Eisenberg, 2010). A National Survey of Counseling Center Directors (2008) found that 95% of college directors surveyed reported that there has been in increase in the amount of students with severe psychological problems. In a more recent National Survey of Counseling Centers (2014), it was found that 86% of directors reported a steady increase in the number of students arriving on campus with existing psychiatric medication. Zivin et al. (2009), examined college students problems over a two year period of time (Baseline $N = 2843$ and 2 year follow-up $N = 763$). It was found that over half of the college students suffered from at least one mental health problem at baseline or two year follow-up, such as depression, anxiety, suicidal ideation, or eating disorder. Of the students who

reported mental health problems at baseline and 2 year follow up, less than half have received treatment.

The American College Health Association's National College Health Assessment Spring 2008 Reference Group Data Report (NCHA) found that 14.9% of the 80,121 college students they surveyed reported they have been diagnosed with depression, with 9% reporting that they have seriously considered suicide at least once in the past. In another study done by Yorgason et al. (2008), the prevalence rate of psychological and psychiatric symptoms (e.g. suicidality, depression, anxiety, and substance use) was around 30% in a non-clinical college student sample. Gallagher (2014) found that 94% of college center directors reported an increase in the number of students with severe psychological problems, with notable increases in anxiety disorders, crises requiring immediate response, psychiatric medication issues, and clinical depression over the past 5 years. Directors who participated in this study also reported 52% of college counseling center clients have severe psychological problems with 8% of these impairments so severe the client cannot remain in school or require extensive psychiatric help. The National Survey of College Centers (Gallagher, 2014) also found that 90% of university counseling centers hospitalize an average of nine students per school year for psychiatric reasons. Even with the increase in severity of psychological problems faced by college students, stigma continues to be a barrier to college students' help-seeking behaviors.

Stigma seems to be a major barrier to seeking psychological help across different populations. Gilchrist and Sullivan (2006) believe that the individuals who seek help are most likely not the individuals experiencing the greatest problems (i.e., suicide or self-harm). Gilchrist and Sullivan also found that stigma and esteem were linked to an unwillingness to seek professional help. Young people felt that they would be perceived as "uncool" (p. 80) or

inadequate, and this concerned both men and women equally. Young people believed it was "taboo" to talk about their feelings and suicide. They also feared what others would think about them and that they would be judged or looked down on within the community. One young participant from this study explained how young people did not ask for help because by doing so they admit they have a problem. Asking for help would demonstrate that young adults cannot fix their own problems and do not fit in, which in turn would lower their self-esteem. Cooper, Corrigan, and Watson (2003) studied college students' care-seeking attitudes. They found that students were less likely to seek care if they also demonstrated that they had anger toward individuals with mental illness who they perceived as being responsible for their own illness, or demonstrated that they would withhold help or pity from them.

College counseling centers are often located on college campuses and typically limit their practice to providing services to college students. Counseling centers offer a range of services to students. According to Robbins et al. (1985), counseling center staff is expected to perform services in nine areas which can be broken up into three categories: primary service delivery, consultative/expert services, and indirect services. Primary services refer to the delivery of time-limited individual and group therapy, and structured groups. Crisis intervention, consultation, and differential diagnosis and assessment instead fit under consultative/expert services. Indirect services include supervision and program administration duties. Similar to other mental health professionals, college counselors are experiencing a lack in resources as the demand for services rises (Smith et al., 2007). Along with an increase in demand, counselors are facing increased accountability from the universities they work with. This increased accountability refers to counselors being required to increase their workload in order to collect an increasing amount of required data and reports.

Personal Growth and Professional Burnout

Pressures placed on mental health professionals due to lack of funding and high caseload contribute to counselors reports of high levels of professional burnout (Smith et al., 2007; Schaufeli et al., 2004; Lim et al., 2010). Professional burnout occurs due to occupational stress as a result of the demanding and emotionally charged relationships between health care providers and their clients (Lim et al.). According to Maslach (1993) there are three dimensions to burnout: emotional exhaustion, depersonalization, and level of personal accomplishment. Emotional exhaustion is characterized by feelings of being emotionally depleted or drained from one's working relationship with mental health clients. Depersonalization is characterized by a lack of empathy, negative attitudes, or emotional distance from clients. Lastly, personal accomplishment refers to feelings of competence and satisfaction in regard to work. Lim et al. performed a meta-analysis comparing the results of 15 scholarly articles with a total of 3,613 participants and found individual and work-related variables that correlated with burnout among mental health professionals. Emotional exhaustion was significantly predicted by younger age, level of education, work hours and work settings. Depersonalization was significantly predicted by young age, male gender, years of work experience, work hours, and work settings. Age was the most significant predictor of personal accomplishment with years of experience and education level also being moderate predictors. Older and more educated mental health professionals reported higher levels of personal accomplishment, suggesting that as professionals get older and become more educated they become better at providing services to their clients.

Given the level of professional burnout and job stress counselors are reporting, it might be expected that mental health professionals would also experience some personal growth in order to continue working with their clientele. Researchers have examined the degree to which mental

health professionals experience personal growth as a result of their work with clients (Tedeschi, 2004; Stein et al., 2007). Stress related growth, also called personal growth, occurs when an individual experiences positive changes as a result of a challenging life event (Tedeschi, 2004). Joseph and Linley (2005) explained that positive changes occur in the way they view themselves or their life philosophy and the values they place on their relationships. Tedeschi described an appreciation of life, an increase in meaningful relationships, and a change in priorities as possible positive changes.

Although working with clients with mental illness is often stressful, it is not comparable to a traumatic life event. For that reason, this study examines personal growth as a result of working with clients rather than stress-related personal growth. Much research has been done to examine the individual and job characteristics related to job turnover, satisfaction, and professional burnout in a variety of helping professions (Ferrel et al, 2000; Scheela, 2001; Stein and Craft, 2007; Smith et al., 2007).

Sex Offender Counselors

In a study assessing the job satisfaction among 162 counselors who provided group therapy in state correctional facilities, the most job satisfaction was reported in the direct provision of services (i.e., facilitating group, individual therapy, and crisis intervention services; Ferrel et al., 2000). Counselors reported less satisfaction with non-direct services including completing paperwork and supervision. Dreier & White (2011) interviewed 5 sex offender counselors about the impact of their work with sexual offenders. Counselors reported that negative impacts of their work centered on feeling disconnected from the general society, intrusive thought of traumatic material, and increased suspicion of others. Although counselors reported negative experiences due to their work with sex offenders, they identified positive

aspects of their work. Counselors found rewards with a feeling of increased general competence in work with clients, feeling closer to their coworkers and supervisors and a mission to keep the community safe. It seems that sex offender counselors enjoy the increased competence and feel like they make a difference within the community. Scheela (2001) interviewed 17 sex offender counselors about their experiences and found that counselors reported that the negative impacts of their work centered around the "system" (i.e., lack of funding and legalities), society's attitudes towards sex offenders, the media, and fear of failure. Sex offender counselors reported feeling hardened or more vulnerable towards abuse as a result of their work. Although counselors reported negative experiences due to their work with sex offenders, they identified positive aspects of their work. Counselors found their work rewarding when they witnessed the growth and change in their offender clients.

A preliminary study, completed by Jesse and Stein (2013), examined the degree to which sex offender counselors reported the experience of secondary stigma and how it related to other perceptions of their jobs. Results of this study yielded similar results to previous research. Findings suggested that counselors who work with sexual offenders found their clients' progress as the most rewarding aspect of the job, while working with the legal system and policies were the biggest obstacles. Counselors also reported experiencing more professional growth than personal growth as a result of their work with sexual offenders.

Case Managers

A number of empirical studies focus on individual traits and job characteristics that relate to job turnover and professional burnout in case manager and community mental health workers (Stein et al., 2009; Prosser et al. 1996). Kraus and Stein (2012) examined perceptions of recovery-oriented services and reports of professional burnout and job satisfaction in 114 case

managers. Researchers found that case managers reported lower levels of depersonalization and emotional exhaustion at work and higher personal accomplishment and job satisfaction when they perceived their agency to offer higher levels of recovery-oriented services. In a study examining 285 mental health providers, Green et al. (2014) found case managers that offered more traditional case management services (i.e. coordination of services) reported higher levels of depersonalization than wraparound providers who offered a team and strength-based family centered approach to case management.

Stein and Craft (2007) examined 98 case managers and found that case managers who reported higher levels of personal growth related to their work with clients also reported higher levels of job satisfaction and personal accomplishment, while case managers who reported lower levels of personal growth also reported feelings of professional burnout. Lloyd et al. (2004) also examined burnout experienced by 304 social workers who worked in the mental health field and found that social workers reported high rates of emotional exhaustion with average rates of depersonalization and low rates of personal accomplishment. In general, these studies suggest that the demands placed on case managers and the severity of the client population are related to case managers' reported levels of job satisfaction, personal growth, and burnout.

College Counselors

Smith et al. (2007) surveyed 133 mental health professionals who work in a counseling center, examining the experiences and opinions of college counselors about pressing issues in their field. It was found that college counselors reported high levels of job satisfaction despite the pressures they face in their profession. In a study of 169 doctoral level staff at a counseling center, Ross et al. (1989) examined the effects of social support and stressful job experiences on burnout of counseling center staff. Counselors who reported a great number of stressful

experiences also reported higher levels of emotional exhaustion and lower levels of personal accomplishment. Counselors who had supportive supervisors reported higher levels of personal accomplishments with lower levels of depersonalization and emotional exhaustion.

Given the lack of research on burnout and professional well-being among college counselors, studies examining burnout among school counselors will be presented in order to provide a framework of burnout experienced in a school setting. Bardhosi et al. (2014) examined impact of school factors on 252 school counselors' reported burnout. It was found that school counselors reported higher levels of burnout as a result of performing non-counseling duties (e.g. paperwork). However, school counselors reported significantly higher levels of burnout as a result of school factors (e.g. case load and level of principal's support). In a study of 272 professional school counselors using the Counselor Burnout Inventory, it was found that school counselors reported higher levels on exhaustion and negative work environment as compared to other professional counselors (Gnilka et al., 2015). School counselors also reported lower levels of devaluing the client and incompetence than other professional counselors.

Summary

Stigma occurs when an individual is associated with a negative characteristic that serves to marginalize the individual from society (Goffman, 1963). According to Jones et al. (1984), there are six dimensions of stigma: concealability, course, disruptiveness, aesthetic quality, origin, and peril. These dimensions can be used to determine the severity of the stigma placed on an individual. Stigma not only affects the marginalized person but can also impact people who associate with these individuals. Secondary stigma occurs when a negative characteristic is placed on individuals who are close to a member of a stigmatized group (Halter, 2008). Although much research has been done on the impact of stigma on the individual with mental

illness, relatively little has been done to examine the secondary stigma experienced by mental health professionals. Halter (2008) found that nurses held stigmatizing views about psychiatric nurses and psychiatric nursing was viewed as the least preferred specialty. Previous research shows that college students report a reduction in help-seeking behaviors due to stigma. Research has also suggested that adults with mental illness and sexual offenders are among the most stigmatized client populations.

Secondary stigma associated with mental health professionals who work with marginalized populations, and the role it plays in their experiences of professional burnout and personal growth, is an area of research with implications for professional training and clinical practice. Previous research has found that both sex offender counselors and case managers reported both negative and positive aspects of their work in relation to personal growth and professional burnout (Scheela, 2001; Stein & Craft, 2007). Gaining a better understanding of secondary stigma and how it relates to professional burnout and personal growth may provide insights into the individual well-being and working conditions of mental health professionals.

PRESENT STUDY

The present study examined counselors' experience of secondary stigma as a function of working with clients who have committed sexual offenses as compared to that of counselors working with other client populations. Specifically, the study compared perceptions of secondary stigma in accounting for perceptions of professional burnout, job choice regret, and personal growth due to work with clients for counselors who work with sex offenders to that of case managers who work with people with psychiatric disabilities and university counselors who work with college students. The mixed-method research design included both quantitative and qualitative analysis of these counselors' experiences with secondary stigma and the impact of their work on their professional and personal lives.

The research examined between-group differences in counselors' responses to self-report measures of secondary stigma, professional burnout, job choice regret and personal growth due to work with clients as a function of type of client population served by the three groups of counselors. It was expected that sex offender counselors would report higher perceived levels of secondary stigma and job choice regret than case managers, who in turn would report higher perceived levels of secondary stigma and job choice regret than college counselors. It was also expected that sex offender counselors would report higher levels of professional burnout than case managers and college counselors. Based on past research in personal growth experienced by case managers (Stein & Craft, 2007), it was expected that case managers who work with people with psychiatric disabilities would report the highest levels of personal growth from working with their clients, followed by university counselors and sex offender counselors. Within each group of counselors, the study would examine the role of individual characteristics,

perceived job demands, and secondary stigma in accounting for variance in reported levels of professional burnout, job choice regrets, and personal growth as a result of working with clients.

The study used open-ended response questions to solicit participants' descriptions of their experiences with secondary stigma and the rewarding aspects of their work. Specifically, the study asked participants to describe their views and experiences with the following: 1) social stigma associated with their clientele (sex offenders, people with psychiatric disabilities, college students) and stigma of individuals who work with their clientele; 2) nature of public disclosure about the population of clients with whom they work; and 3) their views on the impact of their work with their clients on their professional and personal lives. Content analysis techniques were used to identify potential themes in counselors' descriptions of working with their client groups in these three domains.

METHOD

Participants

Participants in the present study consisted of 196 mental health professionals: 64 sex offender counselors, 64 case managers, and 68 college counselors who were asked to participate in an online survey. A link to the survey was be posted on national forums for counselors of sex offenders such as the Association for the Treatment of Sexual Abusers (ATSA), case managers (National Association of Case Management), and college counselors (Association for University and College Counseling Center Directors and American College Counseling Association) inviting counselors to participate in an online study examining their experiences.

To be eligible to participate in the research, individuals must have been over the age of 18, and must have worked primarily with either a population of sexual offenders, individuals with serious mental illness, or college students. Participants who reported working with sexual offenders in an individual or group setting, regardless of type of agency in which they work, were classified as a sexual offender counselor. Participants who reported that they worked as a case manager with individuals with serious mental illness, regardless of setting were classified as a case manager. Participants who reported that they worked with college students in a college university setting were classified as a college counselor. Participants were offered the opportunity to enter to win one of six $50 Visa gift cards.

Sexual Offender Counselors

The sample of 64 counselors who work with individuals who have sexually offended (25 male, 39 female) were members of the Association for the Treatment of Sexual Abusers (ATSA). Of the completed 69 surveys, five surveys were eliminated from the study due to substantial missing data. The average number of years of professional experience for the present sample of

sex offender counselors was 26.2 years (*SD = 54.64*) and study participants worked in the following professional capacities: court mandated individuals with offenses towards adults (*n* = 55, 85.9%), voluntary individuals with offenses towards adults (*n* = 24, 37.5%), court mandated individuals with offenses towards juveniles (*n* = 53, 82.8%), and voluntary individuals with offenses towards juveniles (*n* = 23, 35.9%). Descriptive statistics about the sample are presented in Table 1.

In terms of ethnicity, the sexual offender counselor sample was Caucasian (89.1%), African-American (1.6%), Hispanic-American (6.3%), and Other (1.6%). The mean age of the sample was 50.17 years old (*SD* = 12.39). The sample was married (63.5%), single (17.2%), divorced (9.4%), partnered (4.7%), and cohabitating (3.1%). In regard to education, 1.6% of the sample reported that they hold a Bachelor's degree, 50.0% hold a Master's degree, 43.8% hold a Doctoral degree, and 4.7% hold another degree not listed. Eight percent of the sample reported an annual income of $40,000 or below, with 20.3% of the sample reported income of between $41,000 – 60,000, 23.4% reported income of between 61,000 – 80,000, 21.9% of the sample reported income of between 81,000 – 100,000, and 25.0% of the sample reported earnings of over $100,000.

The majority of the sexual offender counselor sample reported being employed full time (79.7%), with an average of 39.46 (*SD* = 13.04) hours worked a week. The mean number of years at current agency reported for the sample is 11.95 (*SD = 9*.99). A total of 21 (32.8%) participants of the present sample reported that they work at a private practice, 16 (25%) work at a prison or juvenile detention center, 14 (21.9%) work at a community mental health agency, 8 (12.5%) work in a secure inpatient setting, 4 (6.3%) work in setting another setting. Mental health professionals offer multiple services, such as assessments and individual or group therapy.

About three-fourths of the present sample (76.6%) indicated that they offer individual therapy for offenders, 75.0% offer group therapy for offenders, 73.4% offer sex offender assessment, and 26.6% offer case management services for offenders. The mean caseload for the present sample was 31.14 (*SD* = 35.50). The mean reported percentage of adult male offenders in current caseload being 82.02% (*SD* = 29.69), adult female offenders 4.75% (*SD* = 14.16), juvenile male offenders 26.68% (*SD* = 38.13), and juvenile female offenders 0.85% (*SD* = 2.33).

Case Managers

The sample of 64 case managers who work with individuals with serious mental illness (13 male, 50 female, 1 missing) were members of the National Association of Case Management (NACM). Of the completed 66 surveys, two surveys were removed from the study due to substantial missing data. The average number of years of professional experience for the case managers was 12.6 years (*SD* = 58.94) and study participants worked in the following professional capacities: clients diagnosed with a depressive disorder (*n* = 59, 92.2%), clients diagnosed with an anxiety disorder (*n* = 59, 92.2%), and clients diagnosed with a psychotic disorder (*n* = 52, 81.3%). Descriptive statistics about the sample are presented in Table 1.

