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Integrating Trauma Informed Care into the Treatment of Adult Male Sex Offenders: A Systematic Review

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Integrating Trauma Informed Care into the Treatment of Adult Male Sex Offenders: A
Systematic Review

by

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Presented to the Faculty of the
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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University-University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social work research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Physical, sexual, or emotional childhood trauma increases the risk for violence, aggression, and criminality in adulthood (Wolff & Shi, 2012). While not all children who experience childhood trauma go on to commit sexual offenses, the research highlights the fact that a large majority of the individuals who commit sexual offenses have experienced some form of childhood trauma (Dutton & Hart, 1992; Levenson, 2014; Wolff & Shi, 2012). The purpose of this study was to explore the relevance of integrating trauma-informed care in the treatment of adult men participating in evidence-based sex offender treatment programs. This systematic review collected data pertaining to trauma-informed care and the treatment of adult male sex offenders. Of the data reviewed, ten articles met the final search criteria for study inclusion.

Three notable themes emerged from the research analysis in regard to integrating trauma-informed care as it relates to adult male sex offender treatment. These themes include 1) Attachment style correlates with sexual offending; 2) Unresolved childhood trauma negatively impacts treatment outcomes; and 3) Adverse childhood experiences correlate with perpetration of sexual offending. Results of this review conclude that integrating trauma-informed care in the treatment of adult male sex offenders has significant relevance. Further research in the area of integrating trauma-informed care as it specifically relates to this population would be beneficial to effective service delivery for the treatment of adult male sex offenders.

Keywords: trauma-informed care, adult male, sex offender treatment

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Introduction

According to the 2012 Bureau of Justice Statistics, approximately 6.9 million individuals in the United States were under the supervision of adult correctional systems (Glaze & Herberman, 2013). This number equates to about 1 in every 35 adults serving time on probation, parole, or incarcerated (Glaze & Herberman, 2013). Comparatively, the National Center for Missing and Exploited Children reported that in 2012, the United States housed 739,853 registered sex offenders (Harris, Levenson, & Ackerman, 2012). Additionally, case data analyzed from 445,127 registered sex offenders found that 98% were adult males with 47,971 of those individuals living in correctional institutions (Harris, Levenson, & Ackerman, 2012). All of these statistics provide context for understanding the prevalence of trauma, as research indicates that the incidence of childhood trauma increases potential for criminal justice involvement (Dutton & Hart, 1992; Levenson, 2014; Truman & Langton, 2015).

The most recent published data from the Bureau of Justice Statistics reported that by 2015 year end, the number of adults under correctional supervision, either in the community or in institutions, had decreased to approximately 6.7 million individuals (Kaeble & Glaze, 2016). Reported victimizations of persons age 12 or older declined from 26.1 per 1,000 in 2011, to an estimated 18.6 per 1,000 persons in 2014 (Truman & Langton, 2015). While statistics indicate that in recent years, correctional populations continue to decline as do reported sexual assaults, these numbers can be deceiving. The decline can be attributed in part, to the fact that nearly 63% of sexual assaults are not reported to law enforcement and 88% of child sexual abuse goes unreported to authorities (National Sexual Violence Resource Center, 2015). For this reason, it is difficult to accurately quantify the prevalence of sexual violence. Additionally, the

information provided by the Bureau of Justice Statistics does not include valuable information regarding victimization of children under the age of 12. Of the reported sexual assaults, 12.3% of women experienced at least one incident of sexual assault before age 11, and 27.8% of men experienced at least one incident of sexual assault before the age of 11 (Black, et al., 2011).

Sexual assault statistics are important, as they provide a more accurate lens for understanding the prevalence of sexual assault. The statistics also provide context for understanding the frequency in which childhood trauma intersects in the lives of adult men convicted of sexually offending (Alaggia & Millington, 2008).

Levenson (2014) states that childhood trauma and the impact of adverse childhood experiences (ACEs) is associated with deleterious outcomes like substance abuse, mental health diagnosis, and criminal behavior. This is important within the context of treatment for men convicted of sexually offending. The capacity to incorporate a trauma-informed approach into existing evidenced-based sex offender treatment programs has the potential to improve treatment outcomes (Alaggia & Millington, 2008; Dutton & Hart, 1992). This is based on the understanding that ACEs can lead children to develop bio-psychosocial deficits that manifest in aggression, emotional dysregulation, avoidant attachment, and distorted cognitive processing (Alaggia & Millington, 2008; Dutton & Hart, 1992; Levenson, 2014). Maladaptive interpersonal skills such as these can have life-long consequences, increasing the probability that an individual becomes involved in the criminal justice system (Alaggia & Millington, 2008; Dutton & Hart, 1992; Levenson, 2014). While most sex offender treatment programming is based on a cognitive behavioral model that aims to equip individuals with skills meant to improve interpersonal skills; sex offender treatment for men is not aimed at resolving the trauma that may be at the

developmental foundation of identified maladaptive interpersonal skills (Yates, Prescott, & Ward, 2010).

In order to better understand the information present in the literature review, trauma (as defined by the American Psychiatric Association (2013) and the Substance Abuse and Mental Health Services Administration (2014)) will be outlined, as will the definition of trauma-informed care. ACEs criteria will also be explored as it relates to adult development and criminal conduct. Additionally, evidence-based models for the treatment of adult male sex offenders such as Cognitive Behavioral Therapy, Risk, Needs, and Responsivity, and the Good Lives Model will also be presented in the literature. Lastly for the purpose of clarity, sex offender is a broad term that includes any adult male individual convicted of rape, incest, child sexual abuse, intimate partner violence, sexual exploitation, human trafficking, unwanted sexual contact, sexual harassment, exposure, and voyeurism.

As understanding in regard to the impact of trauma in the form of adverse childhood experiences has grown, so too, can the capacity to provide sex offender treatment for incarcerated adult men (Levenson, 2014). The ability to apply trauma-informed care principles to this work has great potential to encourage healing, treatment success, and overall individual wellness and community safety. The principles of trauma-informed care, when applied to sex offender treatment, have the potential to promote reduction of the adverse impact that childhood trauma can have on the client's capacity to achieve physical, psychological, social, and spiritual well-being (Wilson & Yates, 2009). The purpose of this systematic review therefore, is to explore the integration of trauma-informed care in the treatment of adult men participating in evidence-based sex offender treatment programs.

Literature Review

The Diagnostic and Statistical Manual 5th Edition (DSM5) (2013) defines trauma as, “Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or close friend – in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (American Psychiatric Association, 2013, p. 271).”

