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Clinicians' Perceptions of Adverse Childhood Experiences, Resiliency, and Treatment Engagement with Criminal Offenders

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2025

Abstract

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MPhil, Walden University, 2023

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

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Abstract

This study investigated the pervasive impact of adverse childhood experiences (ACEs) on clinicians, particularly those who provide services to criminal offenders. ACEs contribute to a range of mental and physical health issues that can extend into adulthood, affecting not only individuals who experienced these adversities, but also clinicians who treat them. Despite the growing body of research on the consequences of ACEs, there remained a significant gap in terms of understanding how clinicians' own histories influence their professional resilience and treatment efficacy. Garmezy's resiliency theory, the framework for the study, emphasizes the role of positive contextual, social, and individual factors in overcoming risk and adverse outcomes. A basic qualitative methodological approach was used to investigate how clinician's ACE's influenced their effectiveness, as well as their own resiliency and engagement. Three key themes emerged from data analysis: Client interactions, countertransference, and resilience. There were also eight subthemes including increased empathy, a desire to help others, enhanced clinical traits, an increased awareness of countertransference, participation in their own therapy, and a search for meaning. The results indicate that clinicians can overcome their adversities; however, their personal biases and adversities influence the selection of their clients. Implications for positive social change include normalizing discussion of traumas and increasing effectiveness of personal therapy, self-care, and work-life balance.

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Dedication

First and foremost, I praise God for blessing me with patience, perseverance, and dedication to achieve this lifelong goal. I dedicate my doctoral study to my family and partner, who supported me throughout my work and gave me the strength I needed during those difficult and challenging moments. Each of you put as much time, energy, and dedication into this degree as I did. We all earned this degree together. Thank you all for your patience, sacrifices, and unconditional love.

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To my amazing family, thank you for being patient with me and encouraging me during this long doctoral journey. Thank you for all your prayers, words of encouragement, and constant faith. To my friends and cohort, thank you for your support and understanding during this long and challenging journey. I am eternally grateful to each of you.

Lastly, I would like to thank my participants for their willingness to share their experience with me to better understand the challenges that clinicians face daily and how they maintain resilience while providing treatment services to criminal offenders.

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Chapter 1: Introduction to the Study

Adverse childhood experiences (ACEs) have emerged as an ongoing problem that does not discriminate based on social or economic class, causing lifelong consequences persisting into adulthood. ACEs involve abuse, neglect, and household dysfunction in childhood, which often include physical, sexual, and emotional violence (Brown et al., 2023). Previous studies have explored impacts of ACEs and behavioral outcomes of child abuse and neglect victims; however, there is a limited amount of research examining impacts of ACEs on clinicians as wounded healers. Furthermore, there are few studies that specifically address how ACEs impact clinicians who provide clinical services to criminal offenders. There is a great need to explore how such adversities impact quality of treatment services for criminal offenders and resiliency of clinicians. This study will lead to a deeper understanding of the impact of ACEs on clinicians' resiliency and engagement of criminal offenders.

Felitti et al. (1998) stated individuals who are exposed to four or more ACEs have higher risks of alcoholism, drug abuse, depression, and suicide attempts. ACEs are the most significant predictor of suicide attempts (Clunis, 2023). Additionally, those who are exposed are also at a higher risk physical inactivity and severe obesity, increased smoking habits, more than 50 sexual intercourse partners, and sexually-transmitted diseases (Fleming et al., 2015). Baggio (2022) found those who experienced four or more ACEs were 26 times more likely to report HIV risk behaviors compared to respondents who did not report any ACEs.

In this chapter, I present the background, purpose, research questions, conceptual framework, nature of the study, definitions of key terms, assumptions, scope and delimitations, limitations, significance, and asummary and preview of the literature review in Chapter 2.

Background of the Study

ACEs are the seventh leading cause of death in the United States as well as health risk behaviors, including substance abuse, physical inactivity, and high-risk sex behaviors (Bailey et al., 2018; Bentall et al., 2014; De Bellis & Zisk, 2014; Varese et al., 2012). The relationship between ACEs and chronic disease is complex, with many variables affecting gene expression, inflammation, and disease progression. Bryan (2019) found people with an ACE score of six or more is 24 times more likely to attempt suicide than a patient with an ACE score of 0.17. The risk for depression nearly triples with ACE exposure, as does risk of drug and alcohol use.

Nuttall and Jackson (1994) stated 13% of male and 20% of female clinicians in clinical social work, pediatrics, psychiatry, and psychology reported personal histories of childhood sexual abuse; 7.3% of men and 6.9% of women reported histories of physical abuse as children. Little and Hamby (1996) found 32% of clinicians reported childhood sexual abuse (CSA) histories, and sexually-abused therapists were more likely to report some countertransference and boundary issues compared to nonabused therapists, but gender differences were more important in terms of determining differences in clinical practice. Female clinicians reported CSA was more difficult to treat, and they screened more regularly for CSA, and they used more coping strategies than male clinicians.

There is a lack of information regarding how practitioners disclose and personally explore their lived experiences, as well as their willingness to engage in difficult or painful topics. Therapists who experience emotional hardening tend to have difficulties engaging in effective therapeutic relationships, showing empathy for their clients, and believing change may happen (Moulden & Firestone, 2007). Despite past trauma, health professionals are increasingly urged to work with patients who have experienced intimate partner and family violence (McLindon et al., 2018).

Rates of CSA among therapists are generally comparable to community samples (Little & Hamby, 2001). I found a research problem and gap in literature regarding clinicians' perceptions of their own ACEs and treatment engagement with criminal offenders. Therefore, additional research was needed to address the gap in research to determine clinicians' perceptions of those experiences that may potentially influence treatment engagement of criminal offenders.

Findings from this study will lead to additional perspectives regarding the influence of ACEs on clinicians' professional growth, resiliency, and treatment engagement of criminal offenders. Results from this study promote transparency, acceptance, and self-awareness for those who are impacted by ACEs. Furthermore, results from this study could result in development of workplace programs that support health professionals with trauma histories, including their clinical practices.

Problem Statement

ACEs include but are not limited to abuse (emotional, physical, or sexual), neglect (emotional, physical), or growing up in households where domestic violence is

witnessed or household members abuse drugs or alcohol, have mental illnesses, or relational stress (Anda et al., 2010; Centers for Disease Control and Prevention [CDC], 2021). ACEs lead to a wide range of deleterious physical and psychological outcomes. Chronic health problems, mental illnesses, and substance misuse in adulthood have been correlated with ACEs. According to the CDC (2021), 61% of adults had at least one ACE, and 16% had four or more types of ACEs. Further, five of the top 10 leading causes of death are associated with ACEs and detrimentally affect health outcomes in childhood, adolescence, and adulthood. Positive and negative childhood experiences shape physical, mental, and social health of individuals throughout their entire lives (Claypool & Moore de Peralta, 2021).

Recent studies have focused on investigating the prevalence of ACEs among mental health providers. Mental health clinicians have higher rates of ACEs (Brown et al., 2022; Reading et al., 2022). Furthermore, 93% to 95% of counselors report at least one to eight traumatic experiences in their lifetime, and may be vulnerable to reexperiencing trauma with clients, which could negatively impact client care (Brown et al., 2022). Mental health clinicians are often drawn to the mental health field because they want to make impacts on their clients' lives (Brown et al., 2022; Symister, 2023).

It is important for mental health clinicians to understand psychological health risks associated with lived traumatic experiences and resiliency. Resilience is critical in terms of adapting to and dealing with stressful circumstances, averting detrimental results of adversities in work settings, and overcoming adverse life situations (Rosenberger, 2023). Rosenberger (2023) stated mental health counselors can become more vulnerable

and incapable of attaining required levels of resilience to deal with daily life concerns, which then negatively impacts effectiveness of providing counseling services. Therapists who experience emotional hardening tend to have difficulties engaging in effective therapeutic relationships, showing empathy for their clients, and believing change may happen (Moulden & Firestone, 2007).

There is a lack of research examining lived ACEs in terms of clinicians' perceptions, resiliency, and treatment of criminal offenders. Research regarding counselors' personal trauma is still emerging; therefore, it is unknown how practitioners disclose and personally explore their lived experiences, as well as their willingness to engage in difficult or painful material. Therapists who experience emotional hardening tend to have difficulties engaging in an effective therapeutic relationship, showing empathy for their clients, and believing change may happen (Moulden & Firestone, 2007). Furthermore, clinical providers are less likely to report having respect for clients who are criminal justice-involved versus those who are not, which can impact therapeutic relationships and treatment engagement (Bandara et al., 2018). Counselors are expected to suspend their personal beliefs to separate themselves from their work with clients. Clinicians are expected to be able to manage stress-inducing work environment situations and follow professional boundaries through awareness of their personal experiences, biases, and worldviews.

Most research focused on the impact of ACEs on physical and mental health outcomes; however, there was a lack of research on clinicians' perceptions of their own

ACEs, resiliency, and treatment engagement with criminal offenders. Therefore, additional research was needed to address this topic.

Purpose of the Study

In this proposed qualitative study, focused on clinicians' perception of how their own ACEs shape their professional practice, resiliency, and engagement with criminal offenders. I proposed to conduct basic qualitative research to gain an in-depth understanding of how such adversities impact resiliency, professional practice, and treatment engagement of criminal offenders. Specifically, it was vital to increase the understanding of this topic through the eyes of those who have experienced and how they interpret the impact of their experiences (Worthington, 2013). I utilized a basic qualitative approach and open-ended interviewing to focus on the phenomenon to provide insight into their experiences, resiliency, and professional growth while working with criminal offenders. Identifying the essence of human experiences about their lived experiences as described by clinicians will bring understanding and bridge the gap in research (Creswell & Creswell, 2018).

Research Questions

RQ1: How do clinicians describe their perceptions of how their ACEs shaped their professional practice, resiliency, and engagement of offenders?

Theoretical Foundation

Resiliency theory, developed by Garmezy, served as the theoretical foundation for this study. Garmezy, considered a pioneer in resiliency research, formulated the theory to identify the protective factors that allow individuals, particularly impoverished African

American children, to navigate life stressors successfully. Resilience has been most frequently defined and characterized as positive adaptation despite adversity and as the capacity to maintain healthy functioning after an acute stressor or traumatic event as well as coping with downstream effects from major life events (Fleming & Ledogar, 2008; Park et al., 2021). The impact of ACEs has been widely studied and found to cause a myriad of physical and psychological problems (Tzouvara et al., 2023). For this research study, resiliency theory was utilized to provide a further understanding of how clinicians cope with their adversities and how it may impact their professional growth.