In regard to ethnicity, the case manager sample was Caucasian (68.8%), African-American (17.2%), Hispanic-American (10.9%), and Other (1.6%). The mean age of the sample was 41.75 (*SD* = 11.69). Thirty five percent of participants were married, 34.5% were single, 12.5% were divorced, 7.8% were partnered, 6.3% were cohabiting, and 3.1% were widowed. In terms of education, 48.4% obtained a Bachelor’s degree, 40.6% had a Master’s degree, 1.6% had a Doctoral degree, and 9.4% hold another degree not listed. In regard to income, 39.1% of participants reported an annual income of $40,000 or below, 37.5% of the sample reported income of between $41,000 – 60,000, 10.9% reported income of between 61,000 – 80,000, 6.3%

of the sample reported income of between 81,000 – 100,000, and 6.3% of the sample reported earnings of over $100,000.

The majority of the case manager sample reported being employed full time (98.4%), with an average of 40.88 (*SD* = 8.57) hours worked a week. The mean number of years at current agency reported for the sample is 7.74 (*SD* = 4.21). Forty-eight (75%) participants of the present sample reported that they work at a community mental health agency, 6 (9.4%) work at a housing agency, 3 (4.7%) work at a private agency, 3 (4.7%) work at a group home, and 4 (6.3%) work in setting another setting not listed. In regard to services offered, 93.8% indicated that they offer case management services, 28.1% individual therapy, 23.4% offer group therapy, and 4.7% offer sex offender assessment. The mean caseload for the present sample was 34.02 (*SD* = 33.90). The mean reported percentage of clients diagnosed with a depressive disorder in current caseload was 41.73% (*SD = 2*4.14), anxiety disorder 32.61% (*SD* = 21.69), and psychotic disorders 33.81% (*SD* = 30.69).

College Counselors

The sample of 68 counselors who work with college students (8 male, 60 female) were members of the Association for University and College Counseling Center Directors (AUCCCD) and American College Counseling Association (ACCA). Of the completed 69 surveys, one survey was removed from the study due to substantial missing data. The average number of years of professional experience for the present sample was 15.1 years (*SD = 10.06*) and study participants worked in the following professional capacities: college students dealing with relationship issues (*n* = 66, 97.1%), academic problems (*n* = 58, 85.3%), and severe mental illness (*n* = 67, 98.5%). Descriptive statistics about the sample are presented in Table 1.

In terms of ethnicity, the college counselor sample was Caucasian (82.4%), African-American (5.9%), Hispanic-American (5.9%), Asian American (1.5%), American Indian/Native American (1.5%) and Other (2.9%). The mean age of the sample was 43.48 (*SD* = 12.24). Sixty percent of the sample was married, with other statuses reported as divorced (13.2%), partnered (10.3%), single (8.8%), cohabitating (4.4%), and widowed (1.5%). In regard to education, 1.5% of the sample reported that they hold a Bachelor's degree, 64.7% hold a Master's degree, 26.5% hold a Doctoral degree, and 5.9% hold another degree not listed. A total of 17% percent of the sample reported an annual income of $40,000 or below, with 38.2% of the sample reported income of between $41,000 – 60,000, 26.5% reported income of between 61,000 – 80,000, 7.4% of the sample reported income of between 81,000 – 100,000, and 7.4% of the sample reported earnings of over $100,000.

The vast majority of the college counselor sample reported being employed full time (95.6%), with an average of 40.56 (*SD* = 9.25) hours worked a week. The mean number of years at current agency reported for the sample is 9.75 (*SD* = *8.22*). Sixty-six (97.1%) participants of the present sample reported that they work at a college counseling center, 1 (1.4%) works in a setting not listed, and 1 participant did not respond with where they work. Ninety-five percent of the participants indicated that they offer individual therapy for college students, 64.7% offer group therapy for college students, 29.4% case management services for college students, and 0% offer sex offender assessment. The mean caseload for the present sample was 23.38 (*SD* = 17.01). The mean reported percentage of college students dealing with stress/anxiety in current caseload being 49.53% (*SD* = 23.82), relationship issues 28.77% (*SD* = 22.95), depression 37.49% (*SD* = 22.70), academic problems 23.84% (*SD* = 22.73), severe mental illness 17.45% (*SD* = 20.43), and eating disorders 8.77% (*SD* = 15.39).

Measures

Background Characteristics and Structural Aspects of Counselors' Job

Participants completed a demographic questionnaire assessing age, gender, ethnicity, level of education, years of experience, and client specialization. Type of clientele and agency type, length of time spent at current agency, average caseload, and types of services offered were assessed through the use of open ended questions. Participants' intentions to remain in the job were assessed using two items that tapped: 1) the probability of remaining in their current profession in the next five years; 2) the probability of remaining at their current place of employment in the next five years (see Appendix A).

Mental Health Professional Secondary Stigma Scale (MHPSSS)

For the purpose of the study, 37 items were generated to assess the secondary stigma experienced by mental health professionals (see Appendix B). Development of the measure involved a review of literature on stigma (Jones et al., 1984, Goffman, 1963). The MHPSSS was created as an attempt to assess secondary stigma using the six dimensions of stigma defined by Jones et al.: concealability, course, disruptiveness, aesthetic quality, origin, and peril. Items were initially generated to reflect the six dimensions of secondary stigma described in the literature of Jones et al., validity of items was tested using an independent sample of mental health professionals who work with stigmatized populations recruited from a Northwestern Ohio mental health agency. Higher scores indicate more experience with stigma and discrimination within social relationships due to clients with whom participants work. Items were scored on a 5-point Likert scale ranging from 1(strongly disagree) to 5 (strongly agree).

Maslach Burnout Inventory (MBI)

The MBI (Maslach & Jackson, 1986; see Appendix C) is a 22-item self-report measure designed to assess professional burnout of individuals who work in human services (e.g., mental health workers, social workers). Participants are asked to rate statements using a seven-point scale (0 = *never* and 6 = *everyday*). Sample items consist of "I feel like I am at the end of my rope" and "I feel frustrated at my job." The MBI consists of three subscales measuring feelings of Emotional Exhaustion (nine items), Depersonalization (five items), and Personal Accomplishment (eight items). Emotional Exhaustion refers to feelings of being emotionally overextended or drained from one's contact with mental health clients. Depersonalization refers to negative attitudes toward mental health clients. Personal Accomplishment reflects feelings of competence and achievement in regard to work. The reported coefficient alphas for this scale from a study examining employees who sought psychological health care are: Emotional Exhaustion = 0.89, Depersonalization = 0.67, and Personal Accomplishment = 0.75 (Schaufeli et al. 2001). In the present study, the reported coefficient alphas for this scale are: Emotional Exhaustion = 0.92, Depersonalization = 0.81 and Personal Accomplishment = 0.86.

Case Manager Personal Growth Scale (CMPGS)

The CMPGS (Stein et al, 2007; see Appendix D) is a 16-item scale that assesses case managers' self-reported personal growth associated with their work with clients. For the purpose of this study, case manager was changed to sex offender counselor, college counselor, or stayed the same based on sample. Items are scored on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The CMPGS demonstrated good convergent and discriminant validity by being negatively correlated with scores on professional burnout and positive correlations with personal accomplishment and job satisfaction scores (Stein et al.). Higher

overall scores on the scale indicate higher levels of personal growth associated with their work as a mental health professional. The reported coefficient alpha for the present study is 0.91.

Decision Regret Scale (DRS)

The DRS (O'Connor, 1996; See Appendix E) is a 6-item scale that measures distress or remorse after a healthcare decision. For the purpose of the study, the decision to become a sex offender counselor, case manager, or college counselor was used as the healthcare decision measured by the DRS. Items are scored on a 5-point Likert scale ranging from 1 (strongly agree) to 5 (strongly disagree). Higher scores on this scale indicate more regret for choice of job. Brehaut et al. (2003) studied four samples of medical patients and reported coefficient alphas for this scale ranging from 0.81 to 0.92. The reported Cronbach alpha for this present sample was 0.91.

Open Ended Questions

Participants were asked to respond to open ended questions assessing public views, rewards and obstacles of their job, and impact on personal and professional lives. Participants' perceptions of the way the public views them based on the clientele they work with were assessed with the following questions: 1) How do you think the general public views people who are sex offenders/have a mental illness/college students; 2) How do you think the general public views counselors who work with sex offenders/individuals with mental illness/college students; 3) How do people typically respond upon hearing that you work with sex offenders/individuals with mental illness/college students; 4) If a member of the community asked you why you have chosen to work with sex offenders/individuals with mental illness/college students, what would you say; 5) In what ways have people treated you differently because you work with sex offenders/people with mental illness/college students.

Rewarding aspects and obstacles of the job were assessed by the following questions: 1) What do you consider to be the biggest obstacles or problems that you face in your work with sex offenders/ individuals with mental illness/college students; 2) What do you consider to be the biggest rewards that you have in your work with sex offenders/ individuals with mental illness/college students. Lastly, participants' responded to questions assessing the impact of their work on their professional and personal lives: 1) In what ways, do you feel that he public's views of sex offenders/people with mental illness/college students/impact how you feel towards your clients; 2) In what ways has working with sex offenders/individuals with mental illness/college students impacted your professional life; 3) In what ways has working with sex offenders/ individuals with mental illness/college students impacted your personal life (see Appendix F).

Scales to Establish Construct Validity of the MHPSSS.

Perceived Organizational Support (POS)

The POS (Eisenberger et al, 1997, See Appendix G) is an 8-item scale that measures the level of perceived organizational support experienced. Items are scored on a 7-point Likert scale ranging from 1 (strongly agree) to 7 (strongly disagree), with two items that are reversed scored. Higher scores on this scale indicate less perceived organizational support. The reported coefficient alpha for this scale was 0.90.

Social Desirability Scale (SDS-17)

The SDS-17 (Stober, 2001, See Appendix H) is a 17-item scale that measures the likelihood that a person would respond in a socially acceptable manner or manner that would be viewed favorable by the others. Items are scored as either true (1) or false (0), with six items that are reverse scored. The reported coefficient alpha for this scale ranged from 0.52 to 0.80 across four studies testing the validity of the scale.

RESULTS

Psychometric Evaluation of the MHPSSS

Item Reduction

Floyd and Widaman (1995) and Clark and Watson (1995) outlined the process of item reductions that was used to evaluate whether items should be eliminated from the MHPSSS. The frequency counts for each of the 37 items were examined in order to identify any items that were highly skewed or "unbalanced." Items with at least 75% of the reported responses that are "strongly disagree" or "somewhat disagree" were deemed suitable for elimination. Items that were "unbalanced" were expected to be weakly correlated with other items on the scale, have low mean scores, and convey little information on participants' experiences with secondary stigma. Mean scores were examined to determine if there were specific components or items on the MHPSSS that were endorsed more frequently. Six items met the criteria for elimination and were removed from the final scale.

Factor Structure of the Measure

A principal components factor analysis with Varimax rotation using remaining 31 items was conducted to examine the factor structure of the MHPSSS. This method was chosen to extract components of the scale that account for the greatest possible variance in the variables. Factor loadings were also analyzed to determine the structure of the measure. A three factor solution was selected that accounted for 45% of the total variance.

A total of 10 items were eliminated because they failed to meet the minimum criteria of having a primary factor loading of 0.35 or above and no cross-loading of 0.3 or above. Items for MHPSSS, factor loadings, and internal consistency coefficients for each of the three subscales are presented in Table 2. The first subscale, Aesthetics, consists of 10-items and measures the

degree to which the mental health professionals' clientele elicited a negative reaction (i.e. disgust) from the public. The second subscale, Concealability, consists of 6-items and measures the degree to which the mental health professionals hide the type of client they work with from others. The third subscale, Peril, consists of 7-items and measures the degree to which mental health professionals feel unsafe or at risk due to the population they work with. Internal consistency for the overall scale and subscales were examined using Cronbach's alpha. The alphas were moderate to high: 0.88 for Overall scale, 0.90 for Aesthetics (10 items), 0.78 for Concealability (6 items), and 0.71 for Peril (5 items).

Scores on the Social Desirability Scale (SDS-17) and the Perceived Organizational Support (POS) scale were compared to the MHPSSS to help to establish construct validity for the secondary stigma measure. It was expected that scores on the SDS-17 would be uncorrelated and scores on the POS would be slightly negatively correlated with the MHPSSS. Scores on mental health provider secondary stigma were not significantly correlated to social desirability ($r = -.13$, p = n/s) or perceived organization support ($r = -.10$, p = n/s).

Group Differences in Counselors' Reports of Background and Job Characteristics

One-way ANOVAS were performed to examine the differences between counselor type and background and job characteristics. There was a significant effect of counselor type on age, $F(2,191) = 8.65$, $p < .001$. A post hoc Tukey test showed that the three counselors groups differed significantly in age at $p < .005$; sexual offender counselors ($M = 50.17$, $SD = 12.39$) were significantly older than case managers ($M = 41.75$, $SD = 11.69$) and college counselors ($M = 43.48$, $SD = 12.24$). There were not a significant effect of counselor type on caseload ($F(2,166) = 1.82$, p = n/s), years of experience in current profession ($F(2,179) = 2.91$, p = n/s), or years at current agency ($F(2,98) = 2.25$, p = n/s).

Chi square tests were performed to examine the relationship between background and job characteristics as a function of counselor type. The relationship between counselor type and gender was significant (X^2 (2, N = 195) = 14.08, $p < .001$). Sex offender counselors (39.1%) had significantly more males than case managers (20.6%) and college counselors (11.8%). The relationship between counselor type and education was significant (X^2 (8, N = 195) =87.29, $p < .001$). Sex offender counselors (98.4%) and college counselors (98.5%) had significantly more advanced degrees than case managers (51.6%). The relationship between counselor type and income was also significant (X^2 (4, N = 193) = 37.70, $p < .001$). Forty eight percent of sex offender counselors reported an income of over $81,000 compared to 12.5% of case managers and 15.2% of college counselors. The relationship between counselor type and ethnicity was significant (X^2 (2, N = 195) = 7.70, $p < .05$). Eighty nine percent of sex offender counselors were Caucasian compared to 69.8% of case managers and 82.4% of college counselors.

Group Differences in Counselors' Reports of Secondary Stigma, Job Choice Regret, Professional Burnout, and Professional Growth

To address the first research question, a series of four, one-way ANOVAs were performed to examine the differences between sex offender counselors' reports of secondary stigma, personal growth, professional burnout, and job choice regret to that of case managers and college counselors. In the first ANOVA, differences in mean scores on the secondary stigma measure were examined as a function of type of counselor. There was a significant effect of counselor type on secondary stigma ($F(2, 193) = 60.83$, $p < .001$). A post hoc Tukey test showed that the three counselors groups differed significantly in reports of secondary stigma at $p < .001$. Counselors who work with individuals with sexual offenses reported more secondary stigma (*M*

= 2.99, *SD* = .49) than case managers (*M* = 2.39, *SD* = .52) who in turn reported more secondary stigma than college counselors (*M* = 2.00, *SD* = .52).

In the second ANOVA, differences in mean scores on personal growth were examined as a function of type of counselor. There were significant main effect in mental health professionals' reports of personal growth ($F(2, 193) = 3.56$, $p < 0.5$). A post hoc Tukey test showed that case manager reported significantly higher levels of personal growth (*M* = 3.75, *SD* = .64) than counselors who work with individuals who have sexually offended (*M* = 3.45, *SD* = .69) and university counselors (*M* = 3.69*, SD* = .69) at $p < 05$.

The third ANOVA, differences in mean scores on the professional burnout measure were examined as a function of type of counselor. There were no significant differences in counselors' reports of emotional exhaustion ($F(2, 193) = .66$, *p* = n/s) or personal accomplishment ($F(2, 193) = 1.18$, $p = .31$). However, there was a significant main effect in mental health professionals' reports of depersonalization ($F(2, 193) = 5.44$, $p < .01$). A post hoc Tukey test showed that sexual offender counselors reported significantly higher levels of depersonalization (*M* = 1.79, *SD* = 1.33) than college counselors college counselors (*M* = 1.13, *SD* = .99) and case managers (M = 1.51, SD = 1.09) at p < .01.

ANOVA results comparing scores on job choice regret as a function of counselor type suggest no significant differences in mental health professionals' reports of job choice regret (($F(2, 192) = 1.49$, *p* = n/s).

Relationship between Counselors' Reports of Background and Job Characteristics, Secondary Stigma, Job Choice Regret, Professional Burnout, and Professional Growth

A series of bivariate Pearson correlations among age and job characteristics were calculated for the overall sample (see Table 3 for additional details). Pearson correlations

examining the relationship between age and job characteristics have been computed separately for the three types of counselors groups and can be found in Table 4.

For the overall sample, older age was associated with greater years of experience (r = .38, p <.001), greater years at the current agency (r = .57 p <.001), and higher levels of personal accomplishment (r = .23, p <.001). Older age was also associated with lower levels of job choice regret (r = -.21 p <.01) and emotional exhaustion (r = -.22, p <.01). Greater number of years at current agency was associated with higher caseload (r = .31, p <.01). Greater years of experience in current profession was associated with higher levels of personal accomplishment (r = .17, p <.05).

Greater job choice regret was associated with high levels of emotional exhaustion (r = . 22, p <.01), depersonalization (r = .26, p <.001), and professionals feeling unsafe in their work with clientele (r = .20, p <.01). Greater job choice regret was also associated with lower levels of personal accomplishment (r = -.27, p <.001). Greater personal growth was associated with lower levels of depersonalization (r = -.27, p <.001), lower levels of concealing the clientele professionals work with (r = -.29, p <.001) and higher levels of personal accomplishment (r = . 37, p <.001).