Interestingly, while the Diagnostic and Statistical Manual 5th Edition (2013) definition identifies traumatic events, Briere and Scott (2015) conclude that an event is also defined as traumatic if it is extremely upsetting, temporarily overwhelms individual internal resources, and produces lasting psychological symptoms. Of note in these two explanations of trauma is the recognition that, as Briere and Scott (2015) report, trauma may have lasting psychological symptoms. This can provide valuable insight for both the clinician and client when working with adult male sex offenders. This may be particularly so if the individual struggles to make progress in sex offender treatment, and has been identified as having elevated scores in the areas identified through ACEs .

Through a collaborated effort, SAMHSA (2014) identifies trauma as resulting from a single instance or multiple events that are experienced by the individual in a way that is life threatening or physically or emotionally harmful. The traumatic event or series of events negatively impacts individual capacity to achieve physical, psychological, social, or spiritual

well-being (SAMHSA, 2014). With SAMHSA's definition of trauma in mind, the event(s) that precipitate trauma are consistent with the DSM-5 in that they are events or circumstances that may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that jeopardizes healthy development (SAMHSA, 2014). The traumatic event may be a single occurrence or ongoing. The way in which an individual assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic (SAMHSA, 2014). SAMHSA's (2014) definition of trauma highlights the importance of recognizing individual differences in terms of how trauma is perceived. Perception and impact of traumatic experiences may be influenced by developmental factors associated with biological, emotional, and sociological underpinnings.

Applying SAMSHA's (2014) concept of trauma to the treatment of adult male sex offenders recognizes that the ways in which individuals experience traumatic events can vary in severity and interpretation. Based on a range of factors including individual cultural norms, availability of social support, and developmental stage of the individual, this concept of trauma identifies the long-lasting adverse effects of the event as a critical component of trauma (SAMHSA, 2014). Although duration may vary, symptoms of trauma range from hyper-vigilance, a constant state of arousal, to numbing or avoidance (SAMHSA, 2014). Additionally, individuals experiencing symptoms related to trauma may struggle to trust others, benefit from relationships, and cope with the normal stresses of daily living (SAMHSA, 2014). Symptoms of trauma may also affect the individual's ability to effectively manage cognitive processes, such as memory, attention, thinking; and to regulate behavior or to control the expression of emotions (SAMHSA, 2014).

For the purpose of understanding trauma as it relates to men participating in sex offender treatment programs, SAMHSA (2014) highlights the importance in understanding that individual interpretation of traumatic events can vary. SAMHSA's (2014) definition of trauma also clearly articulates the lasting impact that traumatic experiences can have on individual well-being as it relates to maladaptive cognitive processing and interpersonal relationships. This directly shows a relationship to the development of criminal behavior.

Adverse Childhood Experiences (ACEs)

In considering best practices with men who commit sexual offenses, it is important to view the individual from a lens that looks at each client as part of a larger system of experiences that has shaped who he has become. In part, this requires a detailed look at early childhood experiences. Alaggia and Millington (2008) state that exploration of childhood experiences can be used as a tool to identify the presence of traumatic experiences that may serve as potential barriers in achieving treatment goals. While trauma in and of itself, does not cause a child to become a sex offender, the culmination of adverse childhood experiences can be a contributing factor to the development of sexual deviancy and a precursor to difficulties in forming healthy sexual relationships as adults (Alaggia & Millington, 2008). The Adverse Childhood Experiences (ACEs) study categorizes formative childhood experiences into three groups: abuse, neglect, and family/household challenges. Each category is further divided into the following multiple subcategories.

Abuse

TRAUMA-INFORMED CARE AND TREATMENT OF SEX OFFENDERS

- Emotional abuse: A parent, stepparent, or adult living in your home swore at you, insulted you, put you down, or acted in a way that made you afraid that you might be physically hurt.
- Physical abuse: A parent, stepparent, or adult living in your home pushed, grabbed, slapped, threw something at you, or hit you so hard that you had marks or were injured.
- Sexual abuse: An adult, relative, family friend, or stranger who was at least 5 years older than you touched or fondled your body in a sexual way, made you touch his/her body in a sexual way, or attempted to have any type of sexual intercourse with you.

Household Challenges

- Mother treated violently: Your mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by your father (or stepfather) or mother's boyfriend.
- Household substance abuse: A household member was a problem drinker or alcoholic or a household member used street drugs.
- Mental illness in household: A household member was depressed or mentally ill or a household member attempted suicide.
- Parental separation or divorce: Your parents were ever separated or divorced.
- Criminal household member: A household member went to prison.

Neglect

- Emotional neglect: Adults in your family did not help you feel important or special, you did not feel loved, people in your family did not look out for each other and feel close to each other, and your family did not provide a source of strength and support.
- Physical neglect: Your parents did not take care of you, protect you, and take you to the doctor if you needed it, you didn't have enough to eat, your parents were too drunk or too high to take care of you, and you had to wear dirty clothes.

(Center for Disease Control, 2016)

Prevalence of Childhood Trauma in Adult Male Sex Offenders

As treatment with individuals who commit sex offenses continues to evolve, growing empirical evidence supports the finding that trauma in the form of ACEs is often identified among the sex offender population (Dutton & Hart, 1992; Levenson, 2014; Wolff & Shi, 2012). According to Wolff and Shi (2012), 56% of incarcerated adult men have experienced physical childhood trauma. Additionally, 1 in 6 incarcerated men in the United States have experienced physical or sexual abuse before the age of 18 and an additional 25% experienced some form of emotional abuse as children (Dutton & Hart, 1992; Levenson, 2014; Wolff & Shi, 2012).

Social Problems and Impact Associated with Childhood Trauma in Sex Offenders

It is important to understand the impact that early childhood trauma has on individuals who sexually offend. Baldwin, Faupel, Leverage, Lobanov-Rostovsky, Przybylski, Rich, and Seto (2013) report that both biological and social learning factors influence the development of sexual offending behaviors. With the understanding that all individuals seek to have their basic

needs met, how this is accomplished largely depends on each individual's environmental experiences (Alaggia & Millington, 2008; Baldwin, et al., 2013). Baldwin, et al. (2013) also state that individuals learn how to meet their needs through their environment . This is accomplished appropriately through the early interactions and development of relationships with healthy caregivers or inappropriately through violence and unhealthy caregiver relationships (Baldwin, et al., 2013). This research posits that childhood trauma can lead to maladaptive coping strategies, as well as issues related to attachment and intimacy, which can lead to abusive behaviors (Baldwin, et al., 2013; Briere & Scott, 2015).