Further, resilience is the natural, human capacity to navigate life well. It is something every human being has wisdom and common sense. It means coming to know how you think, who you are spiritually, where you come from, and where you are going. The key is learning how to utilize innate resilience, which is the birthright of every human being. It involves understanding our inner spirit and finding a sense of direction (Fleming & Ledogar, 2008). The three aspects of the resiliency model are compensatory, protective, and challenge which explains how resiliency factors operate to alter the trajectory from risk exposure to negative outcomes (Fergus & Zimmerman, 2005). Resiliency theory focuses attention on positive contextual, social, and individual variables that interfere with or disrupt developmental trajectories from risk to problem behaviors, mental distress, and poor health outcomes (Zimmerman, 2013).

Utilizing the resiliency theory in this research study related to my research problem by determining how lived ACEs of clinicians are influenced in the treatment engagement of criminal offenders. The resiliency theory guided this study to determine if

past trauma has had any delayed effects on clinicians' ability to adapt and cope with current adversities while providing treatment to criminal offenders. Furthermore, resiliency theory was utilized by Bovee (2024) in their study as a framework to evaluate the variables of resiliency, support, and perceived stress in counseling practitioners for measuring professional development. Moreover, the resiliency theory and a basic qualitative approach helped gain an in-depth understanding of how clinicians perceive their own lived experiences, resiliency, and their treatment engagement with criminal offenders. A more detailed examination of resiliency theory is included in Chapter 2.

Nature of the Study

In this qualitative study, I employed a basic qualitative approach to answer the research question to understand the clinicians' perceptions of their own ACEs, resiliency, and treatment engagement with criminal offenders. Previous researcher such as that of Kounenou et al. (2023), Straussner et al. (2018), and Symister (2023), have suggested that it is important to understand clinicians' lived experiences and their willingness to engage criminal offenders in treatment services. Utilizing a basic qualitative approach in this study helped to answer the research question and achieve the intended purpose of this study by gathering and interpreting interview responses from participant's experiences and perceptions.

A basic qualitative study demonstrated (1) how people interpret their experiences, (2) how they construct their worlds, and (3) what meaning they attribute to their experiences. The overall purpose was to understand how people make sense of their lives and their experiences. If the unit of analysis is a bounded system, a case, one would label

such a study a qualitative case study (Merriam & Tisdell, 2015). A basic qualitative approach focused on obtaining information directly from clinicians about their perception of their lived experiences and their treatment engagement with criminal offenders.

Using a qualitative design increased the understanding of clinicians' perceptions of their lived childhood experience, resiliency, and treatment engagement of criminal offenders. A basic qualitative approach helped to address the research question by gaining insight into how lived experiences shape clinicians' professional practice. A basic qualitative approach also provided a clear and in-depth understanding of clinicians' childhood adversities and how they have impacted the treatment services offered to criminal offenders, and professional practice.

For this research study, I collected data by conducting semi-structured interviews with clinical professionals such as social workers, licensed professional counselors, licensed psychological associates, or psychiatric nurse practitioners who attend a university, and who worked or had worked with incarcerated offenders in prisons or jails and experienced ACEs before 18. Those who were interested in participating in this study must work or have experience working in a correctional setting. After the data had been collected, I used thematic analysis to analyze the data, and interpreting patterns or themes in a data set through thick descriptive data led to new insights and understanding (Boyatzis, 1998; Elliott & Guy, 1993; Thomas, 2006). The purpose of thematic analysis is to identify significant commonalities within the collected data, which collectively describe the phenomenon of a study (Braun & Clarke, 2012).

Definitions

Key terms are defined as follows:

Adverse Childhood Experiences: Traumatic events that occur in childhood (0-17 years) such as experiencing violence, abuse, or neglect; witnessing violence in the home or community; having a family member attempt or die by suicide; growing up in a household with substance use problems, mental health problems, and instability due to parental separation or household member being jailed or prisoned (Centers for Disease Control Prevention, 2021; Claypool & Moore de Peralta, 2021).

Clinician: An individual who is licensed to provide therapeutic services in a clinical setting to patients and have worked with offenders. Examples of clinical professionals include psychotherapist, forensic psychologists, social workers, psychiatric nurse practitioners, and licensed counselors. These professionals may hold master's level or doctoral level degrees from various universities (McCartan et al., 2020).

Resilience: The ability to adapt to stress and negative experiences in a healthy way and being able to maintain functioning after an acute stressor or traumatic event (Fleming & Ledogar, 2008; Kte, 2023; Park et al., 2021).

Wounded Healer: An individual who experienced previous wounding and who engages in personal healing and assists others with wounding (Jung, 1951, 1957). The wounded healer becomes a wounded healer only after completing their healing process (Bryant, 2006; Houston, 1987; Jung, 1951; Nouwen, 1979).

Criminal Offender: A person who commits an illegal act, does something wrong, or causes problems and found guilty (OFFENDER | *Definition in the Cambridge English Dictionary*, 2024).

Perceptions: A way of understanding or interpreting a concept or phenomenon; mental impressions. For example, This finding may reflect a general perception that this form of offending is atypical for females" (Mellor & Deering, 2010).

Assumptions

Assumptions are inherent in all research, particularly true in qualitative studies (Creswell & Creswell, 2018). First, qualitative inquiry believes that reality is subjective and that social environments are personal constructs created by individual interpretations that are not generalizable (Gall et al., 2007); these beliefs are rooted in constructivism rather than positivism. Furthermore, Sechrest and Sidani (1995) assume that rich description and deep understanding are indicative of their methodology, which insinuates that other research paradigms lack depth.

Second, it was assumed that participants answered interview questions, honestly reflect on their history of how ACEs have impacted their willingness to engage offenders in treatment services. When conducting research, there is a need to assume that people will answer truthfully (Simon et al., 2018). Third, I assumed that participants met the eligibility criteria for inclusion based on their interest in participating in the study and their answers to a short demographic inclusion questionnaire (Appendix B and C). Finally, participants were guaranteed anonymity and could choose to cease the interview process and withdraw from the study at any time.

Scope and Delimitations

The scope of this study was limited to licensed clinicians who are enrolled in graduate-level programs at a university. The topic was limited to students who work or have previous experience working in corrections. The focus of this study excluded other disciplines and those who were not licensed clinicians. A limitation of the study was the small sample size therefore, results are not transferable and cannot be generalized across the larger population or other settings, groups, or populations outside of the mental health field (Maxwell, 2021). Furthermore, Maxwell (2021), postulates that generalization has been a problematic issue for qualitative researchers, partly because it has been intrinsically connected to the concept of causation.

Limitations

This study involved a qualitative approach, and the main limitation included the results not being generalizable. The sample size for this study results being less than the necessary threshold, which limits generalizing the study outside of the psychology department. To address the limitation of this research not being generalizable it was recommended that future research explore clinician's lived childhood experiences from different geographic locations. A limitation of this study is the separation of roles due to my experience working with criminal offenders. Further, a bias that could result from my experience working in a correctional setting is how I could potentially interpret information in a way that conforms with my preconceptions or favor theory. Furthermore, other biases that could have been present in this study based on my experience working in corrections are affinity bias, prototype bias, confirmation bias, anchoring bias, and

value attribution. To address my bias, I followed the interview protocol and allow for the lived experiences of each participant to be expressed naturally without asking leading questions. I committed to creating a trusting and confidential environment for each of the participants where they could express themselves freely. Lastly, a limitation of this study was my role as a researcher's confirmation bias based on my experience working in a correctional/forensic setting providing treatment to criminal offenders. Necessary steps were developed to limit these biases to influence this research.

Significance of the Study

This proposed research study filled the gap in understanding how the clinicians' perceptions of their own ACEs, resiliency, and their treatment engagement with criminal offenders. The significance of this study was based on the need to understand how childhood adversities can impact treatment services rendered in correctional settings. This study addressed the identified gap and sought clinicians' input on the effects of adversities. Steen et al. (2021) stated clinicians with high ACEs scores need more support from their managers to process their mental health challenges that manifest due to ACEs, without the stigma often associated with disclosure. While the workplace is not responsible for providing treatment to its social workers, institutions can use these findings to support in-service training and promote participation in continuing education training for clinicians that involves educating them on ACEs and using behavioral health resources (Beavers, 2023).

Significance to Practice

This proposed research study was a necessary contribution to scholarly knowledge as it increased the understanding of clinicians' perceptions of their lived ACEs. This study contributed to the available literature on ACEs on clinicians' professional growth, resiliency, and treatment engagement of criminal offenders. This research advanced professional growth by identifying the potential impact on clinicians and bringing self-awareness for self-care and resiliency. The data also encouraged social workers to seek trauma-informed supervision and implement self-care practices to improve their personal quality of life (Beavers, 2023). Moreover, findings from my study encouraged clinicians to consider participating in therapy before and after entering the field to address their childhood adversities, and their impact, and increase awareness of the likelihood of countertransference. Lastly, this study could potentially contribute to mental health programs to address personal traumas and biases before clinical practice to reduce the risk of countertransference and poor-quality treatment services.

Significance to Theory

My research contribution to this study addressed the gap in the literature and provided an understanding of how clinicians' own lived adversities impact their engagement with criminal offenders, professional growth, and resiliency. Knowing and understanding the early signs of countertransference enhanced clinicians' awareness, physical and mental health, and treatment quality. Specifically, the current study contributed to the understanding of lived experiences and provides insight into the support to clinicians who may benefit from treatment and increase self-awareness of

countertransference. This study also provided insight and guided future researchers who can benefit from utilizing resiliency theory.

Significance to Social Change

This study may have the potential to provide insight into clinician's willingness to engage criminal offenders in treatment services. Further, this study may have the potential to understand how the lived childhood experiences of clinicians influence their professional practice. Given the psychological impacts of the centrality of negative events and ACEs, data from my study may support social work administrators who implement or revise impairment policies including wellness components of the policy (Beavers, 2023). Further, this study may have a potential effect on social change in prisons that have clinical services available to offenders and clinicians to seek supervision and clinical services should their past adversities impact the quality of services provided to offenders. This study may potentially impact treatment quality, engagement, and clinician countertransference. Organizations that employ social workers need to provide appropriate supervision to allow for optimal success (Beavers, 2023). Lastly, this study can also serve as a platform to guide future research to discover other gaps in the literature and reduce the gap in research literature.