Higher levels of emotional exhaustion were associated with higher levels of depersonalization (r = .47, p <.001), secondary stigma (r = .24, p <.001), professionals feeling unsafe in their work with clientele (r = .38, p <.001), negative reactions elicited by their clientele (r = .15, p <.05), and lower levels of personal accomplishment (r = -.45, p <.001). Higher levels of depersonalization were associated with higher levels of secondary stigma (r = .50, p <.001), negative reactions elicited by their clientele (r = .46, p <.001), higher levels of concealing their clientele professionals work with (r = .22, p <.01), professionals feeling unsafe in their work

with clientele ($r = .45$, $p <.001$) and lower levels of personal accomplishment ($r = -.49$, $p <.001$). Lower levels of personal accomplishment were associated with higher levels of secondary stigma ($r = -.30$, $p <.001$), negative reactions elicited by their clientele ($r = -.18$, $p <.01$), higher levels of concealing the clientele professionals work with ($r = -.26$, $p <.001$), and professionals feeling unsafe in their work ($r = -.36$, $p <.001$).

Higher levels of secondary stigma were associated with higher levels of concealing the clientele professionals work with ($r = .62$, $p <.001$), negative reactions elicited by their clientele ($r = .91$, $p <.001$), and professionals feeling unsafe in their work ($r = .66$, $p <.001$). Higher levels of negation reactions elicited by the type of clientele worked with was associated with professionals concealing the clientele they work with ($r = .32$, $p <.001$) and professionals feeling unsafe in their work ($r = .49$, $p <.001$). Mental health professionals' concealing the clientele they work with was associated with higher levels of mental health professionals feeling unsafe in their work with their clientele ($r = .19$, $p <.01$).

Demographics, Job Characteristics, and Secondary Stigma in Describing Counselors' Views of Burnout, Job Regret, and Personal Growth

Hierarchical multiple regression analyses were conducted to examine the relative contribution of participants' individual characteristics, job characteristics, and perceived secondary stigma in accounting for variation in participants' reports of 1) professional burnout (MBI), 2) job choice regret (DRS), and 3) personal growth (CMPGS). Regression results in Table 5.

The criterion variables were participants' mean scores of the subscales on the Maslach Burnout Inventory (MBI; Emotional Exhaustion, Depersonalization, and Personal Accomplishment), Decision Regret Scale (DRS; forth regression analysis), and Case Manager

Personal Growth Scale (CMPGS; fifth regression analysis). For each of the regression analyses, Step 1 consisted of the demographic variables of age and gender, Step 2 consisted of job characteristics (e.g. education, income, and type of counselor), and Step 3 consisted of scores on Mental Health Professional Secondary Stigma Scale (MHPSSS). In the above regression type of counselor was dummy coded into two variables, SOCoun and CaseMgr. If the participant was a sex offender counselor, SOCoun was coded with a 1 and CaseMgr was coded as 0. For participants that were case managers, SOCoun was coded with a 0 and CaseMgr was coded as 1. Lastly, for college counselors both SOCoun and CaseMgr were coded as 0.

Burnout

When using emotional exhaustion scores as the criterion measure, the overall regression model was significant, F (7, 182) = 6.22, $p < .001$, $R^2 = .19$. In Step 1, age ($\beta = -0.21$, $p < .01$) but not gender significantly predicted emotional exhaustion ($R^2 = .05$). In Step 2, age remained significant ($\beta = -0.22$, $p < .01$) but the addition of type of client worked with, education and income did not significantly predict emotional exhaustion ($\Delta R^2 = .01$). In Step 3, age remained significant ($\beta = -0.18$, $p < .05$), working with individuals who have sexually offended became significant ($\beta = -.34$, $p < .01$), and secondary stigma ($\beta = .47$ $p < .001$) significantly predicted emotional exhaustion ($\Delta R^2 = .12$). These findings suggest that after accounting for individual variables and job characteristics such as education and income, participants who reported higher levels of secondary stigma were more likely to report higher levels of emotional exhaustion.

When using depersonalization scores as the criterion measure, the overall regression model was significant, F (7, 182) = 11.05, $p < .001$, $R^2 = .30$. In Step 1, age and gender did not significantly predict depersonalization ($R^2 = .03$). In Step 2, the addition of education and income did not significantly predict depersonalization, though the addition of working with

individuals who have sexually offended significantly predicted depersonalization (β = .32, p < .001) (ΔR^2 = .07). In Step 3, working with individuals who have sexually offended no longer significantly predicted depersonalization, and the addition of secondary stigma (β = .62, p < .001) significantly predicted depersonalization (ΔR^2 = .21). These findings suggest that after accounting for individual variables and job characteristics such as education and income, participants who reported higher levels of secondary stigma were more likely to report higher levels of depersonalization.

When using personal accomplishment scores as the criterion measure, the overall regression model was significant, F (7, 182) = 5.62, p < .001, R^2 = .18. In Step 1, age (β = .22, p < .01) but not gender significantly predict personal accomplishment (R^2 = .05). In Step 2, the addition of education and income did not significantly predict personal accomplishment, though the addition of working with individuals who have sexually offended significantly predicted personal accomplishment (β = -.25, p < .01) (ΔR^2 = .05). In Step 3, age significantly predicted personal accomplishment (β = .23, p < .01), working with individuals who have sexually offended no longer significantly predicted personal accomplishment, and the addition of secondary stigma (β = -.38, p < .001) significantly predicted personal accomplishment (ΔR^2 = .08). These findings suggest that after accounting for individual variables and job characteristics such as education and income, participants who reported higher levels of secondary stigma were more likely to report lower levels of personal accomplishment.

Job Choice Regret

When using job choice regret scores as the criterion measure, the overall regression model was not significant, F (7, 181) = 2.03, p = n/s, R^2 = .0.07. These findings suggest that after

accounting for individual variables and job characteristics, such as education and income, perceived secondary stigma did not significantly predict job choice regret.

Personal Growth

When using personal growth scores as the criterion measure, the overall regression model was not significant, F(7, 182) = 1.91, p = n/s, $R^2 = .07$. These results indicate that demographic characteristics, job characteristics, and perceived secondary stigma did not significantly predict perceived personal growth.

Qualitative Results

Open-ended response questions were used to solicit participants' descriptions of their experiences in the three following domains: 1) social stigma associated with their clientele (sex offenders, people with psychiatric disabilities, college students) and stigma of individuals who work with their clientele; 2) nature of public disclosure about the population of clients with whom they work; and 3) their views on the impact of their work with their clients on their professional and personal lives.

Content analysis techniques were to examine participants' descriptions of secondary stigma and factors that sustain them in their work. Specifically, verbatim responses to open-ended questions were reviewed and categorized by theme to assess participants' reports of community views of their profession, their experiences of secondary stigma, and rewarding aspects of their profession. All identifying information was removed from participants' responses. Each response was read several times by the first author to code for content and theme categories based on similarities and differences in participants' responses. Direct quotes and verbatim excerpts were selected from each first-person account to reflect that content of accounts by topics. Topics were then organized into overarching categories or themes according

to content. If a single response contained two themes it was coded in both categories. If a single response contained similar statements in the same theme it was coded once in that theme. Participants' responses were compared across samples to examine differences between types of counselors.

Percentages of utterances were calculated using total number of utterances in response to the individual questions. A second coder reviewed 20 randomly selected responses for every question. The second coder was given a list of the codes with operational definitions. After the coders met to discuss coding disputes, coders agreed on 98% of the codes across questions. This was calculated by taking the number of codes both coders agreed on divided by the total number of codes for the responses. The themes are organized by question and type of counselor and described below.

Public Views in General

How do you think the general public views people who are sex offenders/who have mental illness/college student?

The most common themes are described below, for an explanation of all themes found see Tables 6a, 6b, 6c. Sex offender counselors and case managers reported that the public views the population with whom they work in a negative manner (sex offender counselors: 7% of the utterances; case managers: 5% of the utterances). Sex offender counselors and case managers also reported the public views the population they work with as dangerous (sex offender counselors: 20% of the utterances; case managers: 19% of the utterances), clients were seen as unable to change (sex offender counselors: 12% of the utterances; case managers: 2% of the utterances), and deserving of being punished (sex offender counselors: 7% of the utterances; case managers: 3% of the utterances).

Sex offender counselors were more likely to report their clientele being viewed as evil (42% of the utterances) and child molesters (11% of the utterances). Case managers also reported that the public views individuals with mental illness as different (40% of the utterances) and crazy (32% of the utterances). College counselors were more likely to report their clientele being viewed in a positive manner (43% of the utterances). College counselors also reported that college students were viewed as “party animals” or heavy drinkers (33% of the utterances).

How do you think the general public views counselors who work with sex offenders/who have mental illness/college student?

The most common themes are described below, for an explanation of all themes found see Tables 7a, 7b, 7c. Across all three samples, mental health professionals reported that the public views them negatively (sex offender counselors: 40% of the utterances; case managers: 17% of the utterances; college counselors: 8%), positively (sex offender counselors: 20% of the utterances; case managers: 60% of the utterances; college counselors: 46%), and with interest (sex offender counselors: 25% of the utterances; case managers: 29% of the utterances; college counselors: 30%). Sex offenders and case managers reported that the public misunderstands why they work with their population (sex offender counselors: 16% of the utterances; case managers: 8% of the utterances), views these counselors as bleeding heart liberals (sex offender counselors: 14% of the utterances; case managers: 5% of the utterances), and wasting their time (sex offender counselors: 7% of the utterances; case managers: 1% of the utterances). College counselors reported that the public misunderstands or underestimates the problems faced by college students (10% of the utterances) or has no opinion of college counselors (10% of the utterances).

Personal Experiences with Secondary Stigma

How do people typically respond upon hearing that you work with sex offenders/individuals with mental illness, college students?

The most common themes are described below, for an explanation of all themes found see Tables 8a, 8b, 8c. Across the three samples, mental health professionals reported that the public responds with interest (sex offender counselors: 25% of the utterances; case managers: 29% of the utterances; college counselors: 30%), positively (sex offender counselors: 10% of the utterances; case managers: 31% of the utterances; college counselors: 33%), and with self-disclosure about their problems (sex offender counselors: 3% of the utterances; case managers: 6% of the utterances; college counselors: 4%) upon hearing the populations they work with. Sex offender counselors and case managers reported that the public responds in a negative manner (sex offender counselors: 29% of the utterances; case managers: 11% of the utterances), with misunderstanding of why they work with their population (sex offender counselors: 23% of the utterances; case managers: 19% of the utterances), or they do not tell people about the population they work with (sex offender counselors: 3% of the utterances; case managers: 1% of the utterances).

Sex offender counselors also reported that the public responds by distancing themselves from the counselor (7% of the utterances) or that they are wasting their time (1% of the utterances). Case managers also reported that the public responds with concern for the case managers' safety (3% of the utterances). College counselors also reported that the public responds with confusion on what the counselor does (24% of the utterances) and by asking questions about the stereotypes of college students (2% of the utterances).

If a member of the community asked you why you have chosen to work with sex offenders/individuals with mental illness/college counselors, what would you say?

The most common themes are described below, for an explanation of all themes found see Tables 9a, 9b, 9c. Across the three samples, mental health professionals reported that they respond with reasons they enjoy the job (sex offender counselors: 10% of the utterances; case managers: 27% of the utterances; college counselors: 10%) and positive aspects of the job (sex offender counselors: 15% of the utterances; case managers: 29% of the utterances; college counselors: 24%). Sex offender and case managers reported that they respond they are helping others (sex offender counselors: 21% of the utterances; case managers: 42% of the utterances) or that they did not willingly choose the job (sex offender counselors: 18% of the utterances; case managers: 4% of the utterances).

Sex offender counselors also reported that they respond that they are protecting the community (39% of the utterances) or they want to better understand victims (3% of the utterances). Case managers also reported that they want to learn more about human behaviors (7% of the utterances) or they have someone in their family with mental illness (6% of the utterances). College counselors also reported that they respond that they can make a difference (13% of the utterances).

In what ways have people treated you differently because you work with sexual offenders/individuals with mental illness/college counselors?

The most common themes are described below, for an explanation of all themes found see Tables 10a, 10b, 10c. Across the three samples, mental health professionals reported that as a result of the population they work with, they have been treated negatively (sex offender counselors: 39% of the utterances; case managers: 19% of the utterances; college counselors:

13%), positively (sex offender counselors: 10% of the utterances; case managers: 12% of the utterances; college counselors: 21%), or they do not treatment them differently (sex offender counselors: 20% of the utterances; case managers: 40% of the utterances; college counselors: 61%). Case managers and college counselors reported that people often respond by asking if they are psychoanalyzing them (case managers: 5% of the utterances; college counselors: 4%).

Sex offender counselors also reported that people respond to these counselors by distancing themselves (16% of the utterances), asking a lot of questions (6% of the utterances), with caution (4% of the utterances), or the counselor does not tell people the clientele that they work with (4% of the utterances). Case managers also reported people respond to them with misperceptions of mental illness (5% of the utterances), negative curiosity (3% of the utterances), or concern about the case managers safety (2% of the utterances). College counselors did not report any unique themes.

Obstacles and Rewards of the Job

What do you consider to be the biggest obstacles or problems that you face in your work with sex offenders/individuals with mental illness/college students?

The most common themes are described below, for an explanation of all themes found see Tables 11a, 11b, 11c. Across the three samples, one of the biggest obstacles reported by mental health professionals was problems within their respective systems (sex offender counselors: 25% of the utterances; case managers: 10% of the utterances; college counselors: 12%). Mental health professionals also reported problems within the community (sex offender counselors: 19% of the utterances; case managers: 14% of the utterances; college counselors: 13%) as one of the biggest obstacles. Seventeen percent of the utterances reported by sex offender counselors, 32% of case manager utterances, and 27% of college counselors suggested lack of resources for

clients was also a big obstacle faced by mental health professionals. Mental health professionals also reported problems at the agency level (sex offender counselors: 15% of the utterances; case managers: 2% of the utterances; college counselors: 7%), problems with negative aspects of the job (sex offender counselors: 12% of the utterances; case managers: 11% of the utterances; college counselors: 18%), or attitudes of their clientele (sex offender counselors: 7% of the utterances; case managers: 28% of the utterances; college counselors: 23%). Sex offender counselors and case managers reported that problems with professionals they work with within the system as one of the biggest obstacles (sex offender counselors: 4% of the utterances; case managers: 3% of the utterances). Sex offender counselors were the only sample that reported a unique theme. Sex offender counselors also reported keeping current with research as one of the biggest obstacle (1% of the utterances).

What do you consider to be the biggest rewards that you have in your work with sex offenders/individuals with mental illness/college students?

The most common themes are described below, for an explanation of all themes found see Tables 12a, 12b, 12c. Across the three samples, mental health professionals found rewards through clients' progress (sex offender counselors: 59% of the utterances; case managers: 82% of the utterances; college counselors: 57%), in their personal life (sex offender counselors: 24% of the utterances; case managers: 13% of the utterances; college counselors: 13%), or through clients' appreciation (sex offender counselors: 2% of the utterances; case managers: 5% of the utterances; college counselors: 6%).

Sex offender counselors also reported that they found protecting the community to be rewarding (24% of the utterances). Case managers did not report any unique themes. College

counselors also reported finding rewards with the population they worked with (13% of the utterances) and helping college students and making a difference (11% of the utterances).

Impact of Work on Non-Work Life

In what ways, do you feel that the public's views of sexual offenders/individuals with mental illness/college students' impact how you feel towards your clients?

The most common themes are described below, for an explanation of all themes found see Tables 13a, 13b, 13c. Across the three samples, mental health professionals reported that the public's views of their clientele had no impact on how they felt towards their clients (sex offender counselors: 50% of the utterances; case managers: 53% of the utterances; college counselors: 60%), had a positive impact on how they feel towards their clients (sex offender counselors: 44% of the utterances; case managers: 29% of the utterances; college counselors: 32%), or had a negative impact on how they feel towards my client (sex offender counselors: 6% of the utterances; case managers: 18% of the utterances; college counselors: 7%)

In what ways has working with sex offenders/individuals with mental illness/college students impacted your professional life?

The most common themes are described below, for an explanation of all themes found see Tables 14a, 14b, 14c. Across the three samples, mental health professionals reported that working with their clientele has impacted their professional life in a positive way (sex offender counselors: 72% of the utterances; case managers: 92% of the utterances; college counselors: 71%), had a negative impact on their professional life (sex offender counselors: 20% of the utterances; case managers: 3% of the utterances; college counselors: 6%), has had no impact on their professional life (sex offender counselors: 4% of the utterances; case managers: 3% of the

utterances; college counselors: 3%), and has caused additional stress at work (sex offender counselors: 3% of the utterances; case managers: 3% of the utterances; college counselors: 2%)

In what ways has working with sex offenders/individuals with mental illness/college students impacted your personal life?

The most common themes are described below, for an explanation of all themes found see Tables 15a, 15b, 15c. Across the three samples, mental health professionals reported that working with their clientele has had a positive impact on their personal life (sex offender counselors: 13% of the utterances; case managers: 78% of the utterances; college counselors: 36%) or has had no impact on their personal life (sex offender counselors: 11% of the utterances; case managers: 4% of the utterances; college counselors: 6%). Sex offender counselors and case managers also reported that working with their clientele has made them more cautious in their personal life (sex offender counselors: 34% of the utterances; case managers: 1% of the utterances) or caused additional stress in their personal life (sex offender counselors: 4% of the utterances; case managers: 16% of the utterances). Case managers and college counselors also reported that the work with their clientele has improved their personal relationships (case managers: 1% of the utterances; college counselors: 17%)

Sex offender counselors also reported that working with sex offenders has had a negative impact on their personal relationships (14% of the utterances), caused them to develop a negative attitude (14% of the utterances), or they experienced vicarious trauma (9% of the utterances). Case managers did not report any unique themes. College counselors also reported that working with college students have helped them to grow and be more reflective (27% of the utterances) or had a negative impact on their personal life (14% of the utterances).