Physical, sexual, or emotional childhood trauma increases the risk for violence, aggression, and criminality in adulthood (Wolff & Shi, 2012). While not all children who experience childhood trauma go on to commit sexual offenses, the research highlights the fact that a large majority of the individuals who commit sexual offenses have experienced some form of childhood trauma (Dutton & Hart, 1992; Levenson, 2014; Wolff & Shi, 2012). Men convicted of child abuse, domestic violence, stalking, and sexual offending have significantly higher instances of ACEs when compared to those in the general population (Wolff & Shi, 2012). Furthermore, there is a clear association between childhood adversity (as indicated by higher ACE scores) and sexual offending. Male sex offenders reported three times the rate of childhood sexual abuse when compared to general population male offenders (Levenson, 2014). In a study of 679 sex offenders, 42% reported child physical abuse, 38% reported sexual abuse and 38% reported emotional neglect (Levenson, 2014). Additional research states that individual risk for lasting adverse effects of childhood trauma, such as cognitive distortions and criminal behavior, increases significantly in relation to the number and duration of adverse childhood

experiences (Baldwin, et al., 2013; Center for Disease Control, 2016; Dutton & Hart, 1992; Levenson, 2014).

Unresolved Trauma and Poor Treatment Outcomes

The Substance Abuse and Mental Health Services Administration (SAMHSA) states that the association between unresolved childhood trauma and involvement in the criminal justice system indicates a growing need to redefine the ways in which individuals who are involved in the system are viewed as well as the systems with which those individuals interact (SAMHSA, 2014). Similarly, unresolved trauma can serve as a barrier for successful treatment outcomes, which subsequently increases the risk of re-offense.

Research indicates that with appropriate support and intervention, individuals who have experienced childhood trauma have the potential to overcome adverse experiences (Alaggia & Millington, 2008; Briere & Scott, 2015; Epperson, Wolf, Morgan, Fisher, Frueh, & Huening, 2011; Levenson, 2014). For adult male sex offenders, the potential to address adverse childhood experiences during sex offender treatment encourages increased individual capacity for healing and as such, increases capacity for positive change (Alaggia & Millington, 2008). An increased capacity for lasting change and overall wellness decreases an individual's risk of re-offense (Beech, Mandeville-Norden, & Goodwill, 2012; Bosma, Kunst, Reef, Dirkzwager, & Nieuwbeerta, 2016; Duwe & Goldman, 2009; Epperson, Wolf, Morgan, Fisher, Frueh, & Huening, 2011).

Trauma-Informed Care Principles

According to SAMHSA (2014) trauma-informed care, or a trauma-informed approach is based on the understanding that, "all people at all levels of the organization or system have a

basic realization about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals” (SAMHSA, 2014). More than simply understanding trauma, the principles of a trauma-informed approach recognize that individual behaviors and coping strategies should be viewed within the context of trauma and as such, may be in response to the individual’s experience of traumatic events (Levenson, 2014). These behaviors and coping strategies may be displayed regardless of whether the traumatic event(s) is currently being experienced. Additionally, SAMHSA (2014) states that while the experience of trauma correlates with substance abuse and mental health disorders, trauma-informed care should not be limited to these behavioral health service areas. The principles of trauma-informed care should also be considered as fundamental to other systems of care such as child protection, criminal justice, primary health care, peer-run and community organizations as it is often a barrier to positive outcomes in those areas as well (SAMHSA, 2014).

According to SAMHSA (2014), trauma-informed care service providers recognize the signs of trauma as exhibited in various populations and individuals. Trauma-informed care systems and organizations recognize the vast impact of trauma and appreciate the potential paths of recovery. These systems and organizations are able to distinguish the signs and symptoms of trauma in the individuals they serve and respond by integrating knowledge about trauma into policies, procedures, and practices that aim to avoid re-traumatization (SAMHSA, 2014). Moreover, SAMHSA (2014) identifies the response of an organization, program, or system as one that applies the principles of a trauma-informed approach to all areas of functioning, integrating an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly (SAMHSA, 2014). Lastly, an organization’s approach to trauma-informed care seeks to resist re-traumatization of clients and staff and promotes an environment

that is psychologically and physically safe (SAMHSA, 2014). With these things in mind, SAMHSA identifies the following six key principles of a trauma-informed approach: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, and cultural, historical, and gender issues (SAMHSA, 2014).

Similar to the person-in-environment perspective, the principles behind trauma-informed care promote a greater awareness in regard to the influence of adverse childhood experiences on the formation of maladaptive behaviors in adult male sex offenders (Levenson, 2014). Each client is viewed as an individual whose unique life experiences impact capacity for change as well as ability to achieve treatment success. The principles of trauma-informed care service delivery are based on the understanding that the impact of early childhood trauma often influences behavior across the lifespan (Briere & Scott, 2015; Cassidy, Jones, & Shaver, 2013; Center for Disease Control, 2016). For this reason, trauma-informed care service providers optimize a client-centered environment in which maladaptive behaviors are viewed and responded to within the context of traumatic experiences (Alaggia & Millington, 2008; Dutton & Hart, 1992). Trauma-informed services focus on safety, seek to reduce trauma triggers, provide rehabilitation counseling, and create opportunities to develop individual pro-social and non-harmful coping skills (Levenson, 2014).

Trauma-informed service principles aim to reduce disempowering relational patterns by modeling respectful and collaborative client/therapist interactions (Levenson, 2014). Similarly, trauma-informed care principles highlight the necessity of creating a safe therapeutic environment that fosters self-empowerment through skill-building and emphasis on individual strengths and decision making (Levenson, 2014). Through this process, the helping relationship attempts to model healthy boundaries and respectful interpersonal communication while

encouraging corrective emotional experiences and improved relational skills (Briere & Scott, 2015; Duwe & Goldman, 2009; Epperson, Wolf, Morgan, Fisher, Frueh, & Huening, 2011; Levenson, 2014).

A trauma-informed approach recognizes that trauma can have a significant impact on an individual's identity and sense of self. Within the context of trauma-informed care the clinician can better understand how traumatic experiences shape the client's assumptions about the world. This increases the clinician's capacity to encourage the client to construct healthy strategies to organize and understand coping skills, behaviors, and relationships (Levenson, 2014). Trauma-informed care emphasizes a holistic approach to understanding the individual within the context of his/her life experiences. Maladaptive skills and behaviors that were once believed necessary for survival are reframed as current barriers impacting the individual's ability to achieve pro-social goals and establish intimate relationships and healthy boundaries (Levenson, 2014).