Summary

In Chapter 1, highlighted the components of this research study and provided background information regarding this research study. I presented an introduction to this study by demonstrating the purpose for further research on the impact of ACEs on clinicians' professional growth, resilience, and treatment engagement of offenders. I

addressed how ACEs have lifelong consequences that can affect individuals into adulthood, regardless of their social or economic status. There was a need to understand how these experiences impact the quality of treatment services for criminal offenders and the resiliency of clinicians. This qualitative research study aimed to explore the impact of ACEs on clinicians and their engagement with criminal offenders. It focused on how clinicians disclose and explore their own experiences, as well as their willingness to work with difficult material.

While most research on ACEs focused on physical and mental health outcomes, there was a lack of research on how clinicians perceive their own childhood experiences and how it affects their work with criminal offenders. By utilizing a basic qualitative research approach, this study sought to gain a deeper understanding of how ACEs influence the resiliency, professional practice, and treatment engagement of clinicians working with criminal offenders. This research aimed to address a gap in the literature and provided insight into how clinicians' own experiences impact their ability to engage with criminal offenders in treatment settings. Although limitations were identified, this study was a significant contribution to the mental health field to not only guide novice clinicians, counseling programs, professional awareness and growth, and improve the quality-of-service delivery to criminal offenders.

In Chapter 2, a literature review was presented exploring existing literature on clinicians, ACEs, resiliency, and theoretical framework guiding this study. Chapter 3 discusses the research methods applied in the study. Chapter 4 presented the results of the

study, and Chapter 5 presented the discussion, conclusions, and recommendations based on the data collected and analyzed.

Chapter 2: Literature Review

I begin this chapter with a discussion of the impact of ACEs on mental health providers and previous research findings on ACEs and mental health professionals. I then discuss my literature search strategy. I then identify and discuss the theoretical foundation for this basic qualitative study, rationale for using the resiliency theory, significant contributors to the theory, and previous studies that have used the theory. I then identify and discuss core themes such as impacts of ACEs, neurodevelopment, mental health outcomes, helping professionals as wounded healers, exposure to trauma and traumatization, professional competence, resiliency and clinicians, ACEs and gender, ACEs and criminal behavior, and engagement of criminal offenders.

Literature Search Strategy

I used the following databases for this study: EBSCOHost, PsycArticles, ProQuest, PubMed, and PsycInfo via the Walden University Library. I searched peer-reviewed journals about types of criminal offending, treatment engagement, resiliency, ACEs, and clinicians. Due to the limited research on clinicians' perceptions of their lived ACEs, resiliency, and treatment engagement of criminal offenders, I had to review older articles that were published between 1982 and 2023 to compare and identify gaps in literature.

Furthermore, all sources with the exception of some seminal sources were published between 2018 and 2023. I used the following search terms: *criminal offenders*, *inmates*, *detainees*, *felons*, *prisoners*, *mental health*, *clinicians*, *counselor*, *therapist*, *wounded healer*, *professional clinician engagement*, *treatment engagement*, *trauma*,

adverse childhood experiences, *ACE*, *child physical abuse*, *sexual abuse*, *domestic violence*, *substance use*, and *child maltreatment*.

Theoretical Foundation

The resiliency theory as developed by Garmezy was the theoretical foundation for this study. Garmezy , formulated the theory to identify protective factors that allow individuals, particularly impoverished African American children, to navigate life stressors successfully. The impact of ACEs causes physical and psychological problems (Tzouvara et al., 2023). I used the resiliency theory to address how clinicians cope with their own ACEs and how they may impact their professional growth.

Resilience is the ability to adapt positively in the face of adversity (Park et al., 2021). It involves the capacity to cope with stress and negative experiences in a healthy manner while maintaining functioning even after experiencing acute stressors or traumatic events. The concept of resilience is rooted in psychology . Wild et al. (2020) stated three essential qualities of the resiliency theory are cognitive, emotional, and behavioral adaptations to coping with stress and negative experiences. Resilience involves wisdom, common sense, and a deep understanding of one's inner spirit and life direction (HeavyRunner & Marshall, 2003). The theory also emphasizes the significance of positive contextual, social, and individual factors that can disrupt or impede development of problem behaviors, mental distress, and poor health outcomes among individuals.

The resiliency theory has been used in research to emphasize the ability of individuals to thrive despite adversity. It involves the multifaceted nature of resilience,

addressing the capacity to maintain healthy functioning after challenges and cope with trauma and major life events.

Richardson (2002) found resiliency can develop in response to adversity, and people can use this to grow and thrive personally and professionally. Resiliency is a reintegrative process that leads to growth through adversities and disruptions via protective factors to cope with stress. Boys are more likely to experience certain types of ACEs, such as physical abuse and witnessing domestic violence. Girls are more likely to experience sexual abuse and emotional neglect (Anda et al., 2006).

Nowell (2024) indicated social determinants of health for children of incarcerated parents can have positive outcomes as a result of appropriate interventions.

Park et al. (2021) underscored the importance of the resiliency theory and potential for resiliency to be achieved through the use of positive coping skills to manage daily stress, are not only significant but also inspiring for our future research.

Hou and Skovholt (2020) found highly resilient therapists are drawn to strong interpersonal relationships, actively engage with themselves, possess core values and beliefs framework, and desire to learn and grow. Researchers can gain insights into how resilience can be nurtured and fostered by focusing on the interplay between individual characteristics, social support, and environmental factors (Clunis, 2023). This literature review focuses on resiliency theory and its impact on positive contextual, social, and individual variables that interrupt developmental trajectories from risk to detrimental behaviors, mental distress, and poor health outcomes. Overall, resiliency theory provides a framework for investigating and comprehending the factors that enable individuals to

overcome challenges and thrive despite adverse circumstances. Resiliency theory in this study will provide an understanding of the research question of how clinicians cope with their own adversities and professional growth while working with criminal offenders. Further, resiliency theory will delineate how clinicians cope with daily stressors while treating criminal offenders, which affects their professional growth because of past childhood adversities. Understanding the protective factors associated with resilience among older adults contributes to the advancement of resilience theory (Bolton et al., 2016). This proposed study will also understand the basic assumption that resiliency aids people in overcoming hardships after adversity.

Literature Review

This chapter addresses previous research on ACEs and their different outcomes on an individual, such as neurodevelopment, resiliency, professional growth, and engagement of others like criminal offenders. This present section presents the major themes uncovered. The themes are as follows: a) impact of ACEs, b) ACEs and neurodevelopment, c) ACEs and mental health outcomes, d) ACEs and helping professionals, e) clinicians as wounded healers, f) exposure to trauma and traumatization, g) ACEs and professional competence, h) resiliency and clinicians, i) ACEs and gender, j) ACEs and criminal behavior, and k) engagement of criminal offenders. It is essential to understand how ACEs can impact neurodevelopment outcomes, leading to mental health issues and resiliency. I wanted to address the impact of ACE, the reason why many clinicians enter the field of counseling, and how these individuals can be exposed to re-

traumatization daily while working with criminal offenders, impacting resiliency and professionalism.

Research on the impact of ACEs on mental health providers shows that mental health clinicians have higher rates of ACEs (E. M. Brown et al., 2022; Reading et al., 2022). There is a great need for attention to be given to the traumatic experiences of clinicians and how such events impact professional resilience. E. M. Brown et al. (2022) suggested that there are questions about how practitioners disclose and explore their lived experiences and engage in difficult or painful material. E. M. Brown et al. (2022) further indicated that 93% to 95% of counselors report at least one to eight traumatic experiences in their lifetime, which may leave them vulnerable to re-experiencing trauma with their clients and negatively impact their client care.

Impact of ACEs

ACEs are a pandemic that poses significant mental and physical health risks for victims. These experiences, which include neglect, abuse, and household dysfunction, can have long-lasting effects on individuals, including an increased risk of depressive/anxiety symptoms, alcohol use and misuse, neurodevelopmental impairments, poor health persisting into adulthood, and even early death (Zhen-Duan et al., 2023). The prevalence of ACEs is striking, with an estimated 61% of adults having at least one ACE and 16% experiencing four or more types of ACEs (Centers for Disease Control and Prevention, 2021; Claypool & Moore de Peralta, 2021). ACEs are a widespread issue that affects a significant portion of the population, particularly female and racial/ethnic minority groups who are at a higher risk for experiencing multiple ACEs. In a study by

Zhen-Duan et al. (2023), they wanted to investigate the impact of ACEs on health outcomes of racially/ethnically minoritized and economically diverse populations, many of which are rooted in structural racism and discrimination. The study utilized a multilevel conceptualization of ACEs that emphasized the structural and social determinants of ACEs exposure. Using this approach established that the illuminations of traditional ACEs are related to social conditions. Zhen-Duan et al. (2023) found that social and structural inequalities further shape adversity, and there is a need to shift the focus on the ACEs conceptual model- (1) generational embodiment and historical trauma and (2) social conditions and local context to promote health equity. This study addressed the underlying problems that are a result of social conditions rather than focusing on the individual level to address mental health disparities. Understanding the underlying causes of ACEs in this study was a strength; however, disparities in our social conditions can be challenging to control. Furthermore, it would be difficult for a minority with limited access to resources, which was not addressed in the Zhen-Duan et al. (2023) study, which would be essential to address in future studies.

The impact of ACEs on individuals can be profound, affecting brain development and the ability to regulate emotions. Children who are exposed to trauma and adverse experiences during their formative years may experience changes in brain development that can impact their ability to regulate emotions throughout their lives, leading to a higher incidence of mental health issues, substance abuse, and adverse physical health (Anda et al., 2006). Furthermore, individuals who experience ACEs may be more likely to engage in risky and maladaptive behaviors as a coping mechanism to deal with the

stress and trauma they have experienced, which can lead to criminal justice involvement (Sheffler et al., 2019). ACEs can have a cascading effect on an individual's life, leading to a myriad of challenges and difficulties that can persist into adulthood.

In a study by Sheffler et al. (2019), they examined whether coping strategies mediate the link between ACEs and adult psychiatric and physical health outcomes. Data were drawn from Wave I (N = 7108), Wave II (N = 4963), and Wave III (N = 3294) of the Midlife Development in the United States (MIDUS) Survey. The results from their study showed that ACEs, reported at Wave I, were associated with worse psychiatric and physical health outcomes at Wave III. ACEs at Wave I were associated with greater use of avoidant emotion-focused coping and lower use of problem-focused strategies at Wave II. Avoidant emotion-focused coping at Wave II partially mediated the relationship between ACEs, reported at Wave I, and psychiatric and physical health outcomes reported at Wave III.