DISCUSSION

The present research examined mental health professionals' experience of secondary stigma, personal growth, professional burnout, and job choice regret as a function of working with clients using a sample of 196 mental health professionals who work with sexual offenders (64 sexual offender counselors), serious mental illness (64 case managers), and college students (68 college counselors). Counselors in the present study had ample professional experience with the three types of counselors having an average of 18 years of experience in their respective fields. Sex offender counselors and case managers reported higher caseloads than college counselors. A majority of sexual offender counselors and college counselors reported offering individual and/or group therapy for their respective client populations while a vast majority of case managers reported providing case management services to individuals with serious mental illness.

Results from the present study suggest that sexual offender counselors generally reported experiencing more secondary stigma than case managers who in turn reported more secondary stigma than did college counselors. Qualitative results support this finding and suggest that sex offender counselors are more likely than case managers and college counselors to perceive that the public holds negative views of their clientele and the counselors themselves. Sex offender counselors' higher perceived levels of secondary stigma may be due to the public holding highly stigmatized views of sex offenders more so than individuals with mental illness and college students. It may be that the public views sex offenders as causing their stigma by committing their offense while individuals with mental illness are not seen as responsible for their stigmatizing characteristic.

Interestingly, qualitative findings of the present study suggest that college counselors perceive the public as holding negative views of college students even though they appear to have little understanding of the severity of problems they face. Although the public's misunderstanding of problems faced by college students may contribute to college counselors' lower reported levels of secondary stigma, counselors appear to perceive that college students are looked upon poorly by the public. College counselors responses suggest that the public often views college students as entitled, spoiled, or “party animals.” Taylor (2006) wrote about emerging issues of generation NeXt and suggested that the media does not paint a positive picture of college students or college life. Specifically, across a number of avenues college life is promoted as a drunken and promiscuous time in development. Media's negative portrayal of college students contributes to the public's negative perceptions which they then voice to college counselors. While the public views college students negatively (as “party animals”), they also view them as hard-working and educated which may help to explain the lower levels of reported secondary stigma experienced by college counselors.

Case managers generally reported significantly higher levels of personal growth than did college counselors and sexual offender counselors. Qualitative results of this study support this finding and suggest that case managers were more likely to report that their work with individuals with mental illness has had a positive impact on their personal life. Case managers higher perceived level of personal growth may be due to case managers witnessing more growth in their clients as a result of the proximity in which they work with their clients. Case managers work closely with their clients while coordinating their clients' services and resources. This hands-on involvement in the client’s life (King et al., 2000) may allow case managers more opportunity to witness change within their clients than sex offender and college counselors.

Individuals with mental illness are the most likely of the three client populations in the present study to have problems across multiple areas of life functioning that are not attributed to volitional control. Pescosolido et al. (2010) completed a study that examined the impact of a campaign that presented mental illness as a medical disease in order to reduce stigma and increase service utilization. Results from their study suggested that over a 10-year period, there was an increase in the public attributing mental illness as having a neurobiological cause. As the public becomes more understanding on the etiology of mental illness, individuals appear to be more open to behavioral health treatment for individuals with mental health issues (Pescosolido et al., 2010). The public becoming more understanding of mental illness may contribute to case managers' higher reports of personal growth in the present study due to individuals with mental illness feeling more comfortable engaging in treatment compared to other client populations. Individuals who have committed sexual offenses may also experience problems in multiple areas of their life though the public views the sex offender as responsible for their stigmatizing mark. The public lacks empathy for sex offenders and views their offenses as taboo and outside the range of acceptable behavior (Quinn et al., 2004). Maruna and King (2009) found that the public views offenders as being evil because they chose to commit their crime and are unable to be rehabilitated.

Qualitative results suggest that college counselors reported that problems within the system (e.g. the limited number of sessions) were one of the biggest obstacles faced. Minami et al. (2009) examined the effectiveness of psychological treatment provided at university counseling centers and found that stress and loss of productivity were conducive to a shorter-length of sessions and more significant problems (i.e. psychological distress and anhedonia) tend to require longer sessions. The limited number of sessions may contribute to college counselors

not experiencing as much personal growth due to feeling like they are not given an adequate opportunity to address the problems faced by their clients. College counselors also reported that they felt underappreciated and the public's misunderstanding of the severity of problems they work with as obstacles which may also contribute to counselors' not experiencing as much personal growth as a result of their work. Sex offender counselors reported the lowest levels of personal growth, which may be attributed to the higher levels of depersonalization they reported.

In regards to professional burnout, the present study found no significant overall differences in mental health professionals' reports of emotional exhaustion or personal accomplishment. However, sexual offender counselors in the present study generally reported higher levels of depersonalization as a result of their work with sexual offenders than did case managers or college counselors. Maslach (1993) defined depersonalization as lack of empathy, developing a negative attitude, or emotionally distancing from clients. Sex offender counselors may have a more difficult time relating with their clients due to sex offenders being viewed as causing their stigma by choosing to commit their offense while individuals with mental illness and college students are not viewed as causing their mental illness or problems. Sex offender counselors' difficulty relating to their clients may contribute to counselors emotionally distancing themselves from the client out of their own disgust towards the offenders' offense. Qualitative results in the present study suggest that a greater percentage of sex offender counselors than other mental health professionals in the present study reported that they did not willingly choose to work with sex offenders, which may also contribute to their distancing themselves from their clients.

In the present study, higher levels of depersonalization reported by sex offender counselors as compared to that of case managers and college counselors is consistent with

previous research (Scheela, 2001; Kraus & Stein, 2012; Gnilka, 2015). Sex offender counselors' higher levels of reported depersonalization is consistent with the findings of Scheela (2001) that sex offender counselors reported feeling hardened as a result of their work. Case managers' lower levels of reported depersonalization are similar to findings from Kraus and Stein (2012). Kraus and Stein found that that case managers reported low levels of depersonalization and emotional exhaustion at work and high levels of personal accomplishment and job satisfaction. Findings of the present study are also similar to those of Gnilka et al. (2015). Gnilka studied counselors that work in a school setting and found that school counselors reported higher levels of exhaustion and lower levels of devaluing the patient.

Quantitative findings in the present study also suggested that secondary stigma accounted for variation in mental health professionals' reports of burnout and job choice regret, after controlling for individual and job characteristics. Similar to findings of the present study, past research has found that psychologist, psychiatrist, and psychiatric nurses reported that stigma contributed to job stress more that direct patient care (Schulze, 2007). Stigma related to population worked with may contribute to the job choice regret reported by mental health professionals due to feeling overwhelmed with the pressure put on them to 'cure' those who are mentally ill or sexually offend. Across the three samples, mental health professionals reported that they were treated negatively as a result of the population with they work. Mental health professionals in the current study reported negative interactions or experiences with the public and fellow mental health professionals. These negative experiences or reactions along with the increased pressure to 'cure' their patients may contribute to mental health professionals regretting their decision to work in the mental health field.

Past research has found that mental health professionals reported contact with clients to be the most satisfying or least stressful aspect of their job (Schulze, 2007; Ferrel et al. 2000). Findings from the present study further support this notion. Over half of the qualitative utterances for all three samples of mental health professionals suggested that the sample found client's progress to be the most rewarding aspect of the job. In contrast to the findings of Craft and Stein (2007), none of the variables in the regression model significantly related to mental health professional reports of personal growth. However, all three samples of mental health professionals reported working with their selected clientele as having a predominately positive impact on their professional life. These findings suggest that mental health professionals experience greater professional growth than personal growth from their work with clients.

In response to open-ended questions, counselors who work with individuals who have sexually offended reported their work has had more of a negative impact on their personal life than that reported by case managers and college counselors. Over a third of the college counselor and case managers' utterances suggested that people respond in a positive manner while 76% of sexual offender counselors' utterances suggested that people respond in a negative manner upon hearing the population with which they work. Sexual offender counselors reported that they work with individuals who sexually offend in order to protect the community while college counselors reported they enjoyed the college population and case managers reported they wanted to give back to the community. A majority of college counselors and case managers reported that people do not treat them differently upon hearing what population they work with while sexual offender counselors reported that they are often treated negatively. Across the three samples of mental health professionals, participants reported issues due to lack of funding and stigmatizing views about the population they work with from the general public as the biggest

obstacle. These findings seem to be consistent with previous research (Scheela, 2001; Stein & Craft, 2007; Smith et al., 2007) who found that sex offender counselors, case managers, and college counselors generally reported both positive and negative experiences while working with this clientele. Results of the present study suggest that regardless of population mental health professionals work with, they experience some degree of secondary stigma, burnout, and personal growth. However, type of population does impact the significance of the secondary stigma, personal growth, and burnout experienced by mental health professionals. Gaining a better understanding of secondary stigma could improve insights into the personal well-being and work conditions of mental health professionals.

Study Limitations

The present study provides an important step in understanding the relative contribution of individual characteristics, job characteristics, and secondary stigma in accounting for variation in mental health professionals' reports of individual well-being (i.e. personal growth, professional burnout, and job choice regret). Although findings of the present study are interesting, they are limited in a number of ways. The present study used a relatively small, non-random sample of predominately Caucasian mental health professionals who work with sexual offenders, serious mental illness, and college students who were members of professional guild organizations. The study also compared a sample of case managers to clinicians. Case managers and clinicians vary in their roles and demographics which may limit the generalizability of findings. Case managers were selected as a sample in the present study due to their exposure and nature of their interactions with individuals with serious mental illness and their advocating for serious mental illness within the community. In order to determine generalizability of findings to other samples larger more representative samples composed of mental health clinicians are needed. The degree

to which findings generalize to other samples of mental health professionals is not clear given that there may be selection bias by recruiting through professional organizations. The study was cross-sectional in nature, so inferences cannot be made in the direction of causality. Future studies should use a representative and diverse sample drawn from a more diverse sample of professional organizations and mental health agencies. However, findings from the present study are important because they shed light on challenges and rewards that are often associated with working in the mental health profession.

The present study offered preliminary evidence that the MHPSSS has acceptable convergent and divergent validity using the Social Desirability Scale and Perceived Organizational Support Scale. Further validation of the MHPSSS is needed. The MHPSSS should be compared to another construct that is expected to be related to secondary stigma in order to establish convergent validity. Future studies could compare scores on the MHPSSS to scores on a measure of shame. In order to establish discriminate validity, the MHPSSS should be compared to another construct that is not expected to be related to secondary stigma.

Future Directions for Research and Practice

In the present study, mental health professionals reported experiencing secondary stigma and burnout as a result of their work with marginalized populations. Counselors who worked with individuals who have sexually offended generally reported higher levels of secondary stigma and depersonalization than case managers who reported higher levels than college counselors. A direction for future research could be to examine how mental health professionals cope with the secondary stigma and burnout they experience and how they prevent it from interfering with their work. By gaining a better understanding of how mental health professionals cope with secondary stigma and burnout, professionals may improve their work

with clients. Another direction for future research could be examining the public's actual views of mental health professionals in order to compare mental health professionals' perceptions with that of the public's perception. Understanding the public's perceptions of mental health professionals and their clients could better inform mental health professionals to combat the secondary stigma they experience.

Support groups that offer a safe environment for mental health professionals to discuss their experiences may be one way to counteract the effects of secondary stigma and burnout experienced by mental health professionals. Satterfield and Becerra (2010) found that medical residents attended support groups to share their struggles and elicit support. Another study done by Bartlett and Coulson (2011) found that online support groups offered participants the opportunity to feel empowered by comparing their experience with other group members. Support groups for mental health professionals could offer education on the potential for burnout as a result of the stigma they experience. Results of this study suggest that counselors who work with individuals who have sexually offended could especially benefit from support groups to share their experiences with negative treatment from the public and social isolation as a result of the clientele they work with. Sex offender counselors may also benefit from sharing their struggles with being empathic and developing negative attitudes in order to normalize their experience as well as receive support and suggestions on how to cope.

In the present study, college counselors reported feeling underappreciated and misunderstood by other departments and professionals in the academic setting. A common theme among college counselors' responses was that people often did not understand their role or the severity of the mental health problems college student face. Kitzrow (2003) suggested that college counseling centers use outreach to educate students and university faculty about the mental

health problems faced by college students. Educating students and staff about the common problems faced by college students may be beneficial in reducing stigma related to mental health and increase help-seeking behaviors, though it does not adequately address the secondary stigma experienced by college counselors. The present findings suggest that college counseling centers should extend their outreach programs to educating faculty, staff, and the public about their role as a counselor, the importance of counseling center services, and misconceptions about college students. By educating other professionals on the services offered within the counseling center as well as the problems faced by college students, faculty and staff will be better informed about the importance of the counseling center as well as the significant issues their students are likely to be facing.

The present research is among the first to compare the role of secondary stigma in the lives of mental health professionals who work with populations who are more or less marginalized by society. The present study serves as a powerful reminder of the importance of understanding how social context and professional relationships between clinicians and clients shape the nature of mental health care.

Table 1

Sample demographic characteristics

	Sex Offender Counselor	Case Managers	College Counselors
N	64	64	68
Gender			
Female	39 (60.9%)	50 (78.1%)*	60 (88%)
Male	25 (39.1%)	13 (20.3%)	8 (12%)
Ethnicity			
African-American	1 (1.6%)	11 (17.2%)*	4 (5.9%)
Caucasian	57 (89.1%)	44 (68.8%)	56 (82.4%)
Hispanic	4 (6.3%)	7 (10.9%)	4 (5.9%)
Asian-American	0 (0%)		1 (1.5%)
American Indian/Native American	1 (1.6%)		1 (1.5%)
Other	1 (1.6%)	1 (1.6%)	2 (2.9%)
Marital Status			
Single	11 (17.2%)	22 (34.5%)	6 (8.8%)
Married	40 (62.5%)	23 (35.9%)	41 (60.3%)
Partner	3 (4.7%)	5 (7.8%)	7 (10.3%)
Cohabiting	2 (3.1%)	4 (6.3%)	3 (4.4%)
Divorced	6 (9.4%)	8 (12.5%)	9 (13.2%)
Widowed	1 (1.6%)	2 (3.1%)	1 (1.5%)
Education			
B.A. or B.S. Degree	1 (1.6%)	34 (48.4%)	1 (1.5%)
Master's Degree	32 (50.0%)	26 (40.6%)	44 (64.7%)
Ph. D.	22 (34.4%)	1 (1.6%)	11 (16.2%)
Psy. D	6 (9.4%)		7 (10.3%)
Other	3 (4.7%)	6 (9.4%)	4 (4.9%)
Current Income			

Less than $20,000	1 (1.6%)		1 (1.5%)
$20,000 to $40,000	4 (6.3%)	25 (39.1%)	11 (16.2%)
$41,000 to $60,000	13 (20.3%)	24 (37.5%)	26 (38.2%)
$61,000 to $80,000	15 (23.4%)	7 (10.9%)	18 (26.5%)
$81,000 to $100,000	14 (21.9%)	4 (6.3%)	5 (7.4%)
Over $100,000	16 (25.0%)	4 (6.3%)	5 (7.4%)
Employment Status			
Full-time	51 (79.7%)	63 (98.4%)*	65 (95.6%)
Part-time	13 (20.3%)		2 (2.9%)
Clientele Work With			
	Court Mandated Adult 55 (85.9%)	Depressive Disorder 59 (92.2%)	Relationship Issues 66 (97.1%)
	Voluntary Adult 24 (37.5%)	Anxiety Disorder 59 (92.2%)	Academic Problems 58 (85.3%)
	Court Mandated Juvenile 53 (82.8%)	Psychotic Disorder 52 (81.3%)	Severe Mental Illness 67 (98.5%)
	Voluntary Juveniles 23 (35.9%)		
Type of Agency			
	Community MH Agency 14 (21.9%)	Community MH Agency 48 (75%)	Counseling Center 66 (97.1%)
	Prison/Detention Center 16 (25%)	Housing Agency 6 (9.4%)	Other 1 (1.4%) *
	State Hospital 8 (12.5%)	Private Agency 3 (4.7%)	
	Private Practice 21 (32.8%)	Group Home 3 (4.7%)	
	Other 4 (6.3%)	Other 4 (6.3%)	
Types of Services Offered			
Individual Therapy	49 (76.6%)	18 (28.1%)	65 (95.6%)

Group Therapy	48 (75.0%)	15 (23.4%)	44 (64.7%)
Sex Offender Assessment	47 (73.4%)	3 (4.7%)	0 (0%)
Case Management	17 (26.6%)	60 (93.8%)	20 (29.4%)
Other	11 (17.2%)		14 (20.6%)

Note. * Indicates missing data for one or more individuals.