Based on this knowledge, integrating the principles of trauma-informed care into existing evidence-based sex offender treatment for adult men has the potential to reduce risk of re-offense and increase positive outcomes and community safety (Alaggia & Millington, 2008; Baldwin, et al., 2013; Beech, Mandeville-Norden, & Goodwill, 2012; Bosma, Kunst, Reef, Dirkzwager, & Nieuwbeerta, 2016; Duwe & Goldman, 2009; Epperson, Wolf, Morgan, Fisher, Frueh, & Huening, 2011; Levenson, 2014). In viewing the client who has been convicted of sexually offending through the multi-dimensional lens of Ecological Systems Theory treatment goals are more suited to addressing the client's needs and capacity for change.

Bronfenbrenner's Ecological System's Theory (1994) states that behavior is influenced by a variety of systems that interact and influence how an individual views him/herself within

the context of those systems (Hepworth, Rooney, Rooney, & Strom-Gottfried, 2017). It recognizes that an individual's childhood experiences and relationships with caregivers and peers, as well as socioeconomic status, sexual orientation, and culture are among many factors that influence how he/she thinks and responds to his/her environment (Hepworth, Rooney, Rooney, & Strom-Gottfried, 2017). According to Ecological Systems Theory the inherent qualities of a child and his environment interact to influence how he will grow and develop (Hepworth, Rooney, Rooney, & Strom-Gottfried, 2017). Through this approach Bronfenbrenner stressed the importance of studying a child in the context of multiple environments, also known as ecological systems in the attempt to understand his development.

Sex Offender Treatment Concepts

The treatment of individuals convicted of sexual offenses is intended to reduce and/or prevent the recurrence of offending. Evidence-based sex offender programs for adult men target specific areas that have been proven to impact social and psychological factors linked to sexual offending (Yates, Prescott, & Ward, 2010). Cognitive behavioral treatments in conjunction with the Risk/Need/Responsivity model are two specific methods of intervention that are widely accepted and have been shown to be effective in reducing recidivism (Beech, Mandeville-Norden, & Goodwill, 2012; Duwe & Goldman, 2009; Lovins, Lowenkamp, & Latessa, 2009; McGrath, Hoke, & Vojtisek, 1998; Traver & Mann, 2014; Yates, Prescott, & Ward, 2010). The Good Lives Model uses cognitive behavioral treatment and Risk/Need/Responsivity as a cohesive approach designed specifically for the treatment of sexual offenders.

Cognitive Behavioral Treatment

Cognitive behavioral treatment (CBT) assumes that most people can become conscious of their own thoughts and behaviors and then make positive changes to them. It recognizes that a person's thoughts are often the result of experiences, and behavior is often influenced and prompted by these thoughts. The foundation of CBT rests on the principle that cognition, affect, and behavior are linked and as such, each influences the other (Yates, Prescott, & Ward, 2010). Cognitive behavioral treatment places responsibility in the hands of the individual, while supplying him/her with the appropriate tools to achieve success (Bosma, Kunst, Reef, Dirkzwager, & Nieuwbeerta, 2016). Unlike other approaches to psychotherapy, CBT puts the focus on the present and future rather than the past. While it does not deny that a person's past can shape their future, the focus of CBT remains on things that are fluid and changeable, such as learning the skills necessary to solve problems and achieve legitimate goals without the use of violence or criminogenic behaviors (Latessa, 2009).

Cognitive behavioral treatment recognizes sexual offending as a pattern of behavior that develops over time in response to learned behaviors and beliefs (Yates, Prescott, & Ward, 2010). For this reason, treatment concentrates on developing individual client skills to recognize distorted or unrealistic thinking when it happens, and then focuses on changing that thinking or belief to reduce or eliminate problematic behavior (Feucht & Holt, 2016). Characteristics of distorted thinking may include poor problem solving and decision making, inability to consider the effects of one's behavior, egocentric viewpoint and lack of trust in others, inability to reason and accept responsibility for wrongdoing, impulsivity, and lack of self-control (Ferguson & Wormith, 2012). Multiple studies have shown that CBT programs can be highly successful in attacking the core issues of an offender's behavior and essentially reprogramming those

problematic thought processes (Beech, Mandeville-Norden, & Goodwill, 2012; Bosma, Kunst, Reef, Dirkzwager, & Nieuwbeerta, 2016; Ferguson & Wormith, 2012).

One such study conducted by Beech, Mandeville-Norden and Goodwill (2012) found that of the 413 criminal offenders who participated in cognitive behavioral treatment programs, 40% showed a significant reduction from pretreatment risk assessment scores to post treatment risk assessment scores. Beech, Mandeville-Norden and Goodwill (2012) followed CBT program participants for four years after program completion and noted that only 12% of the sample group had recidivated within the follow-up period. Lovins, Lowenkamp, and Latessa, (2009) conducted a systematic review to evaluate over 22,000 convicted sex offenders to determine the effectiveness of cognitive behavioral treatment in reducing recidivism. One of the reviewed studies was comprised of 217 felony offenders; 121 individuals were required to attend CBT treatment, and 96 individuals were not required to attend CBT treatment. Bivariate analysis at six months post-program completion noted that 23% of the treatment group had recidivated versus a 36% recidivism rate for the control group (Lovins, Lowenkamp, & Latessa, 2009).

Yates, Prescott, and Ward (2010) state that in regard to the treatment of sexual offenders, sexual offending is believed to be a pattern of behavior that has developed over time through modeling and learning. Furthermore, this behavior has been sustained through reinforcing thoughts and actions that foster deep-rooted recurring reactions to circumstances that support the individual's desire to sexually offend (Yates, Prescott, & Ward, 2010). The goal of CBT treatment is to encourage clients to develop, enhance, and reinforce prosocial skills while addressing cognitive development and cognitive restructuring (Yates, Prescott, & Ward, 2010). Individuals who commit sexual offenses often endorse a distorted view of themselves and their behavior. Cognitive distortions or deficits in critical thinking contribute to the risk of offending;

CBT-based treatment encourages competencies that will enable individuals to effectively manage life circumstances and difficulties without reoffending. Addressing cognitive development focuses on individual thinking deficits by teaching problem solving skills, moral reasoning and social skills (Yates, Prescott, & Ward, 2010). Cognitive restructuring, on the other hand, focuses on an individual's thinking distortions by addressing attitudes, thinking habits and beliefs (Yates, Prescott, & Ward, 2010).

Risk, Needs, and Responsivity

The principles behind Risk, Needs, and Responsivity, conversely, are based on patterns of criminal conduct (Yates, Prescott, & Ward, 2010). The risk principle states that the intensity of intervention should match the individual's risk level. Individual risk is determined based on assessment of the client's static or unchangeable re-offense factors and dynamic or changeable factors (Lovins, Lowenkamp, & Latessa, 2009). Static factors include young age, previous offense history, early onset of sexual offending, and specific offense characteristics such as male victims, stranger victims, and non-contact offenses (Yates, Prescott, & Ward, 2010). This means that intensive interventions are directed at individuals identified as high-risk offenders and less intense interventions are aimed at offenders who are less likely to re-offend.