Furthermore, no significant mediation was detected for problem-focused coping. The study had a large sample size and a 20-year follow-up; however, there was a lack of identification of what coping strategies were beneficial to respondents in coping with their adversities. Further, there was a lack of information demonstrating factors contributing to worsening psychiatric and physical health outcomes, which should be explored further.

It is also important to acknowledge the impact of ACEs on healthcare professionals who provide treatment services to individuals who have experienced trauma and adversity. Counseling practice can expose clinicians to the pain and suffering of

others, potentially compounding their own painful life experiences (Coaston & Lawrence, 2024). Dealing daily with the trauma and distress of their clients can take a toll on the mental health and well-being of healthcare professionals, highlighting the pervasive nature of ACEs and their impact on both individuals and those who work to help them.

To address the pervasive issue of ACEs, it was crucial to normalize speaking about and addressing such adversities early on to reduce the risk of adverse outcomes for victims. Qualified and relevant individuals and organizations can work to mitigate the long-term effects of these experiences by raising awareness of the prevalence and impact of ACEs and providing support and resources for those who have experienced adversity in childhood. This may involve early intervention programs, trauma-informed care, and comprehensive support services for individuals who have experienced ACEs, as well as training and resources for healthcare professionals who work with this population.

In conclusion, it is evident that ACEs are a widespread and detrimental issue that can have significant mental and physical health implications for individuals; therefore, it is important to address first how ACEs impact neurodevelopment. The impact of ACEs can be far-reaching, affecting individuals across the lifespan and posing significant challenges for both victims and those who work to support them. Although there is an understanding of the prevalence and impact of ACEs and implementing comprehensive support and intervention strategies, there is still a need to address this pandemic and reduce the long-term impact of childhood trauma and adversity. The literature on ACEs is significant; however, there was still a gap in addressing the perceptions and impact of ACEs on clinical professionals.

ACEs and Neurodevelopment

ACEs have a significant impact on neurodevelopment outcomes. ACEs encompass a wide range of traumatic experiences, including physical, emotional, and sexual abuse, as well as neglect and household dysfunction, such as substance abuse, mental illness, and domestic violence. In multiple studies such as those by Dye (2018), Teicher (2002), Teicher et al. (2003), and McLaughlin et al. (2019) found that exposure to ACEs can have a detrimental effect on brain development, leading to long-term cognitive, emotional, and behavioral impairments (as cited in Webster, 2022).

Numerous researchers have found that ACEs have long-lasting impacts on adult mental health (Clunis, 2023; Lee et al., 2022). Multiple, chronic, and repeated trauma exposure in childhood is closely associated with adverse mental health outcomes in adulthood (Nöthling et al., 2019). The impact of early childhood trauma, which can be incredibly complex, can cause neurobiological changes that significantly impact human development and bring about significant changes in brain function. The brain structures responsible for cognitive and physical functioning are also affected (Dye, 2018).

According to McEwen (2017), chronic stress from ACEs can disrupt the development of the brain's architecture and neural circuitry, leading to changes in the structure and function of the brain. This can result in difficulties with emotional regulation, attention, learning, and memory. Additionally, the overactivation of the body's stress response system in response to ACEs can lead to lasting changes in neuroendocrine and immune system functioning, further contributing to adverse neurodevelopment outcomes.

Understanding the impact of early life toxic stress on brain structure and cognitive functioning is crucial to comprehend the behavior of those who have experienced adversities and seek mental health treatment. Early severe stress and abuse can produce a cascade of neurobiological events that have the potential to cause enduring changes in brain development (Teicher et al., 2003). These neurobiological sequelae, in turn, play a significant role in the emergence of psychiatric disorders (Teicher, 2002; Teicher et al., 2003).

In the past decade, the extensive literature on childhood adversities and neurodevelopment has found that children exposed to threat had reduced amygdala, medial prefrontal cortex (mPFC), and hippocampal volume and heightened amygdala activation (McLaughlin et al., 2019). This evidence underscores that childhood adversities have become a burden on society that requires immediate attention due to their significant impact on brain development and mechanisms. The findings of several studies have raised significant concerns about the long-term effects of childhood trauma on mental health in adulthood. Understanding these impacts is crucial for developing effective interventions and support systems for individuals who have experienced trauma in their early years (Webster, 2022). It is crucial to prioritize interventions and policies that aim to prevent and address childhood trauma to ensure the overall well-being of individuals and society as a whole.

Overall, the literature indicated that ACEs impacts neurodevelopment and have life-long effects, yet limited research explores developmental issues in clinicians who experience ACEs. Although significant research has been conducted on the impact of

ACEs on neurodevelopment for decades, there was still a need to normalize speaking about ACEs outcomes to raise awareness and prioritize treatment interventions and policies.

ACEs and Mental Health Outcomes

ACEs have been shown to have a profound impact on children's mental and emotional well-being, and the effects can extend well into adulthood. Studies have shown that children with a history of ACEs are at a higher risk for developing post-traumatic stress symptoms, as well as engaging in negative behaviors such as substance use. This link between early life stress and substance use can be attributed to difficulties with emotion regulation, which are often a result of traumatic experiences in childhood (Wu et al., 2020). In the United States, 60% of individuals in the general population have been exposed to at least one adverse childhood experience (i.e., abuse), which has deleterious effects on the physical, psychological, and mental health of children and adults (Clunis, 2023; Lee et al., 2022).

One of the primary objections is that not all children who experience ACEs will go on to develop post-traumatic stress symptoms or engage in substance use. While this is true, the research suggests a strong correlation between ACEs and these negative outcomes. The Kaiser Permanente Adverse Childhood Experiences Study, conducted by the Centers for Disease Control and Prevention from 1995 to 1997, found that individuals with a history of ACEs were more likely to engage in risky behaviors such as smoking, alcohol and drug use, and risky sexual behaviors (Centers for Disease Control and Prevention, 2021; Claypool & Moore de Peralta, 2021). This study provided compelling

evidence of the link between childhood trauma and negative behaviors in later life. The long-term effects of trauma experienced from witnessing intimate partner violence, according to Curry et al. (2018), can also result in mental health issues such as depression, post-traumatic stress disorder (PTSD), anxiety disorders, eating disorders, substance abuse, and suicidal behavior.

Davis and Shlafer (2017) conducted a study to determine whether adolescents with incarcerated parents reported higher levels of mental health problems than those without an incarcerated parent. Their study used a statewide survey to compare adolescents with currently incarcerated parents to those with formerly incarcerated parents and those with no history of parental incarceration. They found that most children and adolescents exposed to parental incarceration are vulnerable to mental health impacts, including anxiety, behavioral issues, and poor school performance. Their study considered different populations to determine the effects at various stages, such as no parental incarceration, parents currently incarcerated, and a history of parental incarceration; however, there was no elaboration on the length of imprisonment, support systems, and factors influencing mental health problems at these different stages (Davis & Shlafer, 2017). The earlier the exposure to parental incarceration, the greater the risk of marijuana use, sexually transmitted infection, and multiple partnerships in adolescence (Luk et al., 2022). Adolescence is a challenging time for every individual. It is a period marked by significant physical, emotional, and social changes, making it a time of vulnerability for mental health issues.

According to the Canadian Medical Health Association (2022), Larson et al. (2017), and Lawson (2023), several warning signs may indicate a teenager is struggling with mental health concerns. These signs include but are not limited to getting significantly lower marks in school, avoiding friends and family, having recurring outbursts of anger, changes in sleeping or eating habits, and acting out or rebelling against authority. Other signs may include drinking a lot or using drugs, not doing the things they used to enjoy, constant worrying, experiencing frequent mood swings, not being concerned with their appearance, being obsessed with their weight, lacking energy or motivation, increased risk-taking behavior, and feeling very down (Wu et al., 2020). One of the common warning signs of mental health issues in teenagers is a significant decline in academic performance. Adolescents who struggle with mental health problems may find it difficult to concentrate, leading to lower grades and poor performance in school. In addition, they may also withdraw from social interactions, avoiding friends and family. Recurring outbursts of anger and rebellious behavior towards authority figures often accompany this social withdrawal. Research also shows that victims of domestic violence remain at increased risk for adverse life outcomes in areas such as mental health, self-care, substance misuse, and difficulty with academic progression and completion (Richmond, 2024).

Another objection to the argument about the impact of ACEs is the possibility of confounding variables. Other factors, such as genetic predisposition or environmental influences, can also play a role in the development of post-traumatic stress symptoms and substance use. While this is a valid consideration, numerous studies have controlled for

these variables and still found a significant relationship between ACEs and negative behaviors. For example, a study conducted by Wu et al. in 2020 found that early life stress was independently associated with difficulties in emotion regulation, which in turn was related to substance use in later life. Furthermore, Kogan et al. (2021) found that early exposure to stress carries forward to affect the development of social developmental risk factors in emerging adulthood, placing rural African American men at risk for increased substance abuse and depressive symptoms during the emerging adult years.

A considerable body of research, such as those by Bailey et al. (2018), Bentall et al. (2014), De Bellis and Zisk (2014), and Varese, Smeets, Drukker, et al. (2012), support the argument that early life stress is related to difficulties with emotion regulation, which is also associated with substance use in later life. For example, De Bellis and Zisk (2014) found that individuals with a history of childhood trauma had greater difficulty regulating their emotions, and this difficulty was associated with higher levels of substance use. This suggests that the relationship between ACEs, emotion regulation, and substance use is a well-established phenomenon within the field of psychology.

Another objection to this argument is childhood adversities contribute to the significant risk factor for the development of psychosis (Bailey et al., 2018). Although there is considerable evidence that adversities in childhood, such as social deprivation, sexual abuse, separation from parents, neglect, and exposure to deviant parental communication, are associated with psychosis in later life, most studies have considered broad diagnoses as outcomes (Bentall et al., 2014). Varese, Barkus, and Bentall (2012) found an association between childhood adversity and psychosis was also significant in

population-based cross-sectional studies (OR = 2.99 [95% CI = 2.12–4.20]) as well as in prospective and quasi-prospective studies (OR = 2.75 [95% CI = 2.17–3.47]). The estimated population-attributable risk was 33% (16%–47%). These findings indicated that childhood adversity was strongly associated with an increased risk for psychosis.

Another study by Bentall et al. (2014) implicated communication deviance in parents in the development of thought disorder in offspring and childhood sexual abuse in auditory–verbal hallucinations. The authors also reported that attachment-disrupting events (e.g., neglect, being brought up in an institution) may have particular potency for the development of paranoid symptoms. Adversities in childhood and dissociation positively mediated the effect of childhood trauma on hallucination-proneness. This mediational role was particularly robust for sexual abuse over other types of trauma (Varese, Smeets, Drukker, et al., 2012).