Table 2 *Component matrix of reduced MHPSSS items using varimax rotation*

Items	Factor		
	Aesthetic	Concealability	Peril
People sometimes seem disgusted when they find out the type of clients that I work with	**.856**		
People sometimes talk to me about how they find the type of clients that I work with to be disgusting	**.851**		
People tell me that the type of clients I work with are dangerous	**.762**		
People often become uneasy when they learn about the type of clients that I work with	**.760**		
Sometimes even my family and friends seem disgusted by the types of clients that I work with	**.746**		
People think that the type of clients that I see can never really change	**.726**		
I am treated differently by other mental health professionals because of the type of clients I work with	**.616**		
At times, family and friends tell me that I am in danger because of the type of clients that I work with	**.567**		.384
At times, I feel stigmatized by others because of the type of clients that I work with	**.514**	.365	
People will always associate me with the type of clients I work with now	**.356**		
I usually don’t talk about what I do for a living to people that I have just met		**.742**	
I feel reluctant to mention the type of clients that I work with when asked about my job		**.737**	
I try not to talk about what I do for a living unless I am asked directly		**.686**	
I like to talk to people about the work that I do		**.682**	
I feel that it is important to talk with family and friends about the types of problems my clients usually face		**.606**	
People have a strong positive reaction when they learn about the type of clients that I work with		**.400**	
I worry that I could get hurt physically by the type of clients that I work with			**.789**
At times, I am fearful of the type of clients that I work with			**.780**

At times, people hold me responsible for the poor choices made by the types of clients that I work with	.432		**.520**
At times, I worry that I am thinking like the type of clients that I see			**.519**
I would rather work with a different type of client than the clients that I currently work with			**.478**
People who have just met me often treat me differently when they find out the type of clients that I work with*	.458	.390	.422
People have a lot of misconceptions about the type of clients that I work with*			
People sometimes feel sorry for me because of the type of client that I work with*			
Working with the type of clients that I see wasn't really a conscious choice for me*			
I am responsible for working with the type of clients that most counselors don't want to work with*			
I am not responsible for how people view the type of clients that I work with*			
I feel responsible for standing up for the type of clients that I work with when other people are critical of them*			
The types of clients that I work with are not often dangerous*			
At times, I think that other people would like me more if I changed the type of clients that I work with*	.429		.434
I think that people like me more because of the type of clients that I work with*			
I am honest about the type of clients that I work with when asked at a social event**	77.8%		
I have less social contacts because of the type of clients that I work with**	84.8%		
My family and friends treat me differently because of the type of clients that I work with**	82.3%		
Once people find out the type of clients that I work with they tend to keep their distance**	79.8%		
At times I am disgusted by the type of clients that I work with**	78.8%		
I never wanted to work with the type of clients that I	85.9%		

see**			
Number of items within each factor	10	6	5
Cronbach's alpha coefficient for each factor	.901	.781	.705

*Meets criteria for elimination based on low (<.35) loadings on all factors
** Meets criteria for elimination based on 75% of the reported responses that are "strongly disagree" or "somewhat disagree" (Floyd & Widaman, 1995)

Table 3 *Pearson correlations among age and job characteristics for the overall sample*

	Variables	M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	MHPSSS	2.45	.65	--													
2	Aesthetic	2.52	.91	.91**	--												
3	Conceal	2.74	.82	.62**	.32**	--											
4	Peril	1.97	.71	.67**	.49**	.19**	--										
5	DRS	1.76	.87	.096	.02	.08	.20**	--									
6	CMPGS	3.63	.69	-.13	-.04	-.29**	.004	-.120	--								
7	Emotional Exhaustion	2.42	1.25	.24**	.15*	.12	.38**	.22**	-.078	--							
8	Depersonal	1.47	1.17	.50**	.46**	.22**	.45**	.26**	-.27**	.47**	--						
9	Personal Acc	4.48	.85	-.3**	-.18**	-.26**	-.36**	-.27**	.37**	-.45**	-.49**	--					
10	Age	45.12	12.58	.11	.13	.11	-.07	-.21**	-.021	-.22**	-.116	.23**	--				
11	Caseload	29.42	30.24	.05	.095	-.03	.003	-.07	.087	.062	.024	.07	.14	--			
12	Empl Current	10.52	8.82	.09	.06	.16	-.05	-.03	-.103	-.184	.001	.07	.57**	.31**	--		
13	Exp	18.21	33.42	.10	.13	.05	-.03	-.08	.010	-.099	.046	.17*	.38**	.08	.18	--	
14	SDS-17	.42	.21	-.13	-.09	-.19**	-.02	-.01	.132	-.160*	-.26**	.22**	.139	.19*	-.01	.09	--

Note. * $p < .05$. ** $p < .01$.; MHPSSS = Mental Health Professional Secondary Stigma Scale, Aesthetic = Aesthetic subscale of MHPSSS, Conceal = Concealability subscale of MHPSSS, Peril = Peril subscale of MHPSSS, DRS = Decision Regret Scale, CMPGS = Case Manager Personal Growth Scale, Emotional Exhaustion = Emotional Exhaustion subscale of MBI, Depersonalization = Depersonalization subscale of MBI, Personal Accomplishment = Personal Accomplishment subscale of MBI, Age = Participant's current age, Caseload = Number of clients providers are currently responsible for, Empl Current = How long participant has been employed at their current agency, Exp = Participant's years of experience in current career

Table 4 *Pearson correlations among age and job characteristics by type of counselors*

	Variables	M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	Sex Offender Counselor																
1	MHPSSS	2.99	.50	--													
2	Aesthetic	3.28	.66	.83**	--												
3	Conceal	3.29	.74	.60**	.16	--											
4	Peril	2.02	.65	.68**	.42**	.23	--										
5	DRS	1.66	.71	.38**	.14	.33**	.50**	--									
6	CMPGS	3.45	.69	.11	.29*	-.24	.11	-.27*	--								
7	Emotional Exhaustion	2.32	1.35	.42**	.23	.26*	.51*	.69**	-.14	--							
8	Depersonal	1.79	1.34	.51**	.37**	.23	.55**	.499**	-.28*	.56**	--						
9	Personal Acc	4.36	.89	.26*	.00	-.32*	-.40**	-.61**	.35**	-.64**	-.56**	--					
10	Age	50.17	12.39	-.13	-.08	-.09	-.13	-.27*	.01	-.25	-.23	.38**	--				
11	Caseload	31.14	35.50	.04	.14	-.09	-.03	-.21	.15	-.10	-.01	.15	.41**	--			
12	Empl Current	11.95	9.99	-.00	-.02	.07	-.05	-.08	-.03	-.16	.00	.17	.59**	.47**	--		
13	Exp	26.21	54.64	-.03	.09	-.06	-.01	-.08	.050	-.10	.06	.25*	.34**	.13	.15.	--	
14	SDS-17	.47	.12	-.09	.00	-.15	-.09	-.07	.15	-.16	-.09	.25*	.17	.13	.10	.10	--
	Case Managers																
1	MHPSSS	2.39	0.52	--													
2	Aesthetic	2.55	0.79	.89**	--												
3	Conceal	2.33	0.61	.36**	.02	--											
4	Peril	2.17	0.74	.71**	.50**	.04	--										
5	DRS	1.91	0.78	.12	.03	.04	.23	--									
6	CMPGS	3.75	0.64	-.08	.02	-.30*	.02	-.12	--								
7	Emotional Exhaustion	2.38	1.21	.38**	.31*	.11	.38**	.02	-.07	--							

8	Depersonal	1.51	1.09	.60**	.56**	.15	.42**	.25	-.25*	.46**	--						
9	Personal Acc	4.46	0.85	-.33**	-.13	-.44**	-.26*	-.09	.38**	-.32*	-.42**	--					
10	Age	41.75	11.69	-.03	.00	-.01	-.08	-.11	.13	-.37**	-.18	.19	--				
11	Caseload	34.02	33.90	-.20	-.18	-.095	-.12	.07	.10	.16	-.11	.11	-.12	--			
12	Empl Current	7.74	4.21	-.28	-.37	.06	-.10	.01	.07	-.17	-.46*	-.13	.45*	.04	--		
13	Exp	12.59	8.94	-.03	.098	-.18	-.13	-.06	.11	-.22	-.07	.18	.72**	-.26	.53*	--	
14	SDS-17	.57	.14	-.09	-.05	-.08	-.09	.25*	.27*	-.12	-.18	.11	.01	.10	-.08	.05	--
	College Counselors																
1	MHPSSS	2.00	0.52	--													
2	Aesthetic	1.78	0.56	.84**	--												
3	Conceal	2.60	0.78	.69**	.25*	--											
4	Peril	1.74	0.69	.86**	.71**	.42**	--										
5	DRS	1.70	1.06	.04	.01	.11	-.02	--									
6	CMPGS	3.69	0.69	-.15	-.10	-.18	-.10	-.08	--								
7	Emotional Exhaustion	2.56	1.19	.32**	.33**	.09	.35**	.05	-.05	--							
8	Depersonal	1.13	1.00	.31**	.31**	.12	.33**	.13	-.22	.47**	--						
9	Personal Acc	4.59	0.81	-.32**	-.33**	-.06	-.40**	-.21	.38**	-.40**	-.43**	--					
10	Age	43.48	12.24	-.00	-.01	.01	-.01	-.20	-.02	-.03	-.10	.23	--				
11	Caseload	23.38	17.01	.20	.20	.13	.12	-.09	-.04	.37**	.22	-.09	-.02	--			
12	Empl Current	9.75	8.22	.09	.20	-.07	.06	.25	.48*	.15	-.09	.33	.62**	-.17	---		
13	Exp	15.11	10.06	-.07	-.10	.02	-.08	-.19	.08	-.08	-.19	.26*	.87**	-.07	.45*	--	
14	SDS-17	.49	.12	-.07	-.01	-.12	-.06	-.17	.05	.07	-.10	-.04	.19	.03	-.19	.20	--

Note. * $p < .05$. ** $p < .01$.; MHPSSS = Mental Health Professional Secondary Stigma Scale, Aesthetic = Aesthetic subscale of MHPSSS, Conceal = Concealability subscale of MHPSSS, Peril = Peril subscale of MHPSSS, DRS = Decision Regret Scale, CMPGS = Case Manager Personal Growth Scale, Emotional Exhaustion = Emotional Exhaustion subscale of MBI, Depersonalization = Depersonalization subscale of MBI, Personal Accomplishment = Personal Accomplishment subscale of MBI, Age = Participant's current age, Caseload = Number of clients providers are currently responsible for, Empl Current = How long participant has been employed at their current agency, Exp = Participant's years of experience in current career

Table 5
Hierarchical Regression Analysis

				β					
Criterion Variable		Predictor Variables	R^2 *Chg*	Step 1	Step 2	Step 3	R^2	Adj R^2	R
Emotional Exhaustion	1.	Age	.056	-.210**	-.217**	-.180*	.056**	.046	.237
		Gender		.101	.107	.121			
	2.	Education	.014		.073	-.020	.070	.040	.265
		Income			-.072	-.027			
		SOCoun			.028	-.335**			
		CaseMgr			-.085	-.210**			
	3.	MHPSSS	.123			.472**	.193**	.162	.439
Depersonalization	1.	Age	.025	-.111	-.150	-.102	.025	.014	.158
		Gender		-.116	-0.46	-.027			
	2.	Education	.065		.036	-.085	.090*	.060	.300
		Income			-.074	-.015			
		SOCoun			.322**	-.151			
		CaseMgr			.134	-.029			
	3.	MHPSSS	.208		.	.615**	.298**	.271	.546
Personal Accomplishment	1.	Age	.050	.222**	.263**	.223**	.050**	.040	.233
		Gender		-.007	-.061	-.072			
	2.	Education	.049		-.099	-.025	.098*	.069	.314
		Income			.093	.057			
		SOCoun			-.246**	.047			
		CaseMgr			-.043	.058			
	3.	MHPSSS	.079			-.380**	.178**	.146	.422
Job Choice Regret	1.	Age	.043	-.208**	-.189*	-.177*	.043	.033	.208
		Gender		-.022	-.025	-.020			

	2.	Education	.016		.074	.044	.059	.028	.243
		Income			-.070	-.055			
		SOCoun			.392	-.084			
		CaseMgr	.013		.890	.033	.073	.037	.270
	3.	MHPSSS				.156			
Personal Growth	1.	Age	.012	-.019	.107	.101	.012	.002	.110
		Gender		.108	.067	.064			
	2.	Education	.053		-.049	-.034	.065	.034	.255
		Income			-.180	-.187			
		SOCoun			-.103	-.042			
		CaseMgr			.045	.067			
	3.	MHPSSS	.004			-.080	.068	.033	.261

Note. * p < .05. ** p < .01.

Table 6a *Sex Offender Counselors: How do you think the general public views people who are sex offenders?*

Themes *Public Thinks…*	**Operational Definition**	**Examples**	**Frequency of Utterances % (N = 106)**
Sex offenders are evil	Public attributes negative characteristics or ways to describe offenders	The public views sex offenders “As "monsters" and as inhuman.”	44/106 = 41.5%
Sex offenders are dangerous [b]	Sex offenders are high risk: Public believes sex offenders are all high risk. Sex offenders are to be feared: Public responds with fear towards sex offenders.	“They offend more than other criminals and that they will always reoffend.” “There is a tremendous amount of fear,” regarding sexual offenders.”	21/106 = 19.8
Sex offenders are unable to change [b]	Public believes that sex offenders are unable to change and therapy is ineffective.	The public “They do not appreciate the positives that can come from treatment of those at risk for offending.”	13/106 = 12.3
Sex offenders are child molesters.	Public is misinformed: The public is misinformed about sex offenders. Public does not understand the difference in types of offenses: Does not understand the different types of offenses (i.e. assume all sex offenders are child molesters)	“The public misunderstands them and sees them as a constant danger to society.” “Through a singular lens with little recognition or understanding of the many differences present within the "sex offender" population.”	12/106 = 11.3
Sex offenders should be punished [b]	Public believe sex offenders should be incarcerated, castrated, sentenced to death, sent to “pedophile island”; believe they should be punished indefinitely or severely	The public views sex offenders as “As people who should be executed posthaste.”	9/106 = 8.5

Negatively of sex offenders [b, c]	Public responds with negative emotions towards offenders: family members respond with denial, public responds with anger, respond with disgust, have negative feelings towards them.	"There is a lot of fear, anger, and reactivity toward people who have committed sexual offenses."	7/106 = 6.6

b= theme also appears in case manager group; c = theme also appears in college counselor group

Table 6b *Case Managers: How do you think the general public views people who have mental illness?*

Themes *Public Thinks...*	Operational Definition	Examples	Frequency % (N = 111)
People with mental illness are different	Public attributes negative characteristics or ways to describe offenders Public believes individuals with mental illness are second-class citizens. The public views individuals with mental illness as less important or deserving Public views individuals with mental illness as incapable of caring for themselves. The public views individuals with mental illness as unable to care for themselves.	The public views individuals with mental illness as, "second-class citizens, as responsible for their own problems." "There is a stigma associated with people with mental illness. They can't do anything for themselves, are lazy, and weird."	44/111 = 39.6%
Individuals with mental illness are crazy	The public is misinformed about individuals with mental illness.	"Their [the Public] view probably coincides with the lens that Hollywood portrays. I think the stereotypical `'mental patient' in a straight jacket or walking back and forth in a white robe on a psyche [*sic*] unit is also still dominating the public's view."	35/111 = 31.5
People with mental illness are dangerous [a]	Public believes individuals with mental illness are all high risk and dangerous	"I believe the general public believes the stereotypes associated with mental illness and are generally afraid of those who have a mental illness."	21/111 = 18.9
Negatively of individuals with mental illness [a, c]	Public responds with negative emotions towards individuals with mental illness: public responds with anger, respond with disgust, have negative feelings or pity towards them.	The public "for the most part they feel sorry for them."	5/111 = 4.5
Individuals with	Public believes that individuals with	"I think that the general public has	3/111 = 2.7

mental illness are unable to change [a]	mental illness are unable to change and therapy is ineffective.	misconceptions about people with mental illness, such as they are not capable of living a "normal" life, they are all aggressive individuals, and they cannot recover from mental illness."	
Individuals with mental illness should be isolated [a]	Public believes that individuals with mental illness should be isolated or incarcerated.	"The public would like people who are mentally ill (at least at my agency) to be warehoused somewhere, but they do not want to pay for it."	3/111 = 2.7

a = theme also appears in sexual offender group; c = theme also appears in college counselor group

Table 6c *College Counselors*: *How do you think the general public views college students?*

Themes *Public Thinks…*	**Operational Definition**	**Examples**	**Frequency % (N = 125)**
College Students are good	Public views college students in a positive light in a positive manner as educated, hardworking, and intelligent	"I think people view college students in a positive light because they are making a choice to continue their education and further their career."	54/125 = 43.2%
College students are "party animals"	Public is misinformed about college student and views them in a negative manner or holds stereotypical beliefs about college students (i.e. "party animals")	"I think generally, the public on average views college students (and emerging adults broadly) as helpless, immature, and irresponsible-- or at the very least there is a perspective that they are under-developed. It seems they are often stereotyped by drunken partiers."	41/125 = 32.8
College students are entitled	Public views college students as entitled or believing that they deserve special treatment	The public views college students as "basically as immature and self-serving with a sense of entitlement."	23/125 = 18.4
College students don't have real problems	Public misunderstands the severity of mental health problems faced by college students.	Public believes "that their only mental health issues are academic stress and relationships."	7/125 = 5.6

a = theme also appears in sexual offender group; b = theme also appears in case manager group

Table 7a *Sex Offender Counselors: How do you think the general public views counselors who work with sex offenders?*

Themes *Public...*	**Operational Definition**	**Examples**	**Frequency % (N = 100)**
Views counselors negatively [b, c]	Public stigmatizes counselors who work with sex offenders. Public holds strong negative reactions: Public has a strong negative reaction towards the counselor Public views counselors as suspiciously: Public views counselors as crazy or naïve.	"Pretty much the same [as sexual offenders] or they pity us for having to listen to their offenses all day, every day." The public views counselors with, "suspicion (what happened in your life to make you want to work with "those" people)."	40/100 = 40.0%
Views counselors positively [b,c]	Public views counselors in a positive manner Public is thankful for what the counselors do: The public is thankful for what the counselors do and view it as God's work. Public views them with curiosity: Public views them with curiosity and interest in learning more about field/work	"I've also met people who admire our ability to work with them and our compassion for them." "I find people generally respect my work and find it interesting."	20/100 = 20.0
Misunderstands why counselors work with sex offenders [b]	Public does not understand the reasons why counselors work with sex offenders.	"They don't understand why someone would work with them or even talk to them. I think they think the counselor is different from other counselor and is less respectful to the counselor."	16/100 = 16.0
Views counselors as bleeding heart liberals [b]	Public views counselors as weak; believe counselor sides with sex offender and holds their hands, believe counselor agrees with offense behavior, believe counselor coddles the offender.	"There are some who would say were are just like them, or we are messed up and we condone their offending behavior"	14/100 = 14.0
Views counselors as wasting their time [b]	Public views sex offender as unfixable/unchangeable therefore therapy	"I think most people think it's pointless because of the misbelief that 1) all sex	7/100 = 7.0

	is ineffective and counselor is wasting their time	offenders are pedophiles and 2) pedophiles can't be cured."	