The need principle relates to identifying intervention targets, or individual criminogenic needs. Criminogenic needs, also known as dynamic risk factors, are areas related to each individual's offending that are changeable (Andrews and Bonta, 2006). Treatment focus, therefore, is primarily aimed at reducing an individual's dynamic risk factors. Dynamic risk factors associated with risk for reoffending can vary in specificity from individual to individual. Typical criminogenic needs of men, who sexually offend however, generally fall into areas

related to treatment motivation, minimization or denial of offending behavior, and cognitive distortions (Traver & Mann, 2014). Criminal attitude and behavior, deviant sexual attitude, arousal, interest, and behavior, as well as sexual risk management deficits are also thought to be typical criminogenic areas of need for men who sexually offend (Yates, Prescott, & Ward, 2010). Equally significant are lifestyle instability concerns related to substance abuse and mental illness, and emotion management deficits such as impulsivity and poor problem solving skills, in addition to social competence deficits related to intimacy and pro-social relationships (Lovins, Lowenkamp, & Latessa, 2009; Traver & Mann, 2014; Yates, Prescott, & Ward, 2010).

Conversely, according to the needs principle directing intervention efforts at non-criminogenic needs such as low self-esteem and a history of ACEs will prove ineffective, given they do not have a direct link to recidivism (Andrews & Bonta, 2006; Hanson & Morton-Bourgon, 2005). The explicit targeting of non-criminogenic needs such as ACEs or childhood trauma are thought to be helpful in strengthening the therapeutic relationship and increasing treatment engagement (Yates, Prescott, & Ward, 2010). Yet, because these needs are viewed as non-criminogenic, targeting these areas is left to the discretion of the treatment team (Yates, Prescott, & Ward, 2010). At this point in time, effective criminogenic needs as treatment targets remain focused on the typical areas of need already mentioned for men who commit sexual offenses.

Lastly, the responsivity principle informs the delivery approach of interventions by identifying individual cognitive ability, learning style, culture, and other characteristics that may impact client progress and intervention success (Yates, Prescott, & Ward, 2010). Responsivity recognizes that such factors influence the effectiveness of the interaction between client and treatment process. Therefore, the treatment program must be reasonably adapted to match those

individual client characteristics (Yates, Prescott, & Ward, 2010). Treatment adaptation can manifest as a treatment plan that incorporates chemical dependency treatment for individuals with a history of substance abuse or additional mental health services for clients diagnosed with mental illness. While the foundation of the treatment does not change with respect to the client being served, responsivity allows for matching service delivery to an individual's ability to receive treatment services (Yates, Prescott, & Ward, 2010).

The Good Lives Model

The Good Lives Model (GLM) is a strengths-based model that aims to equip clients with the necessary internal and external resources to live a life that is socially acceptable and personally meaningful (Yates, Prescott, & Ward, 2010). According to the GLM, offending results from flaws in an individual's life plan, and relates either directly and/ or indirectly to the pursuit of primary goods (Ward, Mann, & Gannon, 2006; Wilson & Yates, 2009). The Good Lives Model conceptualizes typical criminogenic needs as internal or external barriers towards living a good life. These are addressed within the broader strengths-based framework of the GLM. One of the advantages of the GLM is that it outlines the relationship between criminogenic needs and human needs by specifying their relationship to the pursuit of primary human goods (Ward, Mann, & Gannon, 2006). Based on psychological, social, biological and anthropological research, the Good Lives Model asserts that all human beings are goal-directed and predisposed to seek a number of primary human goods (Yates, Prescott, & Ward, 2010). Within this model people recognize primary goods as certain states of mind, personal characteristics, and experiences (Yates, Prescott, & Ward, 2010). Primary goods represent an individual's core values and life priorities; as such, these goods are recognized as inherently valuable and pursued for their own sake (Wilson & Yates, 2009).

Primary goods include life/healthy living and functioning, knowledge, excellence in play and work (including mastery experiences), excellence in agency/autonomy and self-determination, inner peace/freedom from emotional turmoil and stress, friendship/intimate, romantic and family relationships, community, spirituality/finding meaning and purpose in life, happiness, and creativity (Yates, Prescott, & Ward, 2010). The Good Lives Model assumes that all humans attempt to seek out the primary goods in varying degrees and that the individual importance of each good is reflective of that person's values and life priorities (Ward, Mann, & Gannon, 2006). Accordingly, the Good Lives Model places primary goods at the center of the individual's sense of who they are and what makes life meaningful.

Within this model, secondary goods provide concrete means of securing primary goods. Secondary goods represent the actions taken to achieve the goals identified as primary goods. For example, the primary good of excellence in play might be achieved through involvement in sports or other hobbies. Appropriate secondary goods represent socially acceptable means of securing primary goods that are incompatible with offending. Yates, Prescott, and Ward (2010) state that criminogenic needs always exert their influence on, or through, secondary goods. For example, relying on the criminogenic need of antisocial peers can be identified as an attempt to achieve the primary good of relatedness. The Good Lives Model assumes that all humans frame their lives around their core values and as such, follow an often implicit good life plan (Ward, Mann, & Gannon, 2006). The distinction comes when individuals, such as men who commit sexual offenses, have developed maladaptive or deviant core values that impact how they perceive and attempt to achieve a good life plan. The GLM provides comprehensive foundation for therapeutic intervention with adult male sex offenders. Ward, Mann, and Gannon (2006) state that the Good Lives Model encompasses the core principles of rehabilitation, promotes

explanation and individual understanding of sexual offending and its functions; and provides treatment implications that focus on goals (goods), self-regulation strategies, and ecological variables.

Conceptual Framework

Attachment Theory. According to Bowlby's (1969) theory of attachment, an individual begins to perceive the world through early experiences with his or her primary caregiver. When the relationship between the child and primary caregiver lacks continuity in response, and the nurturing required to form a secure parental attachment, the child then develops an insecure attachment. Ainsworth and Bell (1970) further identified insecure attachment styles as characterized by three distinct patterns; avoidant, ambivalent, and disorganized. Avoidant attachment is associated with a history of rejection, neglect, or emotional remoteness by the primary caregiver; while ambivalent attachment is associated with caregiver inconsistency in meeting the child's needs (Ainsworth & Bell, 1970). Lastly, Ainsworth and Bell (1970) theorized that disorganized attachment is associated with abuse, neglect, and family chaos.