Overall, the evidence supported the relationship between ACEs, post-traumatic stress symptoms, and substance use is compelling. While there are valid objections to consider, such as the role of resilience and confounding variables, the research consistently demonstrated a strong association between early life stress, negative behaviors in later life, and negative behaviors in later life. There are significant research and approaches; however, there was a need to address potential factors that could diminish adverse effects from ACEs or influential support groups for adolescents who experience adversities. A weakness of the research on ACEs and mental health outcomes in adolescents is that there is minimal information addressing what school systems implement when they begin to exhibit deteriorating behaviors. There was a lack of

information on the training and interventions utilized with adolescents in a school setting. By understanding the mechanisms underlying this relationship, we can better support children with a history of ACEs and work to prevent the long-term adverse outcomes associated with childhood trauma.

ACEs and Helping Professionals

Although significant research has been conducted to examine the impact of ACEs on clients, the impact of ACEs on mental health counselors themselves has been relatively unexplored. This is a crucial area of study as mental health clinicians play a pivotal role in assisting the public with managing the effects of traumas and mental illness, yet they are not immune from its effects (Symister, 2023). The personal experiences of mental health clinicians, particularly those related to ACEs, can significantly influence their work and professional resilience.

In a study conducted by Symister (2023), four participants referenced trauma or a mental health diagnosis as having an impact on their role as mental health counselors. One participant mentioned that her traumas provided her with resilience against vicarious trauma, which is when a therapist becomes emotionally affected by the trauma that their clients have experienced. On the other hand, other participants reported having "maladaptive coping skills and noticing a disconnect from my body" and "taking a tremendous toll to the point that I did have to go on medical leave for major depression." These insights shed light on the complex and multifaceted ways in which personal experiences of trauma can impact mental health clinicians.

E. M. Brown et al. (2022) conducted quantitative research to examine the impact of ACEs on mental health counselors. They found that there is a great need for attention to be given to the traumatic experiences of counselors and how such events impact professional resilience. The study highlighted the importance of understanding the psychological health risks associated with lived traumatic experiences and the need to promote resilience among mental health clinicians.

Resilience is the psychological capacity critical in adapting to and dealing with stressful circumstances, averting any detrimental results of adversities in the work setting, and overcoming adverse life situations as professionals provide clinical services (Rosenberger, 2023). This resilience is essential for mental health counselors to effectively manage and mitigate the impact of their own traumas on their work with clients.

The impact of ACEs on mental health clinicians is a complex and nuanced issue that warrants further exploration. It is essential for mental health professionals to recognize the potential impact of their own traumatic experiences on their work and to develop strategies and interventions to promote resilience and mitigate the potential negative effects. This is crucial not only for the well-being of the clinicians but also for the quality of care they provide to their clients. Overall, the impact of ACEs on mental health clinicians is an under-researched but critical area of study. The personal experiences of mental health clinicians, particularly those related to trauma, can significantly influence their work and professional resilience. Further research in this area is essential to better understand and address the complex interplay between personal

experiences of trauma and the work of mental health clinicians. Straussner et al. (2018) focused their study on the concept of wounded healers to address why clinicians enter the field of psychotherapy.

Wounded Healer

The concept of the wounded healer, as proposed by Carl Jung, has been a topic of interest and debate within the field of psychology and social work. Although there is no comprehensive contemporary theoretical model in the social work literature expanding on Jung's concept of the wounded healer, research has shown that many clinical professionals are attracted to the counseling profession based on their past adversities (Straussner et al., 2018). This has led to the development of a framework for psychologists practicing as psychotherapists.

According to Straussner et al. (2018), a large percentage of counselors who are wounded healers eventually become clinical counseling supervisors. This trend often results from uncontrollable circumstances causing wounds in an individual's life, which catalyzes the healer to enter the healing and helping professions. However, it is important to note that the individual's past adversities may hinder their professional judgment and effectiveness in providing treatment services. Therefore, those who become healers in the counseling profession should increase their awareness of past adversities that may impact their work.

Jung distinguished between wounded healers who can use their wounds to help others and impaired professionals whose emotional problems adversely affect their clinical work (Straussner et al., 2018). Research findings suggest that childhood trauma

may compromise the livelihood of these individuals; therefore, it is crucial to mitigate these problems to improve the livelihood of childhood trauma survivors. This indicates the need for intervention and prevention programs that can mitigate adverse long-term effects that develop from childhood trauma (Litteral, 2023).

Straussner et al.'s (2018) study on addressing the disproportionality in research among social workers and behavioral health problems uncovered significant findings. For example, 40.2 percent of 6,112 respondents reported mental health problems before becoming social workers, increasing to 51.8 percent during their social work career, with 28 percent currently experiencing such problems. Additionally, nearly 10 percent of the sample experienced substance use problems before becoming social workers, decreasing to 7.7 percent during their careers. These findings highlight the importance of addressing the mental health and substance use issues that impact professionals in the social work field.

In conclusion, the concept of the wounded healer has significant implications for professionals in the counseling and social work fields. The recognition of past adversities and the impact they may have on professional judgment and effectiveness is vital in providing treatment services. Addressing the mental health and substance use issues among professionals in these fields is essential for the well-being of both the practitioners and the individuals they serve. Therefore, creating a comprehensive theoretical model based on Jung's concept of the wounded healer could be advantageous for the fields of social work and psychology. As a wounded healer who has experienced adversity in life,

there is a risk of re-exposure to trauma, which can cause burnout, secondary trauma, compassion fatigue, and vicarious trauma, which will be addressed next.

Exposure to Trauma and Traumatization

The effects of exposure to trauma on mental health professionals and those in helping roles cannot be underestimated. According to Kounenou et al. (2023), individuals who are frequently exposed to traumatic incidents are at risk of experiencing re-traumatization, as well as burnout, secondary trauma, compassion fatigue, and vicarious trauma. The work of practitioners, including social workers, therapists, healthcare professionals, and emergency service workers, can quickly become overwhelming as they strive to assist clients who have been exposed to traumatic events.

Chronic exposure to multiple traumatic events over time, known as Type II Trauma, can have significant repercussions. The development of complex post-traumatic stress disorder (C-PTSD) or post-traumatic stress disorder (PTSD) is a potential outcome for individuals regularly exposed to Type II Trauma. Moreover, those in these trauma-prone roles are at risk of experiencing secondary traumatic stress, which refers to the psychological changes they can experience as a result of empathizing with a traumatized individual. Occupational groups such as disaster relief and recovery workers, emergency services and military personnel, healthcare professionals, and media workers in conflict zones are all at increased risk of exposure to traumatic events. However, it is important to recognize that social workers and therapists are also frequently exposed to trauma vicariously and can experience distress as a result.

Recent studies by E. M. Brown et al. (2022), Kounenou et al. (2023), Straussner et al. (2018), and Symister (2023) in the field of mental health have shed light on the prevalence of ACEs among mental health providers. E. M. Brown et al. (2022) found that mental health clinicians have higher rates of ACEs, with 93% to 95% of counselors reporting at least one to eight traumatic experiences in their lifetime. This is a concerning finding, as it suggests that mental health clinicians may be vulnerable to re-experiencing trauma with their clients, which could negatively impact client care.

The prevalence of trauma histories among adults who pursue clinical work as their professional commitment is higher than in the general population (Straussner et al., 2018). Additionally, exposure to trauma-related material in graduate clinical coursework and field training can put students at risk for reactivations of negative past experiences and symptoms of secondary traumatic stress. This risk is further compounded for those with higher ACEs scores, as they are more likely to experience re-traumatization and secondary traumatic stress symptoms.

These findings emphasized the importance of addressing the potential for re-traumatization and secondary traumatic stress in mental health professionals and those in helping roles. It is crucial to provide support and resources for individuals working in these fields to mitigate the impact of vicarious trauma and prevent burnout and other negative outcomes (Butler et al., 2016). Additionally, the role of proximal emotional reactions in mediating the effects of distal adverse experiences on the development of trauma symptoms highlights the need for a proactive approach in addressing the mental health and well-being of those in trauma-prone roles.

The literature reveals the significant impact of past traumatic experiences and exposure to traumatic events on mental health professionals and those in helping roles (E. M. Brown et al., 2022; Kounenou et al., 2023; Straussner et al., 2018; Symister, 2023). Individuals working in these vital roles can get better support by addressing the risk of re-traumatization and secondary traumatic stress and ensuring their wellbeing as they continue to assist those who have been affected by trauma. The frequent exposure to treating individuals with past trauma can trigger our own traumatic experiences to resurface, which can impact treatment engagement and professionalism. It was crucial to understand that professional competence can be negatively affected if clinicians are unaware of their triggers, which can impact professional judgment and treatment effectiveness. The literature about exposure to trauma and re-traumatization is significant in addressing the need for awareness in clinicians and the potential outcomes. There was a need to address effective interventions utilized by clinicians to reduce the impact of re-traumatization. Exposure to trauma daily can have a severe effect on the mental wellbeing of clinicians, so it is essential to normalize that it is appropriate to seek guidance or treatment to cope with the impact of secondary trauma.

ACEs and Professional Competence

ACEs have been linked to several negative outcomes, including mental health issues, physical health problems, and difficulties in interpersonal relationships. ACEs can also impact clinician professional competence. When clinicians have experienced ACEs, they may be more susceptible to triggers that can interfere with their ability to provide effective care for their clients (Pearce et al., 2019). These triggers can lead to emotional

responses, such as anxiety, anger, or avoidance, which can compromise the clinician's professional judgment and effectiveness in therapeutic interventions. Clinicians who have experienced ACEs may also struggle with boundary issues, empathy, and self-care, which are essential components of providing high-quality mental health care. According to Benner et al. (2019), these challenges can impact the clinician's ability to effectively support and treat their clients, ultimately impacting their professional competence.

The need for professional competence among novice clinicians has gained significant attention in recent research. Postgraduate clinicians who have not obtained the necessary training and developed their professional identity may face challenges when working with criminal offenders or dealing with countertransference issues based on their own lived experiences. In addition, mental health counselors working in correctional settings have been found to lack the specialized education, training, experience, and supervision needed to effectively treat offenders while managing the challenges associated with working in a correctional environment (Bernard, 2021). The unique and often high-stress nature of correctional settings can take a toll on mental health professionals, potentially leading to their own mental health. Cruikshanks and Burns (2017) recommended that pre-license counselor trainees should build their professional identity under the guidance of a clinical counseling supervisor to ensure that they are well-equipped to handle the demands of their profession.