b= theme also appears in case manager group; c = theme also appears in college counselor group

Table 7b *Case Managers: How do you think the general public views counselors who work with individuals who have mental illness?*

Themes *Public….*	**Operational Definition**	**Examples**	**Frequency % (N = 78)**
Views case managers positively [a,c]	Public views case managers in a positive manner Public is thankful and respectful of case managers: Public is appreciative for the work of case managers Public responds with interest: Public responds with interest in learning more about case managers' work	"I feel very respected as a case manager and have been praised for the work I do." "I have found people are more interested in my work than criticizing it."	47/78 = 60.3%
Views case managers negatively [a,c]	Public attributes negative characteristics or ways to describe individuals with mental illness to case managers	"It sometimes feels like a forgotten segment of work, stigmatized in some ways and behind in perception/stature to those who do work in physical health fields."	13/78 = 16.7
Misunderstand what case managers do	Public does not understand the role of case managers	"The general public does not even know what a case manager is."	7/78 = 9.0
Misunderstand why case managers work with mental illness [a]	Public does not understand the reasons why case managers work with mental illness	"The they wonder why we would consider doing it - why not get a low stress, "cleaner" job."	6/78 = 7.7
Views case managers as bleeding heart liberals [a]	Public views case managers as weak, do gooders.	The public views case managers as "As do-gooder's trying to make a difference"	4/78 = 5.1
Views case managers as wasting their time [a]	Public views individuals with mental illness as unfixable/unchangeable therefore case management services are ineffective and case manager is wasting their time	"Case managers are wasting their time because these people will never change or they should not need the help."	1/78 = 1.3

a = theme also appears in sexual offender group; c = theme also appears in college counselor group

Table 7c *College Counselors*: *How do you think the general public views counselors who work with college students?*

Themes *Public…*	**Operational Definition**	**Examples**	**Frequency % (N = 87)**
Views college counselors positively [a, b]	Public views college counselors in a positive manner by being respectful and thankful for their work	The public views college counselors as "Intelligent, caring, interesting, and fortunate to be working with such a population."	40/87 = 46.0%
Misunderstands what college counselors do [b]	Public holds misperceptions about the job or does not understand the role of college counselors	The public believes college counselors are "As academic or career counselors - or that 'we just sit around drinking coffee and talking'"	22/87 = 25.3
Misunderstands the problems college students' face	Public does not understand or underestimates the problems faced by college students.	"They don't have a clue as to the serious problems we deal with on a daily basis. They do not realize how stressful our jobs are."	9/87 = 10.3
Has no opinion about college counselors	Public does not have an opinion of or think much of college counselors	"I honestly don't think the general public probably has much of an opinion about it"	9/87 = 10.3
Views college counselors negatively [a,b]	Public attribute negative characteristics or ways to describe college students to college counselors	The public views college counselors "as potentially negligent and incompetent, particularly following the media attention to VA Tech and Colorado theater shooting."	7/87 = 8.1

a = theme also appears in sexual offender group; b = theme also appears in case manager group

Table 8a *Sex Offender Counselors: How do people typically respond upon hearing that you work with sex offenders?*

Themes *People respond...*	**Operational Definition**	**Examples**	**Frequency % (N = 104)**
Negatively [b]	People respond in a negative manner by becoming argumentative, defensive, and voice negative opinions of sex offenders	"Some [people] see me differently, and wonder what my motivations are for working with this population."	30/104 = 28.9%
With interest [b, c]	People respond with interest in learning more about the counselor's profession	People typically respond with, "'Oh! I bet that's an interesting job...' and will then ask me questions about my work."	26/104 = 25.0
With misunderstanding of how I can work with sex offenders [b]	People respond that they don't understand how I could work with sex offenders because they couldn't	"I don't understand how anyone could work with those sort of people"	24/104 = 23.1
Positively [b, c]	People respond in a positive manner, by being impressed or showing respect, upon hearing I work with sex offenders.	The public responds with "admiration," "respect," or think "I am brave."	10/104 = 9.6
By distancing themselves from me	People physically distance themselves from me by either no longer seeing me as a counselor or avoid me all together (coworkers, clients, and in social life)	"Taken aback. Don't know what to say. Eventually drift off."	7/104 = 6.7
With self-disclosure [b, c]	People self-disclose and tell me about their own abuse or views on why people offend	"They relate someone they know who is a victim or predator."	3/104 = 2.9
I don't tell people I work with sex offenders [b]	I avoid telling people about my work	"I tend to be somewhat guarded about sharing specifically about the types of offenders I work with."	3/104 = 2.9
I am wasting my time	People don't think sex offenders can be helped	"Some people reservations about the ability of SOs to change, especially if they've never been in tx themselves."	1/104 = 0.96

b= theme also appears in case manager group; c = theme also appears in college counselor group

Table 8b *Case Managers: How do people typically respond upon hearing that you work with individuals with mental illness?*

Themes *People respond...*	**Operational Definition**	**Examples**	**Frequency % (N = 90)**
Positively [a, c]	People respond in a positive manner, by being impressed or showing respect, upon hearing I work with individuals with mental illness.	"They are often impressed. People always point out that I am 'doing something that is making a difference in someone else`s life.'"	28/90 = 31.1%
With interest [a,c]	People respond with interest in learning more about the case manager's profession	People are typically "eager to hear about what I do. They tend to be really curious."	26/90 = 28.9
Misunderstanding of how I can work with individuals with mental illness [a]	People respond that they don't understand how I could work with individuals with mental illness because they couldn't	"Some people say, 'how can you work with crazy people?'"	17/90 = 18.9
Negatively [a]	People respond in a negative manner by becoming argumentative, defensive, and voice negative opinions of mental illness	"I work with the homeless so from time to time I hear negative talk about how dirty the population I work with is."	10/90 = 11.1
With self-disclosure [a,c]	People self-disclose and tell me about their own mental illness	"Ask me questions to 'fix' their own problems"	5/90 = 5.6
With concern about my safety	People respond with concern or worry for my safety	"People are often astonished. They are surprised at the fact that I would be willing to work in one of the scariest and most dangerous places in Los Angeles working with individuals whose mental capacities may not be considered healthy or predictable."	3/90 = 3.3
I don't tell people I work with individuals with mental illness [a]	I avoid telling people about my work	"I usually don't talk about it and most people really don't care."	1/90 = 1.1

a = theme also appears in sexual offender group; c = theme also appears in college counselor group

Table 8c *College Counselors*: *How do people typically respond upon hearing that you work with college students?*

Themes *Public respond...*	**Operational Definition**	**Examples**	**Frequency % (N = 104)**
Positively [a, b]	People respond in a positive manner, by voicing their appreciation or showing respect, upon hearing I work with college students	"Oh, wow! That great! We need people like you."	30/90 = 33.3%
With interest [a, b]	People respond with interest in learning more about the counselors' profession	"With interest and curiosity about the main issues we treat."	27/90 = 30.0
With misunderstanding the role of college counselors	People misunderstand the role of the counselor or the problems faced by college students	"I don't think they always understand what it means to be a counselor to college students. I often have to explain more in depth because they assume a "counselor" means advisor."	22/90 = 24.4
People don't have an opinion	People do not have an opinion or do not think about college counselors	"I don't think being a counselor of college students changes the valence of others' opinions about someone being a counselor at all."	5/90 = 5.6
With self-disclosure [a, b]	People self-disclose and tell me about their college experience	"They like to talk about their kids and/or their college experiences and wished they had used or had a college counselor at that time."	4/90 = 4.4
By asking about the stereotypes	People respond by asking about stereotypes of college students	"If they "get" what I do (mental health/personal counseling) they ask what's wrong with kids these days."	2/90 = 2.2

a = theme also appears in sexual offender group; b = theme also appears in case manager group

Table 9a *Sex Offender Counselors: If a member of the community asked you why you have chosen to work with sex offenders, what would you say*?

Themes *I respond with...*	**Operational Definition**	**Examples**	**Frequency % (N = 102)**
I am protecting the community	I want to protect and educate the community	"I work with people who have committed sexual offense because I am committed to preventing sexual violence."	40/102 = 39.2
I am helping offenders [b]	I find offenders interesting; I want to offer them a chance to a healthier life; I feel they deserve a chance at a better life	"They are seen as 'the worst of the worst' and are stigmatized and shunned by society. They need help more than anyone. Also, I like to work with people who have real problems, not just discontent housewives."	21/102 = 20.6
I did not willingly choose the job [b]	I chose to work with sex offenders because no one else would and someone has too, agency asked me to, fell into for some reason other than interest (didn't make it in the clinical field/tricked into it)	"No one else will do it and someone has to make our community safer"	18/102 = 17.7
Reasons I enjoy the job [b, c]	I tell them the reasons I love my job and that I am blessed to be doing it.	"It is very rewarding work"	10/102 = 9.8
Positive aspects of the job [b,c]	I respond with positive aspects of the job. For example, the pay is good; it is challenging; I find the job interesting.	"It is important work and that I have grown a lot as a professional as a result of it."	10/102 = 9.8
I want to better understand victims or someone I know was a victim	I want to better understand victims or someone I know was a victim	"I worked with victims for a long time, then realized some of them had offended. I wanted to learn the best way to provide treatment for my clients who had offended."	3/102 = 2.9

b= theme also appears in case manager group; c = theme also appears in college counselor group

Table 9b *Case Managers: If a member of the community asked you why you have chosen to work with individuals with mental illness, what would you say*?

Themes *I respond with...*	**Operational Definition**	**Examples**	**Frequency % (N = 83)**
I want to help others [a]	I want to help individuals with mental illness improve their lives and make a difference	"I feel passionate about helping people who are not always openly accepted by the community. I enjoy helping people feel empowered and showing them that not everyone will discriminate them for being mentally ill."	35/83 = 42.2%
Reasons I enjoy the job [a, c]	I tell them the reasons I love my job and that I find it rewarding and am blessed to be doing it.	"It is rewarding working with those who have a mental illness. The work has challenges just like any work but I feel it has led to my own personal growth. I feel better equipped to take on increasingly challenging clients since I have worked with this population."	22/83 = 26.5
Positive aspects of the job [a, c]	I respond with positive aspects of the job. For example, the pay is good; it is challenging; I find the job interesting.	"I find mental illness interesting and enjoy learning about their lives and stories"	12/83 = 14.5
I want to learn more about human behaviors	I want to learn more about and gain a better understanding of human behavior.	"To help people and enjoy learning about people who come from different backgrounds."	6/83 = 7.2
I have someone in my family with mental illness	I have someone in my family with mental illness	"Having experienced family members who have suffered from mental illness and witnessing a lack of service and support I want to give back to those so easily misguided and/or neglected"	5/83 = 6.0
I did not willingly choose the job [a]	I did not choose to work with individuals with mental illness. I fell into the career or it was the first job that would hire me.	"Because it was the first job that hired me out of college with a liberal arts degree."	3/83 = 3.6

a = theme also appears in sexual offender group; c = theme also appears in college counselor group

Table 9c *College Counselors*: *If a member of the community asked you why you have chosen to work with college students, what would you say*?

Themes *I respond with...*	**Operational Definition**	**Examples**	**Frequency % (N = 84)**
I enjoy working with the college population	I enjoy the unique challenges faced while working with a college-aged population.	"Because they tend to be high functioning, young, resourceful, and pleasant to work with"	45/84 = 53.6%
Positive aspects of the job [a, b]	I respond with positive aspects of the job. For example, the pay is good; it is challenging; I find the job interesting.	"Working for a university offers many benefits that a counselor could never find anywhere else."	20/84 = 23.8
I can make a difference	I want to help improve college students' lives and make a difference	"College is an important transition in someone's life and it is a time when they learn a lot about themselves. I want to be able to support people during this important time of growth."	11/83 = 13.1
Reasons I enjoy the job [a, b]	I tell them the reasons I love my job. I am passionate about my work and find it rewarding.	"College students are a very motivated population who actively work on their issues, and seeing their growth is rewarding."	8/84 = 9.5

a = theme also appears in sexual offender group; b = theme also appears in case manager group

Table 10a *Sex Offender Counselors: In what ways have people treated you differently because you work with sexual offenders?*

Themes *People respond...*	**Operational Definition**	**Examples**	**Frequency % (N = 80)**
Negatively [b, c]	People treat counselors negatively upon hearing they work with individuals who have sexually offended by becoming argumentative, defensive, and voice negative opinions of sex offenders	"The community tried to run me out of town when I moved my office; I was accused of putting the safety of children at risk and not caring about victims. The local police thought I was in danger of being firebombed after I faced such outrage in a public meeting that consisted of 4 hours of people screaming at me, telling me to 'go back where I came from' (even though I grew up in this community) that I had PTSD symptoms for several months afterward. It was months before I felt safe from the community in public again. I do not however feel afraid from my clients."	31/80 = 38.8%
Don't treat me differently [b, c]	People do not treat the counselors differently upon hearing their work with sexual offenders	"I have not experienced negative responses to my work and, in general, no one has treated me differently."	16/80 = 20.0
By distancing themselves from me	People physically distance themselves from the counselor upon hearing they work with sexual offenders.	"People are more reluctant to speak with me or they identify my work as something totally different (I had one woman change my profession to that of a funeral director)"	13/80 = 16.3
In a positive manner [b, c]	People treat me positively, by being impressed or showing respect, upon hearing I work with sex offenders.	People "take more interest in what I do for a living."	8/80 = 10.0
By asking a lot of questions	People respond by wondering how the counselor is able to work with this population.	"People respond by saying 'how could you have anything to do with such disgusting people?'"	5/80 = 6.3
With caution	People treat the counselor with caution upon hearing the counselor works with sexual offenders	People are "more cautious. Never a sleep over for my kids."	3/80 = 3.8

I don't tell people they type of client I work with	Counselors do not tell people that they work with sexual offenders	“I really don't talk about it [my work] much”	3/80 = 3.8
Tell me I am wasting my time	People believe the counselor is wasting their time because sexual offenders are unable to change	“Lectured me about how they will never change and always re-offend.”	1/80 = 1.3

b= theme also appears in case manager group; c = theme also appears in college counselor group

Table 10b *Case Managers: In what ways have people treated you differently because you work with individuals with mental illness?*

Themes *People respond...*	**Operational Definition**	**Examples**	**Frequency % (N = 67)**
Don't treat me differently [a, c]	People do not treat the counselors differently upon hearing their work with individuals with mental illness	"I don't think people have treated me differently."	27/67 = 40.3%
Negatively [a, c]	People treat case managers negatively upon hearing they work with individuals with mental illness by becoming argumentative, defensive, and voice negative opinions of mental illness	"They think I have started developing some of those [mental illness] traits."	13/67 = 19.4
With self-disclosure [c]	People self-disclose and tell me about their own mental illness	"People come to me many times about personal problems with themselves or a family member asking advice of what to do in many different situations dealing with mental illness."	10/67 = 14.9
In a positive manner [b, c]	People treat me positively, by being impressed or showing respect, upon hearing I work with individuals with mental illness	"They actually treat me better. The Mother Teresa syndrome."	8/67 = 11.9
With misperceptions of mental illness	People respond with their misperceptions or stereotypes about individuals with mental illness	"Mostly people feel sorry for me because they have misconceptions about the population I work with or see my job as being difficult."	3/67 = 4.5
I am psychoanalyzing them [c]	People think I am psychoanalyzing them	"People feel that I am psychoanalyzing them so they choose not to share with me their struggles."	3/67 = 4.5
With negative curiosity	People want to hear "war stories" or negative stories about the clients I work with	"Ask for horror stories, 'juicy' stories"	2/67 = 3.0
With concern about my safety	People respond with concern or worry for my safety	"People that are very close to me sometimes express concerns about my safety or stress that I experience at work."	1/67 = 1.5

a = theme also appears in sexual offender group; c = theme also appears in college counselor group

Table 10c *College Counselors: In what ways have people treated you differently because you work with college students?*

Themes *People respond...*	**Operational Definition**	**Examples**	**Frequency % (N = 70)**
They don't treat me differently [a, b]	People do not treat the counselors differently upon hearing their work with college students	"I don't think I am treated differently"	43/70 = 61.4%
In a positive manner [a, b]	People treat me positively, by being impressed or showing respect, upon hearing I work with college students	"I think that they treat me with respect given the importance of the work that I do."	15/70 = 21.4
Negatively [a, b]	People treat college counselors negatively upon hearing they work with college students by looking down on counselors due to misconceptions about the population they work with	"Sometimes other people in the psychology field don't take me as seriously. Specifically, some psychologists who work with more severe clients think that this is just "easy" work."	9/70 = 12.9
With self-disclosure or fear I am "psychoanalyzing" them [b]	People self-disclose and tell me about their own mental illness	"Sometimes, people will share more of their personal life with me then they might with others, they may also express anxiety that I am analyzing them and I usually respond by saying that I'm off the clock or something to set them at ease, but I will refer them, if they are looking for treatment at a dinner party."	3/70 = 4.3

a = theme also appears in sexual offender group; b = theme also appears in case manager group