Recognizing the impact that childhood trauma can have on an individual's offending behaviors provide clinicians with a greater capacity to provide services relevant to the individual's needs. Attachment theory recognizes developmental factors that may serve as barriers during the treatment process, and impact treatment success. Attachment theory as defined by Bowlby (1969) and Ainsworth and Bell (1970) also provide an historical lens with which to view the client beyond that of a sexual offender, but as an individual whose life experiences have shaped how he behaves, responds, and interacts with the world.

This systematic review will examine current and relevant research to determine the significance of integrating trauma-informed care in the treatment of adult men participating in evidence-based sex offender treatment programs. This research aims to gather information on the prevalence of childhood trauma in adult male sex offenders and as such the relevance of integrating trauma-informed care in the treatment of adult males participating in evidence-based sex offender treatment through a systematic review. The findings of this review could be used to support clients who experience barriers in sex offender treatment programming due to unresolved childhood trauma. While significant amounts of research have been done about how trauma affects treatment outcomes for women (resulting in equally substantial amounts of literature on using a trauma-informed approach when working with women) little has been done in regard to the topic of working with men in this capacity who have experienced trauma.

Methods

The purpose of this systematic review is to examine the prevalence of childhood trauma in adult male sex offenders and as such the integration of trauma-informed care in the treatment of adult males participating in evidence-based sex offender treatment. A systematic review is a replicable study that looks at existing literature to find themes relating to the presenting question (Petticrew & Roberts, 1949). There are three steps within the methodology of a systematic literature review: establishing a protocol for finding data, abstracting data from protocol, and data analysis. Through these steps, the researcher reduces the chance for bias due to the systematic approach of gathering and analyzing the literature (Petticrew & Roberts, 1949).

Review Protocol. The review protocol is an important component to the process of searching for articles that are included in this systematic review. It determined the search strategies used when

researching articles to be implemented in this study. Once the first set of articles was determined, a set of inclusion criteria was used to determine which articles fit with the study. Lastly, in an effort to include most relevant data, an exclusion criterion was applied to determine which of those initial articles were used for this systematic review. Once the review protocol was complete, the remaining articles specific to the purpose of this study were analyzed.

Search Strategy. In the preliminary search of academic journals utilized data bases included; PsychINFO, National Criminal Justice Reference Service Abstracts (NCJRS), Criminal Justice Abstracts, Social Work Abstracts, and SocINDEX when searching for trauma-informed care and the treatment of sex offenders. Specific key terms used in the initial search for articles included: sex offender treatment and trauma-informed care. After the initial search, title and abstracts of the identified articles were reviewed to determine applicability to this study. Specific data qualifications were implemented to address the validity of the research and narrow down data specific to the research question.

Inclusion Criteria. Inclusion criteria for this study included peer-reviewed, empirical articles pertaining to trauma-informed care, childhood trauma and the treatment of adult male sex offenders in particular. This study focused on adult male sex offenders; therefore the researcher considered articles that specifically referenced the treatment of men.

Articles including both first time and repeat offenders were considered as well. The researcher considered research design when evaluating quality of relevant studies throughout data collection. Articles were not time limited due to lack of substantial data in regard to trauma-informed care as it relates to the treatment of adult male sex offenders. Studies examining

trauma-informed care for the treatment of adult male sex offenders both in correctional and community settings were also included.

Exclusion Process. This researcher was interested in exploring the relevance of integrating trauma-informed care in the treatment of adult male sex offenders. For this reason, articles focused on the treatment of juveniles and females were excluded from this study. Articles exploring intervention strategies and therapeutic modalities without reference to trauma-informed care were excluded, as were articles not published in English. By using a flowchart, the researcher shows how articles were excluded based on the aforementioned criterion (Figure 1.).

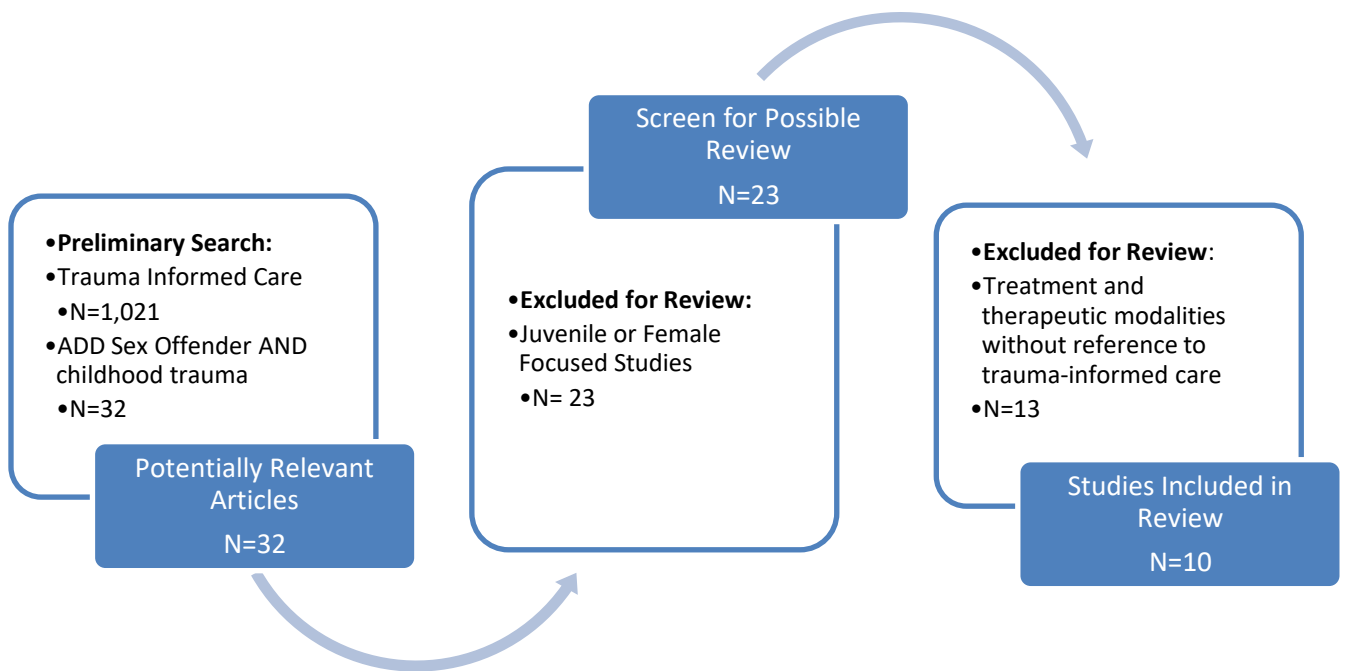


Figure 1.