Furthermore, a study by Sá et al. (2023) explored the impact of past traumatic events (TE) on the clinical communication skills of general practitioners (GPs). The findings indicate that GPs' past traumatic experiences can influence their ability to

communicate effectively with patients about their past adversities. However, evidence has also shown that patients appreciate it when their GPs routinely address their history of traumatic experiences, and that empathic communication can predict positive physiological, behavioral, and emotional outcomes for patients.

It is essential for social workers and mental health counselors to receive adequate support, supervision, and resources to address their own mental health and AOD problems. This not only ensures their well-being but also enables them to support and counsel their clients effectively. Further research and interventions were needed to address these issues within the professions of social work and mental health counselors. Therefore, I addressed how resilience is vital for clinicians to provide professional and effective treatment services.

Resiliency and Clinicians

Resiliency, defined as the ability to cope with adversities, is a critical factor in the mental health counseling profession (Lambert & Lawson, 2013). Counselors are often confronted with the challenging task of supporting individuals through difficult and traumatic experiences. As a result, it is essential for mental health professionals to possess a high level of resiliency to effectively provide treatment services and reduce the risk of harming themselves or hindering their ability to help their clients.

The nature of the counseling profession can lead to increased stress levels, burnout, and compassion fatigue among counselors. This is particularly true for those who have experienced past adversities or who have a personal history of traumatic experiences. Hearing traumatic stories and assisting individuals dealing with

psychological concerns on a daily basis can take a significant toll on the mental and emotional well-being of counselors. Bovee (2024) noted that counseling professionals often report experiencing burnout due to the nature of their professional service and their responsibility to treat individuals with psychological concerns.

The impact of past mental health counselors' adversities on their client engagement is also a significant concern. Tyre et al. (2016) highlighted that fatigue, burnout, and vicarious trauma are common in the counseling profession, and those entering the profession or who are counselors-in-training require resilience to protect their well-being, aid wellness, and ensure professional fitness. The ability to cope with these challenges and remain emotionally and mentally strong is crucial for mental health counselors, as it directly affects the quality of care they can provide to their clients.

Furthermore, it is important for therapists to understand their own vulnerabilities in order to facilitate their clients' healing effectively and not result in transference/countertransference (Rice, 2011). Transference and countertransference can occur when counselors unknowingly project their own unresolved issues onto their clients or absorb their clients' emotions and experiences, leading to decreased effectiveness and potentially harmful consequences for both the client and the counselor. By increasing awareness and fostering resiliency amongst mental health counselors, the risks of transference, countertransference, and burnout can be mitigated.

In light of these challenges, mental health professionals must develop and cultivate resiliency as an essential skill to thrive in the counseling profession. Resiliency is a crucial component of the mental health counseling profession. Resilient counselors

are better equipped to handle the emotional demands of their work, maintain a healthy work-life balance, and provide effective treatment to their clients. Cultivating resilience also helps mental health professionals protect their own mental and emotional well-being, ultimately promoting longevity in their careers and preventing burnout.

Counselors must be able to cope with adversities, such as hearing traumatic experiences and dealing with the emotional toll of their work, to provide effective treatment services and protect their own well-being. By fostering resiliency in the counseling profession, mental health professionals can mitigate the risks of burnout, compassion fatigue, transference, and countertransference, ultimately improving the quality of care they provide to their clients while safeguarding their own mental and emotional health.

ACEs and Gender

Gender plays a significant role in the prevalence and impact of ACEs (Mlouki et al., 2024). Boys are more likely to experience certain types of ACEs, such as physical abuse and witnessing domestic violence, while girls are more likely to experience sexual abuse and emotional neglect (Anda et al., 2006). Additionally, the effects of ACEs can be different for boys and girls. For example, boys who experience ACEs may be more likely to develop behavioral issues, while girls may be more prone to internalizing problems, such as depression and anxiety.

The prevalence of female practitioners who have experienced childhood adversities is a common theme in the literature and has been the subject of numerous studies and research. The CDC's 2021 Kaiser ACE study revealed that a significant

number of females reported experiencing childhood adversity compared to males (Centers for Disease Control and Prevention, 2021; Claypool & Moore de Peralta, 2021). This gender disparity is important to note, as it sheds light on the unique challenges and experiences that women have encountered in their early years.

Childhood adversities such as physical and sexual abuse, as well as parental substance abuse, have been linked to a more complex history of ACEs in females. These adversities have been shown to have a lasting impact on mental health, social functioning, and emotional well-being in adulthood. Studies have found that females are more likely to report a range of ACEs and psychological difficulties, which can influence their decision to pursue a career in the clinical service field (Haahr-Pedersen et al., 2020).

Research has delved into the motivations of clinicians who have experienced childhood adversities and have chosen to enter the field. A common theme identified is "wounded healers," where clinicians who have been sexually, physically, and emotionally abused as children are drawn to the field of therapy. These clinicians have often witnessed substance abuse by parents and have a strong desire to help others heal from past trauma. This drive to help others may be rooted in their own experiences and can be a way to provide support and healing to those who have faced similar challenges.

Furthermore, research has found that psychotherapists and mental health professionals often come from dysfunctional family backgrounds and have experienced significant psychological distress in their adult lives (Elliott & Guy, 1993). This suggests that individuals with childhood adversities are more likely to be drawn to the clinical

field to make sense of their own experiences and provide empathy and understanding to others.

The prevalence of female practitioners who have experienced childhood adversities is a significant theme in the literature. The motivations of clinicians with such backgrounds to enter the clinical service field are deeply rooted in their own experiences and a desire to help others heal. Understanding the impact of childhood adversity on clinicians is crucial in providing support and fostering a better understanding of how personal experiences can shape professional motivations and practices. The findings of studies such as those by Dubowitz et al., (2022), Haahr-Pedersen et al. (2020), and Mlouki et al. (2024) highlighted the importance of addressing childhood adversities and supporting clinicians in their journey to help others heal. It is vital to address the impact ACE can have on deviant behaviors as a result of being unable to cope with past trauma effectively.

ACEs and Criminal Behavior

ACEs have been the subject of extensive research due to their significant impact on an individual's physical and psychological well-being. Exposure to trauma during childhood has been linked to a variety of negative outcomes in adulthood, including criminal behavior (Cantürk et al., 2021). The research delineates the impact of ACEs on physical and psychological well-being because many individuals are unable to cope with toxic stress, which results in engaging in criminal behavior.

While most of the research focuses on adult outcomes associated with ACEs and psychiatric disorders, there is a lack of attention to violent offenders experiencing both

ACEs and self-sufficiency problems (Segeren et al., 2020). However, little is known about the impact of other forms of adversity, beyond abuse and neglect, on juvenile delinquency and criminal persistence (Basto-Pereira et al., 2016).

The link between ACEs and negative attitudes and lifestyles among ex-offenders is a well-documented and complex issue. Many ex-offenders develop negative coping strategies for managing life stressors, often leading to substance abuse problems and further entrenching their criminal behavior. These negative attitudes and lifestyles are often rooted in the ACEs that ex-offenders have faced.

Empirical data supports the notion that a significant percentage of children experience adverse effects when their parents interact with the criminal justice system. According to Y. Johnson (2020), 33% of children experience at least one adverse effect when their parents are involved in the criminal justice system. This statistic highlights the widespread impact that parental incarceration can have on children and the long-term consequences that may follow.

The adverse outcomes and consequences on the lives of children with incarcerated parents are numerous and profound. Research has shown that these children are more likely to engage in criminal behavior, experience mental health challenges, engage in illegal drug use, have lower educational attainment, earn lower incomes, and struggle with intimate relationships (Luther, 2016; Mears & Siennick, 2016; Young & Jefferson Smith, 2019). These outcomes create a cycle of adversity that can be difficult to break, leading to negative attitudes and lifestyles among ex-offenders.

One basic objection to this link is the idea that individuals are solely responsible for their actions and choices. While this is true to some extent, it fails to acknowledge the impact of ACEs on an individual's development and decision-making processes. Children who grow up in environments marked by parental incarceration are often exposed to trauma, instability, and limited resources, which can have lasting effects on their behavior and attitudes (Turney & Goodsell, 2018).

Another objection is the tendency to stigmatize individuals who have been involved in the criminal justice system, failing to recognize the underlying factors that contributed to their negative attitudes and behaviors. This stigma can further marginalize ex-offenders and limit their opportunities for rehabilitation and reintegration into society. Fox et al. (2015) found that exposure to emotional neglect, physical, sexual, and emotional abuse, household substance abuse, exposure to domestic violence, and an incarcerated household member during the first 18 years of life predicted severe, violent, and chronic juvenile offending compared to juveniles with one non-violent felony. This demonstrates the clear link between ACEs and criminal behavior. The literature indicated that ACEs are a factor in criminal behavior due to a lack of coping mechanisms.

According to Blair et al. (2022), the adverse neurodevelopmental impact of childhood maltreatment, particularly neglect, has a significant impact on reinforcement processing, which might increase the risk of conduct problems. While ex-offenders must be held accountable for their actions, it is essential to consider the broader context of their experiences. Addressing the root causes of negative attitudes and lifestyles among ex-offenders requires a multifaceted approach that considers the impact of ACEs and

provides support for rehabilitation and reintegration. Understanding and addressing these underlying factors can break the cycle of adversity and create opportunities for positive change among ex-offenders. The impact of ACEs on physical and psychological well-being is well-documented, with research showing a clear link between ACEs and criminal behavior. It is essential to continue exploring how early adversity impacts individuals and to address the stigmatization and discrimination faced by those with a history of criminal behavior and mental illness.

Engagement of Criminal Offenders

Federal law enforcement agencies play a crucial role in maintaining public safety and upholding the rule of law in the United States. According to the 2024 Federal Justice Statistics report, federal law enforcement agencies made 96,857 arrests during fiscal year 2022, representing a significant 24% increase from the 78,068 arrests in year 2021, which marked the lowest number in two decades (Motivans, 2024).

Bryant (2006) focused on clinicians' perceptions of female sex offender treatment with seven clinical social workers who work directly with female sex offenders who participated in ten semi-structured questionnaires, which lasted sixty minutes in length. A thematic analysis was utilized to identify and interpret patterns and themes in clinician perceptions of female sex offender treatment as well as common themes and experiences from working with female sex offenders with lived traumatic experiences. Clinicians who provided therapy to female sex offenders discussed how their perceptions impacted their ability to provide effective treatment and engage the female offenders in

sessions. The results concluded that clinicians with their childhood traumas were more empathetic towards female sex offenders.