Table 11a *Sex Offender Counselors: What do you consider to be the biggest obstacles or problems that you face in your work with sex offenders?*

Themes *Problems with...*	**Operational Definition**	**Examples**	**Frequency % (N = 91)**
The legal system [b, c]	Problems with sex offender laws, registration laws, housing restrictions.	"The sociopolitical environment of fear, anger, and reactivity has resulted in harsh, one size fits all policy responses that create obstacles to their successful integration into the community."	23/91 = 25.3%
The community/general public [b, c]	Problems with public's stigmatizing views and misunderstanding of sex offenders	"The biggest obstacle is that I would like to share the information than I have about sexual offending with the general public, however I find the general public is not usually very receptive to it"	17/91 = 18.7
Lack of resources for sex offenders [b, c]	Problems with lack of employment and funding	"Lack of funding with so many clients indigent, it is a huge challenge for them to pay fees and my agency is a small private one who relies on fee for service."	15/91 = 16.48
The agency level [b, c]	Problems within the agency. For example, my coworkers' lack of knowledge; group therapy aspect makes it difficult.	"I can't go to other agency staff with client problems, not having supervisor who is in the field. Feel very isolated from other employees"	14/91 = 15.4
Negative aspects of the job [b, c]	Problems with aspects of the job that are frustrating (no money; no appreciation; over worked); how working with SO impacts my personal life (suspicious of others; disgusting thoughts; hard to work with different populations)	"My organization's lack of appreciation for what we do in our program. They respond to the uniqueness of our services as if we were being elitist. The organization allows a culture of bullying by supervisors."	11/91 = 12.1
Attitudes of sex offender and their families [b, c]	Problems with sex offenders feeling they don't have a problem; being court mandated and family being in denial or angry; client's unwilling to change and being in denial	"Sometimes it can be difficult to stay hopeful for the clients' long-term success and sometimes I struggle to believe that the clients actually want to change."	6/91 = 6.6
The professionals in legal system [b]	Problems with probation/parole officers, lawyers, legal officials: arrogant, lack of	"The ignorance of the public and legislators"	4/91 = 4.4

	understanding.		
Keeping current with research	Problems with keeping current with research	"Lack of literature and support regarding the unique experiences female clinicians have when working with male sex offenders."	1/91 = 1.1

b= theme also appears in case manager group; c = theme also appears in college counselor group

Table 11b *Case Managers: What do you consider to be the biggest obstacles or problems that you face in your work with individuals with mental illness?*

Themes *Problems with...*	**Operational Definition**	**Examples**	**Frequency % (N = 92)**
Lack of resources for individuals with mental illness [a, c]	Problems with lack of services and resources available for individuals with mental illness	"Services in rural area of our state. Medicaid reimbursement is low and many doctors, dentist and specialist will not accept Medicare or Medicaid patients. Employment finding employers who will give the client a chance to work and be a contributing citizen of their community. School systems afraid of liability and do not want to integrate classrooms."	29/92 = 31.5%
Attitudes of clients and their families [a, c]	Problems with clients' feeling they don't have a problem; client's unwilling to change and being in denial	"Motivation from the individuals is by far the biggest obstacle for them and me in helping them."	26/92 = 28.3
The community/general public [a, c]	Problems with public's stigmatizing views and misunderstanding of mental illness	"Challenging stigma, increasing empathy and sensitivity in myself and other community members."	13/92 = 14.1
Negative aspects of the job [a, c]	Problems with aspects of the job that are frustrating (no money; no appreciation; over worked)	"The feeling of defeat when I cannot help everyone and not having enough time to spend with my clients."	10/92 = 10.9
Dealing within the system [a, c]	Problems with the behavioral health system.	"The systems who do not understand recovery, resilience and self-determination."	9/92 = 9.8
The professionals in the mental health system [a]	Problems with mental health professionals: arrogant, lack of understanding.	"The attitudes of our "partner" agencies in the communities we serve - how they view our work with people they consider "not yet ready" to be helped...I expect problems with clients, but not the problems that are more frustrating and much bigger that are projected onto our agency and our work by those with different philosophies"	3/92 = 3.3

The agency level [a, c]	Problems within the agency. For example, my coworkers' lack of knowledge; group therapy aspect makes it difficult.	"The biggest problem is the staff turnovers at the agencies"	2/92 = 2.2

a = theme also appears in sexual offender group; c = theme also appears in college counselor group

Table 11c *College Counselors*: *What do you consider to be the biggest obstacles or problems that you face in your work with college students?*

Themes *Problems with...*	Operational Definition	Examples	Frequency % (N = 98)
Lack of resources for college students [a, b]	Problems with lack of available resources for college students	"More serious mental health issues than are resources for on campus"	26/98 = 26.5%
Attitudes of college students [a, b]	Problems with college students feeling they don't have a problem; want a "quick fix;" less emotional resilience; feeling they don't have a problem; no investment to change	"College students today have the developmental emotional maturity of 14 or 15 year old's. They do not respond to interventions aimed at helping them to individuate and take greater responsibility for their lives. They are horrible individual therapy candidates. Adults (the therapist) are simply there to serve them and ideally fix their problems or tell them what to do."	22/98 = 22.5
Negative aspects of the job [a, b]	Problems with aspects of the job that are frustrating (no money; no appreciation; over worked); how working with college students impacts that counselors personal life	"Most staff feeling overworked and exhausted, underpaid and underappreciated as compared to faculty"	18/98 = 18.4
The community/general public [a, b]	Problems with public's stigmatizing views and misunderstanding of college students	"Outsiders often underestimate the pathology that can be present on college campuses"	13/98 = 13.3
The system [a, b]	Problems with within the system: transferring services at end of school year; can only provide short term therapy; students moving	"We can only provide short-term counseling on campus. One of the biggest obstacles is helping them get the help they need with outside treatment providers in an efficient amount of time."	12/98 = 12.2
The agency level [a, b]	Problems within the agency. For example, my coworkers' lack of knowledge; group therapy aspect makes it difficult.	"Understaffing"	7/98 = 7.1

a = theme also appears in sexual offender group; b = theme also appears in case manager group

Table 12a Sex Offender Counselors: What do you consider to be the biggest rewards that you have in your work with sex offenders?

Themes *I find rewards with...*	**Operational Definition**	**Examples**	**Frequency % (N = 85)**
Clients' progress or advocacy [b, c]	The positive behavior and cognitive changes within the client due to treatment (notice behavioral change; improved life; admissions of problems; coping skills; reunification with family or victim); proper treatment/rights of sex offenders (stop punitive measures)	"It's challenging work and the rewards are very few and far between but when you are rewarded with a person who makes significant life changes it is incredible and fuels you to continue your job until the next one comes along."	50/85 = 58.8%
Protecting the community	Protecting community; minimizing recidivism; community rewards	"Making the world a better place/facilitating community safety, assisting individuals in their rehabilitation and moving forward in a positive manner, making a difference in bettering my community"	20/84 = 23.5
In my personal life [b, c]	Not boring job, enjoy job, respect, gratification	"The work is rich and challenging, which I enjoy day to day as a clinician. As a person, I feel rewarded in knowing that we're providing services to a population that has the potential to be very hurtful to others."	12/84 = 14.1
I find nothing rewarding	Counselor unable to see any reward	"I can't think of any."	2/84 = 2.4
Clients' appreciation [b, c]	The client's positive response to treatment (client appreciation; identify how I helped them)	"Their appreciation of the help I offer."	1/84 = 1.8

b= theme also appears in case manager group; c = theme also appears in college counselor group

Table 12b *Case Managers: What do you consider to be the biggest rewards that you have in your work with individuals with mental illness?*

Themes *I find rewards with...*	**Operational Definition**	**Examples**	**Frequency % (N = 78)**
Clients' progress or advocacy [a, c]	The positive behavior and cognitive changes within the client due to treatment (notice behavioral change; improved life; coping skills). I find advocating for and empowering clients to be one of the biggest rewards	"The smile, the accomplishment, the goal reached, the first step taken, the 'Oh my gosh, I did it' look on the face of a client, all of those things are amazing to me and make my work great." "The biggest reward is when they feel empowered to help themselves."	64/78 = 82.05%
In my personal life [a, c]	I find the relationships with their patients and the challenging work to be rewarding.	"I've grown immensely in my personal life and passion in having worked with this population. I've seen the roads they've traveled, I've seen the obstacles they've overcome, and the way they are treated by the general public, and that has made me a more persistent, patient, understanding, and positive."	10/78 = 12.8
Clients' appreciation [a, c]	The client's positive response to treatment (client appreciation; identify how I helped them)	"Being their supports when they have no else and they are so appreciative."	4/78 = 5.1

a = theme also appears in sexual offender group; c = theme also appears in college counselor group

Table 12c *College Counselors*: *What do you consider to be the biggest rewards that you have in your work with college students?*

Themes *I find rewards with...*	**Operational Definition**	**Examples**	**Frequency % (N = 83)**
Clients' progress [a, b]	The positive behavior and cognitive changes within the client due to treatment (notice behavioral change; improved life; admissions of problems; coping skills)	"Watching them walk across the stage and receive their diploma; hearing from them years after graduation and them telling me how well they are doing, and how they still use the skills they learned in counseling."	47/83 = 56.6%
In my personal life [a, b]	I find the relationships with their patients and the challenging work to be rewarding.	"The work is inherently greatly rewarding"	11/83 = 13.3
The populations I work with	I find the clients and the characteristics of the population (intelligent and high-functioning) I work with rewarding.	"Developmentally their ability and willingness to grow - their energy and optimism"	11/83 = 13.3
Helping college students and making a difference	I find helping and empowering my clients rewarding.	"Feeling like I made a difference in someone's life. Feeling accomplished. Helping students navigate through a time a transition/adjustment/identity development"	9/83 = 10.8
Clients' appreciation [a, b]	The client's positive response to treatment (client appreciation; identify how I helped them)	"When they tell you that you've helped them succeed it's an amazing feeling!"	5/83 = 6.0

a = theme also appears in sexual offender group; b = theme also appears in case manager group

Table 13a *Sex Offender Counselors:* I*n what ways, do you feel that the public's views of sexual offenders impact how you feel towards your clients?*

Themes *Public views have...*	**Operational Definition**	**Examples**	**Frequency % (N = 64)**
No impact on how I feel towards my clients [b, c]	The public's view has not impact on how the counselor feels towards their clients	"My work fulfills me and is not really impacted by what others think."	32/64 = 50.0%
A positive impact on how I feel towards my clients [b, c]	The public's view has a positive impact on how I feel towards my clients (better understand the challenge they face, more likely to advocate for them, want to protect them)	"Sometimes I feel more dedicated to do the work that I do after seeing sex offenders being marginalized or pigeon-holed by society."	28/64 = 43.8
A negative impact on how I feel towards my clients [b, c]	The public's view has a negative impact on how I feel towards my clients (develop a negative view of sexual offenders, begin to agree with public)	"They prime me at times to feel badly toward clients."	4/64 = 6.3

b= theme also appears in case manager group; c = theme also appears in college counselor group

Table 13b *Case Managers: In what ways, do you feel that the public's views of individuals with mental illness impact how you feel towards your clients?*

Themes *Public views have...*	**Operational Definition**	**Examples**	**Frequency % (N = 62)**
No impact on how I feel towards my clients [a, c]	The public's view has not impact on how the case manager feels towards their clients	"I don't think the public's view impacts how I feel towards my clients."	33/62 = 53.2%
A positive impact on how I feel towards my clients [a,c]	The public's view has a positive impact on how I feel towards my clients (better understand the challenge they face, more likely to advocate for them, want to protect them)	"I often feel protective of my clients because of the way others speak of and to them. I have learned to look at each person individually and to focus on strengths."	18/62 = 29.0
A negative impact on how I feel towards my clients [a,c]	The public's view has a negative impact on how I feel towards my clients (develop a negative view of individuals with mental illness, begin to agree with public)	"The public view is that my work is very hard and that I will burn out fast so It is difficult to feel strong. The public view is that those with mental illness can take responsibility for all their actions so I push change on my clients too fast."	11/62 = 17.7

a = theme also appears in sexual offender group; c = theme also appears in college counselor group

Table 13c *College Counselors*: I*n what ways, do you feel that the public's views of college students impact how you feel towards your clients?*

Themes *Public views have...*	**Operational Definition**	**Examples**	**Frequency % (N = 56)**
No impact on how I feel towards my clients [a,b]	The public's view has not impact on how the college counselor feels towards their clients	"I do not think it does impact how I feel."	34/56 = 60.2%
A positive impact on how I feel towards my clients [a,b]	The public's view has a positive impact on how I feel towards my clients (better understand the challenge they face, more likely to advocate for them, want to protect them)	"I am simply aware that most students are not entitled or privileged and I am a greater advocate for them."	18/56 = 32.1
A negative impact on how I feel towards my clients [a,b]	The public's view has a negative impact on how I feel towards my clients (develop a negative view of college students, begin to agree with public)	"At times, the stereotypes come into my mind when working with clients, but I have to disregard these ideas because they are not necessarily true"	4/56 = 7.1

a = theme also appears in sexual offender group; b = theme also appears in case manager group

Table 14a *Sex Offender Counselors: In what ways has working with sex offenders impacted your professional life?*

Themes *Working with sex offenders has impacted….*	**Operational Definition**	**Examples**	**Frequency % (N = 71)**
My professional life in a positive way [b, c]	In a positive manner: I have become an expert, I find it rewarding, I experienced some growth from the job	"Very interesting, challenging, and fulfilling clinical work. I've learned a lot. Opportunities to train, teach, and publish in his field. Involvement with state Sex Offender Management Board and the board of ATSA."	50/71 = 72.4%
My professional life in a negative way [b, c]	In a negative manner: I have experienced vicarious trauma; I am isolated from other staff; It is difficult; it is frustrating	"Many private practices are not interested in me. I feel somewhat isolated from other professionals."	14/71 = 19.7
Has not had an impact [b, c]	Working with sex offenders has not had an impact on my professional life	"I wanted to be a criminal psychologist when I was 12, so it has done little to impact my professional life because I always wanted to work with criminals"	3/71 = 4.2
My professional life by causing stress at work [b, c]	I have experienced more stress at work as a result; I have a higher caseload	"I am however feeling the burnout of over 30 years doing the same work."	2/71 = 2.8
My personal life in a negative way	I am less sexual; misunderstanding of my family; difficult to talk about profession with community; counselor has experienced negative impact on their social life	"One of the ways offender work affected me was that it made me more protective of children, both mine and others"	2/71 = 2.8

b= theme also appears in case manager group; c = theme also appears in college counselor group

Table 14b *Case Managers: In what ways has working with individuals with mental illness impacted your professional life?*

Themes *Working with individuals with mental illness has impacted...*	**Operational Definition**	**Examples**	**Frequency % (N = 72)**
My professional life in a positive way [a, c]	In a positive manner: I have become an expert, I find it rewarding, I experienced some growth from the job	"It has been a rich and meaningful career. I never expected to spend this much time doing this work but I have had amazing opportunities to walk alongside people with very different experiences than mine. It is constantly interesting."	66/72 = 91.7%
My professional life in a negative way [a, c]	In a negative manner: I have experienced vicarious trauma; I am isolated from other staff; It is difficult; it is frustrating	"The way it has impacted my professional life is that, I have a doctorate, but because I work in a CBO that runs on grant money and a little Medicaid billing, I will never be able to pay off my educational loan. I will need to work until I am at least 75 or older to pay even a portion of my debt....and no one recruits you and pays off your debts when you work for non-profits"	2/72 = 2.8
My professional life by causing stress at work [a, c]	I have experienced more stress at work as a result; I have a higher caseload	"Cynicism, anger at times at being asked to do more with no raises, less money stress"	2/72 = 2.8
Has not had an impact [a, c]	Working with sex offenders has not had an impact on my professional life	"None"	2/72 = 2.8

a = theme also appears in sexual offender group; c = theme also appears in college counselor group

Table 14c *College Counselors*: *In what ways has working with college students impacted your professional life?*

Themes *Working with college students has impacted...*	**Operational Definition**	**Examples**	**Frequency % (N = 97)**
My professional life in a positive way [a, b]	In a positive manner: I have become an expert, I find it rewarding, I experienced some growth from the job	"Working with college students has helped sharpen my own clinical skills and challenges me to stay current and relevant in my treatment for college students."	69/97 = 71.1%
My personal life in a positive manner	In a positive manner: I experience personal rewards as a result of my work with college students. I have learned more about myself and feel inspired and hopeful for the future	"The students have strengthened my hope for the future and challenged me to become a better clinician."	17/97 = 17.5
My professional life in a negative way [a, b]	In a negative manner: other professionals do not see it as "real" mental health role; I have re-evaluated my career path; I feel stifled	"I do feel like I have been stifled in my career by working with this population versus a private practice because the age group rarely changes."	6/97 = 6.2
Has not had an impact [a, b]	Working with sex offenders has not had an impact on my professional life	"Not that much"	3/97 = 3.1
My professional life by causing stress at work [a, b]	I have experienced more stress at work as a result: asked to do more with less resources; other professionals think my department is difficult to work with	"I also have to maintain student confidentiality, which can lead other professionals to think my department is difficult to work with."	2/97 = 2.1

a = theme also appears in sexual offender group; b = theme also appears in case manager group

Table 15a *Sex Offender Counselors: In what ways has working with sex offenders impacted your personal life?*