Data Abstraction. The researcher used an article analysis grid (Figure 2.) to extract and organize articles used for this study. Within the analysis grid the researcher included author, sample description and design, focus of study, limitations, and findings of each article. Article

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findings were assessed to identify themes and consistencies and/or variations associated with the integration of trauma-informed care into the treatment of adult male sex offenders.

Author	Sample Description & Design	Focus of Study	Limitations	Findings
Adams, 2003	409 sex offenders Cross Sectional Nonrandom Convenience Sample	Treatment for sex offenders and the relationship of early trauma on brain development and sexual recidivism	The relationship between childhood victimization and sexual offending is complex and multi-faceted	Childhood experiences of abuse and neglect were significantly worse in sexual recidivists compared to those of non-recidivists
Craissati & Beech, 2005	310 adult male sex offenders Longitudinal Nonrandom Convenience Sample	Developmental variables related to childhood trauma and sex offender risk prediction	The relationship of developmental variables and risk has yet to be clearly established	Attachment style and childhood sexual victimization are significantly associated with risk of recidivism
Creeden, 2009	Adults in treatment for sexually abusive behaviors Qualitative Nonrandom Convenience Sample	Childhood trauma and attachment impact on neurodevelopment and treatment outcomes	Understanding trauma related neurodevelopmental changes is still evolving	Trauma related neurodevelopmental changes and attachment relationships impede learning and effective use of skills/treatment success
Levenson & Grady, 2016	700 convicted sex offenders in outpatient and confinement-based treatment programs Qualitative Nonrandom Convenience Sample	Determine the influence of various types of childhood adversity on later sexual deviance and sexually violent behavior	ACE's is not a comprehensive assessment for trauma	Factors that predicted sexual deviance included child sexual abuse, and emotional neglect. Factors that predicted sexually violent offending included child physical abuse, substance abuse in the home, mentally illness in the home, and having an incarcerated family member

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Author	Sample Description	Focus of Study	Limitations	Findings
Levenson & Grady, 2016	180 adult criminal offenders Qualitative Nonrandom Convenience Sample	The influence of ACE's on adult perpetrated violence	Information provided by offender self-report may not be completely accurate	Higher ACE scores significantly correlate with higher instances of violent crime/sexual violence.
Lyn & Burton, 2004	178 incarcerated adult men Cross-sectional Nonrandom Convenience Sample	The relationship between attachment style and sexual offending	Retrospective self-report based on childhood experiences / accuracy of participant recall	85% of sex offender participant response correlated with insecure attachment status based on attachment inventory response
Miller & Najavits, 2012	Incarcerated adults Cross-sectional Nonrandom Convenience Sample	Challenges and strengths of trauma-informed correctional care	Trauma often goes unreported and untreated in men	Childhood abuse is associated with institutional difficulties and low program engagement. Offenders may have difficulty benefiting from cognitive-behavioral treatment until the impact of childhood trauma is addressed. Trauma-informed care demonstrates promise in increasing offender responsivity to CBT programming that reduces criminal risk factors.

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Author	Sample Description	Focus of Study	Limitations	Findings
Nunes, Hermann, Malcom, & Lavoie, 2013	462 incarcerated adult male sexual offenders Cross-sectional Nonrandom Convenience Sample	Sexual recidivism and child sexual abuse	Sample size was quite small for some of the analyses, particularly the ones involving specific CSA characteristics and the CSA by risk interaction. Deviation from the scoring instructions for the Static-99R and SSPI due to limited information.	Compared to sex offenders who had not been sexually abused, those who had been sexually abused before age 16 sexually offended against significantly younger victims and had significantly more indicators of pedophilic interest. Child sexual abuse predicted higher rates of sexual recidivism among higher risk offenders
Simons, Wurtele, & Durham, 2007	280 incarcerated adult sexual offenders Qualitative Convenience	Childhood trauma and attachment as it relates to developmental experiences and sexual offending	Study participants represented only 15% of the state's total incarcerated sex offenders which limits generalization of findings.	Participants reported childhood maltreatment and maladaptive behaviors associated with sex and intimacy. 94% of participants described insecure parental attachment; 76% avoidant and 62% anxious attachment. Specific developmental experiences serve as etiological factors in sexual offending.

Author	Sample Description	Focus of Study	Limitations	Findings
Thomas et. al, 2012	23 adult sexual offenders under community supervision Narrative Nondirective Nonrandom Convenience Sample	Childhood experiences of child sexual abuse offenders	Small sample size and reliability of self-report. Interviewee accounts are believed to be narrative truths but may not be historical truths. Researchers did not access case files or therapist records for historical corroboration.	15 of the 23 participants recalled significant childhood trauma. Two themes identified across all participants were identified as “not fitting in” and “longing for what was missed in childhood”. Intimacy deficits, poor emotion regulation and resentment correlate with sexual offending.

Figure 2.

Findings

The goal of this systematic review was to examine current literature exploring the integration of trauma-informed care into the treatment of adult male sex offenders. Through analysis of the literature, ten articles were found to fit with this study. Three notable themes stood out throughout the literature analysis in regard to the integration of trauma-informed care as it relates to adult male sex offender treatment. These themes include 1) Attachment style is associated with sexual offending; 2) Unresolved childhood trauma impacts treatment progress and outcomes 3) Adverse childhood experiences associate with perpetration of sexual offending.

Attachment Style is Associated with Sexual Offending

A significant portion of the research for this study identified the negative consequences that childhood trauma has on developmental factors related to attachment style and sexual offending. Nine out the ten articles identified a strong association between childhood abuse and insecure parental attachment. This research suggests that childhood trauma and insecure attachment style influence the development of maladaptive executive functioning skills such as impulsivity, disorganization, rigidity in problem solving, inappropriate social cue interpretation, and poor attention and concentration (Adams, 2003; Craissati & Beech, 2006; Creeden, 2009; Levenson & Grady, 2016; Lyn & Burton, 2004; Miller & Najavits, 2012; Nunes, Hermann, Malcom, & Lavoie, 2013; Simons, Wurtele, & Durham, 2008; Thomas, et al., 2012). Failure to develop secure attachment bonds during childhood is cited as fostering deficits in the development of social skills and self-esteem, which serve as a barrier to achieving healthy intimate relationships in adulthood (Craissati & Beech, 2006; Creeden, 2009; Levenson & Grady, 2016).