Stapleton (2022) focused on the experiences clinicians encounter when assessing and treating noncontact sex offenders and their impact within the context of treatment. The findings indicated that the participating mental health clinicians shared similar perspectives and clinical attitudes in their support and ability to provide therapeutic intervention to assist in a level of change for noncontact sex offenders. Furthermore, this study indicates that clinicians working with sex offenders experience harmful effects on the intrapersonal and interpersonal aspects of their lives.

In the United States, criminal arrests and offenders with mental illnesses have been a subject of concern and debate. According to the National Institute of Mental Health (2023), approximately 20% of adults in the U.S. experience mental illness each year. However, many of these individuals end up in the criminal justice system rather than receiving appropriate mental health treatment. Mentally ill inmates now comprise a substantial portion of the prison population, presenting administrative and therapeutic challenges to prison administrators and mental health professionals (Adams & Ferrandino, 2008). These individuals often have complex mental health needs, such as severe mental illnesses, co-occurring substance abuse disorders, and histories of trauma or abuse requiring therapy. However, therapy outcomes can be influenced by a variety of factors, including the therapeutic relationship and the cultural humility of the therapist.

Recent research has found that therapy outcomes were negatively associated with positive cultural humility, suggesting that clients who rated their therapist higher on

positive cultural humility had worse therapy outcomes. Cultural humility is the ability to remain open and nonjudgmental to different cultural perspectives and continuously self-reflect on one's own cultural biases (Coleman et al., 2024). It is an essential framework for therapists to effectively work with clients from diverse cultural backgrounds. However, the negative association between positive cultural humility and therapy outcomes raises important questions about the impact of cultural humility on the therapeutic process.

One potential explanation for this finding could be that therapists who exhibit high levels of cultural humility may struggle to effectively address the unique cultural needs of their clients (Coleman et al., 2024). They may be overly cautious or hesitant, leading to a lack of meaningful therapeutic progress. Additionally, clients may perceive cultural humility as a lack of confidence or expertise in the therapist, which could undermine the therapeutic relationship and ultimately impact therapy outcomes negatively.

Bandara et al. (2018) studied the attitudes of providers towards criminal justice-involved clients with serious mental illness and concluded that providers reported lower regard for criminal justice-involved clients than for clients without such involvement; providers were less likely to report having a great deal of respect for clients versus those without criminal justice involvement. This highlights the stigmatization and discrimination faced by individuals with a history of criminal behavior and mental illness.

Individuals with mental illnesses are overrepresented in the criminal justice system (Prins, 2014). This has led to the recognition of the need for specialized mental health training for law enforcement officers, as well as diversion programs that aim to provide mental health treatment instead of incarceration for individuals with mental illness who commit non-violent offenses. Forensic mental health, the intersection of mental health and the legal system is considered a specialty at a doctoral level due to the complex nature of the work involved. However, a majority of mental health services in correctional settings are provided by mental health counselors with master's level qualifications (Bernard, 2021).

Although there is significant literature on the engagement of criminal offenders, there is a need to focus on the clinical setting in correctional settings and how offenders are engaged to address the psychological deterioration of offenders and interventions utilized to address their mental health needs. The disparity between the specialized needs of mentally ill inmates and the level of training of mental health professionals in correctional settings highlights the importance of integrating doctoral-level training in forensic mental health within these settings. Doing so could improve the quality of care and ultimately contribute to better outcomes for mentally ill inmates within the criminal justice system. It is imperative to ensure that those entrusted with the care of others are adequately supported and equipped to provide the highest level of care possible.

Summary and Conclusions

ACE literature has shown a strong correlation between early traumatic experiences and negative mental health and behavioral outcomes. Individuals who have

experienced ACEs are at a higher risk of developing mental health disorders such as depression, anxiety, and post-traumatic stress disorder, as well as engaging in criminal behaviors later in life.

Mental health and behavioral outcomes associated with ACEs can often lead to involvement in the criminal justice system. Consequently, criminal offenders commonly have a history of childhood trauma. As a result, it is essential for clinicians working with this population to understand the impact of ACEs on their clients and the associated challenges they may face.

Furthermore, the treatment engagement of criminal offenders may be influenced by their childhood experiences. Individuals with a history of ACEs may struggle with trust, communication, and vulnerability in therapeutic settings, making it challenging for clinicians to foster a strong therapeutic alliance. Despite these challenges, clinician resiliency is crucial in effectively engaging and treating criminal offenders with a history of childhood trauma.

Clinicians working with this population must be cognizant of the impact of ACEs and focused on promoting resiliency and treatment engagement. Chapter 3 includes information on how the gap in research was explored to increase understanding of the impact between of lived adversities of clinicians, resiliency, and their professional growth. The chapter will include information about this study's research design, methodology, data analysis plan, threats to validity, and ethical procedures.

Chapter 3: Research Method

I aimed to understand clinicians' perceptions of their ACEs, resiliency, and engagement with offenders through semi-structured interviews. ACEs include traumatic events that occur in childhood (0-17 years) involving violence, abuse, or neglect, in homes or communities, substance use problems, mental health problems, and instability due to parental separation or household member being jailed or prisoned.

In this chapter, I outlined methods and procedures to conduct the study, including the process for selecting and recruiting participants, data collection instruments, and procedures for data analysis. I describe my role in this qualitative study. I also discuss issues of trustworthiness and ethical procedures. The chapter closes with a summary and transition to Chapter 4.

Research Design and Rationale

The research question in this study is:

RQ1: How do clinicians describe their perceptions of how their ACEs shaped their professional practice, resiliency, and engagement of offenders?

I used a basic qualitative methodological approach to address clinicians' lived adversities, resiliency, and engagement with offenders. This was the most appropriate method for this study. In qualitative studies, the researchers are interested in how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences (Merriam & Tisdell, 2015).

The quantitative approach involves testing hypotheses via a large or random representative sample of populations using questionnaires, scales, surveys, tests, or computers (Merriam & Tisdell, 2015). In quantitative research, observations are measured and expressed numerically (Wienclaw, 2021).

I used the qualitative methodology in order for participants to express their own lived experiences. For this qualitative study, I used the phenomenological approach to address ACEs via clinicians' perceptions of their lived adversities, resiliency, and treatment engagements of offenders. In this study, I conducted individual interviews using a semi-structured interview guide to ensure that the topic was addressed.

Role of the Researcher

I was the primary instrument for data collection and analysis. The human instrument, which is immediately responsive and adaptive, is the ideal means of collecting and analyzing data. I used interview questions to guide data collection. Data were collected by using open-ended questions in order for participants to freely express experiences and perceptions of their adversities. I only collected data from individuals whom I did not know. There were no professional relationships with participants, nor were they offered any incentives or payments for participating in this study.

Collected data were meticulously analyzed to develop comprehensive themes, categories, concepts, and observations. This involved moving from raw to patterned data as well as segmenting, coding, networking, thematizing, and interpreting data. Interviews were audiotaped and transcribed for data collection. Member checking was utilized to ensured transcripts were accurate before beginning data analysis to minimize researcher

bias. Furthermore, I was able to subordinate my opinions, assumptions, and preferences in order for participant perspectives to drive conversations.

Methodology

In purposive or selective sampling, researchers rely on their judgment when selecting populations for participation in studies (Palinkas et al., 2015). I followed specific procedures for identifying and contacting participants via the Walden Participant Pool. The population included individuals who had professional licenses, such as licensed professional counselors, social workers, registered nurses, and licensed psychological associates who experienced ACEs, worked or had worked as clinicians with criminal offenders, and were students at universities. After criteria were met, participants were asked screening questions via questionnaires to confirm they met inclusion criteria for the study. They were contacted via email informing them of their selection in an introductory email and provided with an informed consent form (see Appendix B) to initiate the data collection process. Those who were not selected for the study were notified. After signing consent forms, participants were scheduled for virtual or face-to-face interviews.

The sample for this study consisted of eight to twelve participants. In the ongoing analysis, I compared every new sample size with the previous analysis to identify similarities and differences until no properties of the category are identified from which additional data can be developed (Malterud et al., 2021). However, the plan to reach the point of saturation is to interview eight to 12 participants (Baker et al., 2012). Glaser and Strauss (1967) initially coined the concept of saturation as a specific element of constant comparison in grounded theory. They referred to the point at which adding more

participants fails to produce new themes or expound upon the identified themes in any meaningful way (Malterud et al., 2021). According to Hennink and Kaiser (2022), saturation is an essential indicator that a sample is adequate for the phenomenon studied – that data collected have captured the diversity, depth, and nuances of the issues studied and thereby demonstrate content validity. Morse (1994) asserted that at least six participants should participate in qualitative research. Based on these recommendations, eight to twelve participants comprised the sample in this study, with additional participants being chosen. If saturation is not achieved, additional participants would be chosen from the Walden Participant Pool to enhance saturation.

Instrumentation

The research used one data collection form in the proposed study: Individual interviews. Through the semi-structured interviews, I aimed to elicit in-depth accounts of the participants' experiences with ACEs, resiliency, and treatment engagement with criminal offenders. I used an interview guide (see Appendix C). The power of interviews lies in their potential to unlock keys to lived experiences by unearthing the voices of people (Katz-Buonincontro, 2022). In an interview, I asked about and listen to what people report about their lived experiences (Brinkmann & Kvale, 2018).

Qualitative interviewing provides an open-ended, in-depth exploration of an aspect of life about which the interviewee has substantial experience, often combined with considerable insight (Charmaz, 2014). Utilizing interviews allowed an understanding of the meaning and experiences of the participant's lived experiences in their own words. The goal of a qualitative interview is to capture the subjective point of

view of the research participant (Rubin & Rubin, 2012). Roberts (2020) emphasizes the importance that I must keep in mind that the purpose of a qualitative interview is not to get the informant to answer the interview questions but to listen to their stories so that they can acquire an understanding of how their experiences unfolded and the meanings that they associated with these experiences. I created open-ended questions to facilitate and support open discovery within the interview, which took awareness, knowledge, "training and practice to write open-ended questions; the hallmark of a qualitative interview" (Sofaer, 2002, p. 334). I identified common questions by gathering content from previously published questionnaires on similar topics.