Themes *Working with sex offenders has impacted….*	**Operational Definition**	**Examples**	**Frequency % (N = 91)**
By making me more cautions [b]	I have become more cautious or paranoid in their personal life (less trusting, more suspicious, more aware of surroundings); More aware when with my children; more aware of how I interact with children	"I am more wary of others and protective of my children."	31/91 = 34.1%
My relationship with my family and friends negatively	I have experienced a decrease in my sex life; my family doesn't understand my profession or why I do it; I have a limited circle of friends due to my profession	"I suspect some people who meet me just think I'm too weird for doing it to pursue a friendship with me. Some people are clearly uncomfortable if I discuss my work."	13/91 = 14.3
By causing me to develop a negative attitude	I have developed a negative attitude (I have become jaded, I have become desensitized, I am resentful, I am disgusted with sex offenders)	"Skepticism reduced respect for the general public; why care for a community that doesn't care for itself or you?"	13/91 = 14.3
My personal life in a positive way [b, c]	Working with sex offenders has had a positive impact on my personal life in that it provides me with a good salary, earns me respect, and I am better able to understand people.	"I think I am better at understanding others perspectives and being empathetic. Made me a better listener with my own family."	12/91 = 13.2
Has had minimal or no impact on my personal life [b, c]	Working with sex offenders has had minimal or no impact on my personal life	"probably not at all"	10/91 = 11.0
By causing me trauma	I have experienced some sort of trauma through working with SO (I have been victimized at work, it is traumatizing to hear what offenders did, emotional responses to stories)	"Sometimes there can be an overflow of information related to offenses or trauma the offenders have experienced before committing their offense that is difficult to deal with: working with any clients in mental health you are exposed to the fact that humans abuse one another but it can be very difficult to hear specific details	8/91 = 8.8

		about horrific abuse that people have experienced/perpetrated."	
By causing stress in my personal life [b]	My work takes over life, I must work harder at separating work from personal life. I am constantly drained and find work hard to escape.	"I've had bad dreams when I am stressed at work. I've had some bad dreams about my clients' offenses."	4/91 = 4.4

b= theme also appears in case manager group; c = theme also appears in college counselor group

Table 15b *Case Managers: In what ways has working with individuals with mental illness impacted your personal life?*

Themes *Working with individuals with mental illness has impacted...*	**Operational Definition**	**Examples**	**Frequency % (N = 80)**
My personal life positively [a,c]	Working with individuals with mental illness has had a positive impact on my personal life in that it provides me with a good salary, earns me respect, and I am better able to understand people.	"It has made me more selfless. My clients enjoy talking with me because they know I listen. I have become a better listener, and thus, communicator, as a result of them. I have brought this enhanced skill into my personal life. I get great reward and satisfaction by simply wholeheartedly listening to someone express themselves without worrying when I am going to chime in. "	62/80 = 77.5
By causing stress in my personal life [a]	My work takes over life, I must work harder at separating work from personal life. I am constantly drained and find work hard to escape.	"Sometimes you get an emotional attachment and are unable to leave work at work "	13/80 = 16.3
Has had minimal or no impact on my personal life [a, c]	Working with individuals with mental illness has had minimal or no impact on my personal life	"It has not"	3/80 = 3.8
My relationships positively [c]	Working with individuals with mental illness has had a positive impact on my personal relationships.	"Made me a better husband, father, friend."	1/80 = 1.3
By making me more cautions [a]	I have become more cautious or paranoid in their personal life (less trusting, more suspicious, more aware of surroundings)	"[I am] more aware of those around me"	1/80 = 1.3

a = theme also appears in sexual offender group; c = theme also appears in college counselor group

Table 15c *College Counselors*: *In what ways has working with college students impacted your personal life?*

Themes *Working with college students has impacted...*	**Operational Definition**	**Examples**	**Frequency % (N = 86)**
My personal life positively [a, b]	Working with college students has had a positive impact on my personal life in that it provides me with a good salary, earns me respect, and I am better able to understand people.	"Given me more hope. Working in community mental health, particularly with juvenile and adult criminal offenders I think jaded me…. Working with college students has been good for me in this sense."	31/86 = 36.1%
By helping me to grow and be more reflective	Working with college students is intellectually stimulating, inspiring, keeps me young/positive; identify areas I want to grow	"They have taught me to be patient with myself and have showed me how much I have grown as a person since my college years. "	23/86 = 26.7
My relationships positively [b]	Working with college students has had a positive impact on my personal relationships. I better parent and improved their relationship with same aged family members	"Exploring many of their issues have challenged me to strengthen my relationships, be more mindful of needs of family members that fall in this age bracket."	15/86 = 17.4
My personal life negatively	Working with college students has had a negative impact on my personal life.	"It makes me feel old!" "Restricts my conversation with members of my family in this age group"	12/86 = 14.0
Has had minimal or no impact on my personal life [a, b]	Working with college students has had minimal or no impact on my personal life	"None, really"	5/86 = 5.8

a = theme also appears in sexual offender group; b = theme also appears in case manager group

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APPENDIX A

Background Characteristics and Structural Aspects of Counselors' Job

We are interested in your thoughts and experiences as a counselor working with clients who have committed sexual offenses/case manager/counselor who works with college students. Let's start with a few simple questions about you and your job. Please fill in the blanks with the appropriate information or draw a circle around the correct response.

Your Age: ______

Gender: Female Male (Please Circle)

Which of the following best describes you?

____ American Indian/Native American
____ African-American/Black
____ Asian-American
____ Hispanic-American/Latino
____White/Non-Hispanic
Other ____

What is your relationship status?

____ Single
____ Married
____ Partnered
____ Cohabiting
____ Divorced
____ Widowed

What is the highest level of education that you have completed?

____ B.A. or B.S. degree
____ Master's degree
____ Ph. D.
____ Psy. D.
____ Other: ___________________

What is your yearly income?

____ Less than $20,000
____ $21,000 – 40,000
____ $41,000 – 60,000
____ $61,000 – 80,000
____ $81,000 – 100,000
____ Over $100,000

Years of experience in current career: __________

Employment Status: ____Full-time _____Part-time

On average, how many hours a week do you work? __________

Type of clientele you work with (check all that apply; for SO counselors):
____ Court mandated offenders with offenses towards adults
____ Voluntary offenders with offenses towards adults
____ Court mandated offenders with offenses towards children
____ Voluntary offenders with offenses towards children

Types of clientele you work with (check all that apply; for case managers)
____ Clients diagnosed with a depressive disorder
____ Clients diagnosed with an anxiety disorder
____ Clients diagnoses with a psychotic disorder

Type of clientele you work with (check all the apply; for college counselors)
____ College students dealing with relationship issues
____ College students dealing with academic problems
____ College students dealing with severe mental illness (depression, bipolar, suicidal ideation)

Type of agency where you work:
____ Community Mental Health Agency
____ College Counseling Center
____ Prison or Juvenile Detention Center
____ Group Home
_____ Other: Please specify __________

How long have you been employed at your current agency: ______________________________

Average amount of clients on your caseload: _____________________________

What percentage (0%-100%) of you current caseload are (sex offender counselors):
____ Adult Male Offenders
____ Adult Female Offenders
____ Juvenile Male Offenders
____ Juvenile Female Offenders

What percentage (0%-100%) of you current caseload are (college counselors):
____ College students dealing with stress/anxiety
____ College students dealing with relationship issues
____ College students dealing with depression
____ College students dealing with eating disorders
____ College students dealing with academic problems
____ College students dealing with severe mental illness

What percentage (0%-100%) of you current caseload are (case managers)
____ Clients diagnosed with a depressive disorder
____ Clients diagnosed with an anxiety disorder
____ Clients diagnoses with a psychotic disorder

What types of services do you offer to your clientele? (Check all that apply)
____ Individual Therapy
____ Group Therapy
____ Sex Offender Assessment
____ Case Management
____ Other: Please specify: ___________

What is the likelihood that you will remain in your current profession for the next five years?

1 2 3 4 5
Not at all To a great extent

What is the likelihood that you will remain at your current place of employment for the next five years?

1 2 3 4 5
Not at all To a great extent

Does your agency offer you an opportunity to consult with colleagues on difficult cases?
____ Yes
____ No

Do you feel you have a way to voice your concerns or frustrations within your agencies?
____ Yes
____ No

Do you feel the agency you work for values your opinion?

1 2 3 4 5
Not at all To a great extent

APPENDIX B
Mental Health Professional Secondary Stigma Scale –

Please fill out the below questions in reference to your role as a sex offender counselor/case manager/college counselor using the following scale.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	2	3	4	5

1. I feel reluctant to mention the type of clients that I work with when asked about my job
2. I usually don't talk about what I do for a living to people that I have just met
3. I like to talk to people about the work that I do
4. I feel that it is important to talk with family and friends about the types of problems my clients usually face
5. I am honest about the type of clients that I work with when asked at a social event
6. I try not to talk about what I do for a living unless I am asked directly
7. I have less social contacts because of the type of clients that I work with
8. I am treated differently by other mental health professionals because of the type of clients work with
9. My family and friends treat me differently because of the type of clients that I work with
10. People who have just met me often treat me differently when they find out the type of clients that I work with
11. Once people find out the type of clients that I work with they tend to keep their distance
12. At times I feel stigmatized by others because of the type of clients that I work with
13. People have a strong positive reaction when they learn about the type of clients that I work with
14. People have a lot of misconceptions about the type of clients that I work with

15. Sometimes even my family and friends seem disgusted by the types of clients that I work with
16. People sometimes talk to me about how they find the type of clients that I work with to be disgusting the people that I work with
17. People sometimes feel sorry for me because of the type of client that I work with
18. At times I am disgusted by the type of clients that I work with
19. People sometimes seem disgusted when they find out the type of clients that I work with
20. At times, people hold me responsible for the poor choices made by the type of clients that I work with
21. Working with the type of clients that I see wasn’t really a conscious choice for me
22. I am responsible for working with the type of clients that most counselors don’t want to work with
23. I am not responsible for how people view the type of clients that I work with
24. I never wanted to work with the type of clients that I see
25. I feel responsible for standing up for the type of clients that I work with when other people are critical of them
26. People often become uneasy when they learn about the type of clients that I work with
27. People tell me that I the types of clients that I work with are dangerous
28. At times, I am fearful of the type of clients that I work with
29. At times, family and friends tell me that I am in danger because of the type of clients that I work with
30. I worry that I could get hurt physically by the type of clients that I work with
31. The types of clients that I work with are not often dangerous
32. People think that the type of clients that I see can never really change
33. At times, I think that other people would like me more I changed the type of clients that I work with

34. I would rather work with a different type of client than the clients that I currently work with
35. I think that people like me more because of the type of clients that I work with
36. People will always associate me with the type of clients I work with now
37. At times, I worry that I am thinking like the type of clients that I see

APPENDIX C
Maslach Burnout Inventory (Maslach & Jackson, 1981)

The following statements deal with how you may or may not feel about your work as a mental health professional (e.g., case manager). For each, please indicate how often you feel this way (Mark only one number for each item).

	Never occurs						Occurs everyday
	0	1	2	3	4	5	6
I feel burned out form my work.	0	1	2	3	4	5	6
I feel like I am at the end of my rope.	0	1	2	3	4	5	6
I feel I am working too hard on my job.	0	1	2	3	4	5	6
I feel used up at the end of the workday.	0	1	2	3	4	5	6
I feel emotionally drained from my work.	0	1	2	3	4	5	6
Working with people directly puts too much of a stress on me.	0	1	2	3	4	5	6
I feel frustrated at my job.	0	1	2	3	4	5	6
Working with people all day is really a strain for me.	0	1	2	3	4	5	6
I feel fatigued when I get up in the morning and have to face another day on the job.	0	1	2	3	4	5	6
I worry that this job is hardening me emotionally.	0	1	2	3	4	5	6
I feel I treat some clients as if they were impersonal objects.	0	1	2	3	4	5	6
I have become more callous toward people since I took this job.	0	1	2	3	4	5	6
I feel clients blame me for some of their problems.	0	1	2	3	4	5	6
I do not really care what happens to some clients.	0	1	2	3	4	5	6
I have accomplished many worthwhile things in my job.	0	1	2	3	4	5	6
I feel very energetic.	0	1	2	3	4	5	6
I can easily understand how my clients feel about things.	0	1	2	3	4	5	6
I feel exhilarated after working closely with my clients.	0	1	2	3	4	5	6
In my work, I deal with my emotional problems very calmly.	0	1	2	3	4	5	6
I deal very effectively with the problems of my clients.	0	1	2	3	4	5	6
I feel I am positively influencing other people's lives through my work.	0	1	2	3	4	5	6
I can easily create a relaxed atmosphere with my clients.	0	1	2	3	4	5	6

APPENDIX D
Case Manager Personal Growth Scale

When thinking about my job as a counselor/mental health professional who works primarily with clients who committed sexual offenses…

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	2	3	4	5

I have made positive changes in my life as a result of my work with my clients. ______

I often think about the lives of some of my clients when I encounter setbacks in my own life. _____

Working with my clients has led me to focus on strengthening my personal relationships. ______

Working as a sex offender counselor/mental health professional has caused a sense of spiritual growth for me. _______

I feel I have more to offer my family and friends as a result of my experience being a sex offender counselor/mental health professional. _______

I feel being a sex offender counselor/mental health professional has led to personal growth in several areas of my life. ______

I often hear profound "stories" from my clients that cause me to reflect on my own life. ______

I have found that working with my clients has caused me to try harder when I encounter personal problems. _____

The longer I work with my clients, the more I realize our lives are not that different. _____

I am more willing to "stand up" for others that experience stigma and discrimination since working with my clients. ________

I've found that I am more willing to help others in need since working as a sex offender counselor/mental health professional. ______

Working with my clients has led me to have a stronger religious faith. ________

I have become more aware of the importance of my family since working as a sex offender counselor/mental health counselor. _______

I have found I can learn a lot about myself from working with my clients. _______

Seeing the struggles of my clients has made me more willing to take on challenges in my own life. _______

I am more open to help and support from family and friends since working as a sex offender counselor/mental health professional. ________

APPENDIX E
Decision Regret Scale

In the following sections, you will find questions that ask you to think about your choice to become and experience as a counselor to sex offenders. Please follow the directions for each section and think carefully about your answers.

When thinking about my decision to be a counselor/mental health professional who works primarily with clients who have committed sexual offenses…

I believe it was the right decision

1	2	3	4	5
Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree

I regret making the choice to work with sexual offender clients.

1	2	3	4	5
Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree

I would go for the same choice if I had to do it over again

1	2	3	4	5
Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree

The choice of working with sexual offender clients did me a lot of harm

1	2	3	4	5
Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree

The decision to work with sexual offender clients was a wise one

1	2	3	4	5
Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree

I didn't have much of a choice about working with sexual offender clients.

1	2	3	4	5
Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree

APPENDIX F
Open-ended Questions

Public views

1. How do you think the general public views people who are sex offenders/have a mental illness/college students?
2. How do you think the general public views counselors who work with sex offenders/individuals with mental illness/college students?
3. How do people typically respond upon hearing that you work with sex offenders/individuals with mental illness/college students?
4. If a member of the community asked you why you have chosen to work with sex offenders/individuals with mental illness/college students, what would you say
5. In what ways have people treated you differently because you work with sex offenders/people with mental illness/college students

Rewards and Obstacles

6. What do you consider to be the biggest obstacles or problems that you face in your work with sex offenders/ individuals with mental illness/college students
7. What do you consider to be the biggest rewards that you have in your work with sex offenders/ individuals with mental illness/college students

Impact on professional and personal life

8. In what ways, do you feel that he public's views of sex offenders/people with mental illness/college students/impact how you feel towards your clients?
9. In what ways has working with sex offenders/individuals with mental illness/college students impacted your professional life
10. In what ways has working with sex offenders/ individuals with mental illness/college students impacted your personal life

APPENDIX G
Perceived Organization Support

When thinking about my place of employment, I feel…

Strongly disagree			Neutral			Strongly agree
1	2	3	4	5	6	7

1) My organization cares about my opinion.

2) My organization really cares about my well-being.

3) My organization strongly considers my goals and values.

4) Help is available from my organization when I have a problem.

5) My organization would forgive an honest mistake on my part.

6) If given the opportunity, my organization would take advantage of me.

7) My organization shows very little concern for me.

8) My organization is willing to help me if I need a special favor.

APPENDIX H
Social Desirability Scale-17 (SDS-17)

For the next set of questions, please be as honest as possible. There are no right or wrong answers.

Item		
1. I sometimes litter.	**True = 1**	**False = 0**
2. I always admit my mistakes openly and face the potential negative consequences.	**True = 1**	**False = 0**
3. In traffic, I am always polite and considerate of others.	**True = 1**	**False = 0**
4. I have tried illegal drugs (for example, marijuana, cocaine, etc.).	**True = 1**	**False = 0**
5. I always accept others opinions, even when they do not agree with my own.	**True = 1**	**False = 0**
6. I take out my bad moods on others now and then.	**True = 1**	**False = 0**
7. There has been an occasion when I took advantage of someone else.	**True = 1**	**False = 0**
8. In conversations, I always listen attentively and let others finish their sentences.	**True = 1**	**False = 0**
9. I never hesitate to help someone in case of emergency.	**True = 1**	**False = 0**
10. When I have made a promise, I keep it-no ifs, ands, or buts.	**True = 1**	**False = 0**
11. I occasionally speak badly of others behind their back.	**True = 1**	**False = 0**
12. I would never live off other people.	**True = 1**	**False = 0**
13. I always stay friendly and courteous with other people, even when I am stressed out.	**True = 1**	**False = 0**
14. During arguments I always stay objective and matter-of-fact.	**True = 1**	**False = 0**
15. There has been at least one occasion when I failed to return an item that I borrowed.	**True = 1**	**False = 0**
16. I always eat a healthy diet.	**True = 1**	**False = 0**
17. Sometimes, I only help because I expect something in return.	**True = 1**	**False = 0**