Unresolved Childhood Trauma Impacts Treatment Outcomes

An equally significant theme present in six of the ten articles included in this research highlighted several factors related to unresolved childhood trauma and treatment outcomes. Craissati and Beech (2006) state that for some individuals, developmental variables influenced by trauma and insecure attachment style, serve as precursors to both offending and re-offending. Craissati and Beech (2006) suggest that while trauma and attachment style are developmental variables generally not included in risk assessment prediction models, the impact that each of these has on an individual's capacity for change is significant. Creeden (2009) states that an individual's trauma history is intertwined with offending behaviors and linked through overwhelming emotional states such as anxiety, fear, abandonment, anger, and shame.

When trauma remains unresolved the individual often struggles to take responsibility for their own harmful behavior. This hinders his ability to learn, and effectively use, the skills necessary to maintain lasting positive change (Adams, 2003; Craissati & Beech, 2006; Creeden, 2009; Miller & Najavits, 2012; Nunes, Hermann, Malcom, & Lavoie, 2013). Miller and Najavits (2012) further report that unresolved trauma restricts with the individual's ability to benefit from treatment programs due to the disorientation and disconnection that traumatic experiences produce. Additionally, Nunes, Hermann, Malcom, and Lavoie (2013) state that when trauma and attachment style result in limited coping skills and an inability to manage dissociative responses, it interferes with engagement in treatment and capacity to utilize intervention strategies. Miller and Najavits (2012) conclude that childhood trauma is associated with institutional difficulties and low program engagement in adult men participating in sex offender treatment programs.

Adverse Childhood Experiences Associate with Sexual Offending

The third theme identified through the analysis process revealed a strong association with ACE's and sexual offending. Levenson and Grady (2016) state that adverse childhood experiences as represented by elevated ACE scores are consistent with increased risk for sexual perpetration. This association is based on the cumulative impact of ACE's as a trajectory of experiences that influence functioning and mastery of skills in multiple areas of an individual's development (Levenson & Grady, 2016). Levenson and Grady (2016) report that ACE's are associated with self-regulation deficits, these deficits subsequently impact academic performance and development of appropriate social skills. Consequently, individuals who experience more ACE's are at an increased risk for developing compromised emotional regulation, social attachment, impulse control, and cognitive processing skills (Levenson & Grady, 2016). Furthermore, Levenson and Grady (2016) state that high ACE scores represent a chronic and

varied history of adversity which has an influence on attachment style and deficits in intimacy as well. These early childhood experiences are believed to shape the ways in which the individual learns to interact with his environment, and as such, attempts to connect with others are made through coercive, violent, or deviant sexual behavior (Levenson & Grady, 2016).

Discussion

The purpose of this systematic review was to examine current literature in regard to the integration of trauma-informed care in the treatment of adult male sex offenders. Ten studies were reviewed with results indicating that there is a significant need for the integration of trauma-informed care in the treatment of adult male sex offenders. A comprehensive review of the research provides evidence to support the notion that adult men participating in sex offender treatment are a population in need of services and treatment that address childhood trauma and subsequent attachment style. Insecure parental attachment, childhood trauma and increased endorsement of ACE's suggest that this population faces many developmental barriers in achieving treatment success. When left unaddressed, these barriers present as significant challenges for men participating in sex offender treatment as attachment style and unresolved childhood trauma correlates with sexual offending (Adams, 2003; Craissati & Beech, 2006; Creeden, 2009; Dutton & Hart, 1992; Levenson & Grady, 2016; Lyn & Burton, 2004). Additionally, unresolved childhood trauma and attachment style impact treatment progress and increase risk of recidivism (Adams, 2003; Levenson & Grady, 2016; Craissati & Beech, 2006; Creeden, 2009; Miller & Najavits, 2012; Nunes, Hermann, Malcom, & Lavoie, 2013).

Strengths and Limitations

Strengths of this review include identifying the gaps in literature as it pertains to trauma-informed care in the treatment of adult male sex offenders. At the same time, this review also highlights a growing consensus that without the integration of trauma-informed care, this population experiences significant barriers to successful treatment outcomes. While this review was designed to include all pertinent research on the integration of trauma-informed care in the treatment of adult men participating in evidence-based sex offender treatment programs, limitations are evident. Of greatest significance, was that a number of the articles based findings on participant recall and self-report. While this is typical for gathering information on past experiences as perceived by the individual, this is a limitation in that corroboration of the information provided may not always be accessible. At the same time, individuals who experience childhood trauma may not recognize themselves as victims, or may choose not to disclose childhood trauma.

Implications for Future Research

The purpose of this systematic review was to examine current literature on the integration of trauma-informed care in the treatment of adult male sex offenders. Ten studies were reviewed with results indicating that there is a significant need for the integration of trauma-informed care in the treatment of adult male sex offenders. This is consistent with the literature review that identified a significant association between childhood trauma and sexual offending. A comprehensive review of the research provides evidence to support the notion that adult men participating in sex offender treatment are a population in need of services and treatment that address childhood trauma and subsequent attachment style. Insecure parental attachment, childhood trauma and increased endorsement of ACE's suggest that this population faces many developmental barriers in achieving treatment success. When left unaddressed, these barriers

present as significant challenges for men participating in sex offender treatment as attachment style and unresolved childhood trauma is significantly linked to sexual offending (Adams, 2003; Creeden, 2009). Additionally, unresolved childhood trauma and attachment style impact treatment progress and increase risk of recidivism (Craissati & Beech, 2006).

Results of this review also highlight the fact that little research has been done in the area of integrating trauma-informed care for the treatment of adult male sex offenders. Much of the literature that recognizes the importance of trauma-informed care in the area of sexual offending focuses on juveniles and women. While this is an equally important area of care, this focus overlooks the research that identifies adult male sex offenders as a population in need of trauma-informed care as well. The current treatment modalities for working with adult male sex offenders offer an opportunity to integrate trauma-informed principles into the therapeutic process for these individuals as a method for encouraging treatment progress and overall individual wellness. Social work clinicians can utilize this knowledge to better serve men participating in sex offender treatment by understanding the impact that traumatic experiences have on the individual's capacity to benefit from sex offender treatment. Through the use of trauma-informed care as an approach to working with this population, clinicians can encourage a therapeutic environment that provides clients with a safe space to process trauma while also addressing individual treatment goals.

Conclusion

As understanding in regard to the impact of trauma in the form of adverse childhood experiences has grown, so too, can the capacity to provide sex offender treatment for incarcerated adult men. As clinicians, the ability to apply trauma-informed care principles to this

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work has great potential to encourage healing, treatment success, and overall individual wellness and community safety. Research indicates that incorporating the principles of trauma-informed care to the treatment of adult male sex offenders has the potential to promote reduction of the adverse impact of childhood trauma. By encouraging healing, social work clinicians can increase the client's capacity to achieve physical, psychological, social, and spiritual well-being.

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