I reviewed the existing literature on ACEs, resiliency, and treatment engagement of criminal offenders in constructing the interview guide. In various disciplines, such as education, psychology, anthropology, sociology, and nursing science, knowledge is gathered through interviewing (Brinkmann & Kvale, 2018). I developed open-ended questions that was utilized in this study (see Appendix A). The questions focused on clinicians' perceptions of their lived adversities, resiliency, and treatment engagement with criminal offenders. The interview questions promoted positive interaction, keep the conversation going, and stimulate the subjects to discuss their experiences and feelings (Brinkmann & Kvale, 2018). According to the literature, interview questions can be evaluated on both a thematic and dynamic dimension: thematically regarding producing knowledge and dynamically about the interpersonal relationship in the interview (Brinkmann & Kvale, 2018). A good interview question contributes thematically to knowledge production and dynamically promotes good interview interaction.

Procedures for Recruitment, Participation, and Data Collection

Before any data collection, I obtained Institutional Review Board (IRB) approval prior to beginning data collection. I used the Walden University Participant Pool to identify participants. I posted a flyer on the Walden University Participant Pool after permission was granted. If participants chose to participate, my contact information was on the flyer (see Appendix D). If the individual was interested in participating, they emailed me to indicate their interest in arranging an interview to determine inclusion criteria (Patterson, 2024). I used an interview guide with open-ended questions that guided this study, supplemented by follow-up and probing questions dependent on the interviewee's responses (DeJonckheere & Vaughn, 2019).

I gathere data from semi-structured interviews with eight to twelve licensed professional counselors, social workers, licensed psychological associates, and psychiatric registered nurses to reach data saturation. Semi-structured interviewing can be a powerful tool for research to understand individuals' thoughts, beliefs, and experiences (DeJonckheere & Vaughn, 2019). Data collection in this study consisted of approximately 45 to 60-minute individual semi-structured interviews that was audiotaped and transcribed. I transcribed each interview verbatim from the audio recording, allowing for the exact words of participants to be analyzed during data analysis (DeJonckheere & Vaughn, 2019). Semi-structured interviews provide a practical and feasible research method (DeJonckheere & Vaughn, 2019).

I built rapport with the participant to obtain honest and open responses during member-checking. Member checking is a practice to increase study credibility and

confirmability (Johnson et al., 2020). During the interview, I restated or summarized information and then questioned the participant for accuracy (Patterson, 2024). Once the study was concluded, the participants will exit the study with an email that will include the name of the study, my contact information, a personal thank-you gift, and a reiteration of the purpose of the research.

Data Analysis Plan

I used thematic analysis to analyze the data. Identifying and interpreting patterns or themes in a data set through thick descriptive data leads to new insights and understanding (Boyatzis, 1998; Elliott & Guy, 1993; Thomas, 2006). The purpose of thematic analysis is to identify significant commonalities within the collected data, which collectively describe the phenomenon of a study (Braun & Clarke, 2012). Braun and Clarke (2006) specify the six steps for conducting thematic analysis in qualitative research. These steps consist of a) transcribing interviews and reading the transcripts, b) generating initial codes, c) searching for themes, d) reviewing and refining themes, e) defining and naming themes to identify central ideas, and f) producing an analysis report once themes are fully identified (Braun & Clarke, 2006; Riger & Sigurvinsdottir, 2016).

In the first step of data analysis, I read through the interviews to become familiar with them and identify possible patterns (Braun & Clarke, 2006). The second step of the data analysis was to generate initial codes. According to Saldaña (2013), the purpose of coding is to pattern, classify, and later reorganize each datum into emergent categories for further analysis. Furthermore, a qualitative data analysis code is often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and evocative

attribute for a portion of language-based or visual data (Saldaña, 2013). The developed codes will be organized into meaningful units to complete this step (Riger & Sigurvinsdottir, 2016). In the third step of data analysis, I sorted codes into potential themes. A thematic map can help develop relationships between codes, themes, and levels, such as primary and sub-themes (Braun & Clarke, 2006).

The fourth step has two levels: reviewing and refining themes. In level one, a review of the codes was read and extracted for each theme, and whether they appear to form a coherent pattern was considered. In level two, I reviewed unclear themes to determine if some data extracts do not belong there, in which case, I reworked the theme, creating a new theme, finding a home for those extracts that did not currently work in an already-existing theme, or discarding them from the analysis (Braun & Clarke, 2006).

In the fifth step in data analysis, themes were defined and named. In this step, I defined and refined the data to determine what aspects of each theme were captured.

Furthermore, Braun and Clarke (2012) suggest writing a detailed analysis of each theme and how it fits into the overall picture of the data set. In the final step of the process, a narrative description of the findings illustrates the trustworthy themes to the reader. (Riger & Sigurvinsdottir, 2016). I observed the six steps to analyze the data and discover themes that describe the perceptions of clinicians' lives, ACE, resiliency, and treatment engagement of criminal offenders.

Issues of Trustworthiness

Merriam and Tisdell (2015) defined trustworthiness as providing credibility to the writing, as when we inform the reader of our research processes. I established

trustworthiness by being up-front or confessional about the analytic or ethical dilemmas we encounter (Shenton, 2004; Taylor et al., 2015;). Furthermore, I utilized prolonged engagement, member checks, and audit trail methods.

Lincoln and Guba (1985) define prolonged engagement as investing sufficient time to learn the culture and testing misinformation and misinterpretation due to distortion. Member checking is sharing data interpretations and conclusions with the participants to clarify intentions, correct errors, and provide additional information if needed (Ravitch & Carl, 2020). Korstjens and Moser (2018) explained that research uses audit trails to document the data collection decisions made throughout the study. For this study, the audit trails included the following information: (a) interviewees met the study's inclusion criteria requirements, (b) dates in which the interviewees gave consent to participate in the study, (c) scheduled interview dates, and (e) start and end times for each interview. To show trustworthiness, I focused on questions such as, "Are my methods aligning with my research question? Do I understand the patterns I see in the data (Ravitch & Carl, 2020)?" Lincoln and Guba (1985) specified four criteria for establishing the trustworthiness of a qualitative study: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability.

Credibility

Credibility is the process where the research ensures and imparts to the reader supporting evidence that the results accurately represent what was studied (J. Johnson et al., 2020). J. Johnson et al. (2020) reported that demonstrating the credibility of research is rooted in honest and transparent reporting of how biases and other possible

confounders are identified and addressed throughout the study processes. [Say how this applies to your proposed research.]

Triangulation is another method to increase credibility, which helps researchers reassure themselves that their emerging theoretical interpretations rest on robust empirical evidence (Cloutier & Ravasi, 2020). Triangulation refers to using identified data from multiple sources and methods to avoid or minimize error or bias and optimize data collection and analysis accuracy (J. Johnson et al., 2020). In this proposed study, I employed individual interviews using open-ended questions which demonstrated triangulation and credibility. Interview methods range from highly structured to increase dependability or entirely open-ended to allow interviewers to clarify a participant's response for increased credibility and confirmability (J. Johnson et al., 2020).

An additional method that increased credibility was member checking. Member checking, a common standard of rigor, is a practice to increase study credibility and confirmability that involves asking the research subject to verify the transcription of an interview (J. Johnson et al., 2020). Member checking, also known as a participant or respondent validation, is a technique for exploring the credibility of results. During the interview, I restated or summarized the participants response for accuracy (Patterson, 2024). I can ensure higher confidence that the transcribed data is not compromised by personal bias after I confirmed its accuracy from the participants. Saturation is another method by which I ensured credibility in the study (Hanson et al., 2011). When no new data is found, saturation had been achieved. Emergent themes emerged fully from the

existing data (Saunders et al., 2017). I can confidently report accurate and credible results when I achieved saturation.

Transferability

Guba and Lincoln's (1989) first description of transferability emphasized the importance of providing readers with sufficient information to evaluate the applicability or fit of findings constructed in one context to other contexts in which the reader might want to apply them. Furthermore, transferability refers to the extent to which the research findings can be extended or applied to other contexts, settings, or participants (Lietz & Zayas, 2010; Stalmeijer et al., 2024). Transferability is only possible when a thick description provides a rich enough portrayal of circumstance for application to others' situations, and usually at the behest of the local constituents (Stahl & King, 2020). Transferability as applicability relates to providing sufficient information for readers to evaluate the relevance of findings to other contexts. Thick description signifies highly detailed and rich description that provides enough illustrative detail to enable the reader to interpret, contextualize, and assess the applicability of the findings (Maher et al., 2018; Younas et al., 2023). In the proposed study, I used thick descriptions to describe the research population, sample, procedures, and the accounts obtained from interview participants.

Dependability

Dependability refers to the degree to which the research findings are stable over time (Morrow, 2005). Dependability ensures that the process is described in detail, allowing another researcher to repeat the work (Maher et al., 2018). Dependability is

attainable through credibility, triangulation, data splitting, duplicating the analysis, audit trails, and member checking (Lincoln & Guba, 1986). Further, this research created an audit trail by providing an in-depth description of the methodological procedures and the findings obtained in the study. Guba and Lincoln (1989) held that member checking enriches dependability, as described previously. The member verifies the answers to the questions and asks, "Do I understand and interpret the participant correctly (Morse, 2015)?" To improve the study's dependability, I followed rigorous and systematic procedures to conduct the research and entirely open-ended questions to allow interviewers to clarify a participant's response for increased credibility and confirmability .

Confirmability

Confirmability denotes the degree to which other research could confirm the study's findings. Confirmability is concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination but are derived from the data (Korstjens & Moser, 2018). The study made use of audit trails to enhance its confirmability. The audit trail refers to the detailed description of the methodological steps followed during the study and providing notes on decisions made during the research process, research team meetings, reflective thoughts, sampling, research materials adopted, the emergence of the findings, and information about the data management (Korstjens & Moser, 2018). Using an audit trail in this study enhanced transparency, acceptability, and appraisal by others in research methodology and results (de Kleijn & Van Leeuwen, 2018).

Ethical Procedures

Authorized Walden University Participant Pool representatives granted organizational approval to recruit participants. Before data collection began, I sought Walden University's Institutional Review Board (IRB) approval to conduct the study. The IRB's ethics review and approval are required for all Walden-affiliated studies before participant recruitment, data collection, or dataset access (Harris, n.d.). The recruitment process include procedures for obtaining informed consent from participants. Informed consent is an ethical and legal requirement for research involving human participants (Nijhawan et al., 2013).

The informed consent process for clinical research required good communication of study risks and benefits so potential research participants can decide whether to participate (Nusbaum et al., 2017). Participants were informed about their rights, the purpose of the study, research procedures, potential risks and benefits of participation, expected duration of the study, and the extent of confidentiality of personal identification and demographic data so that the participation of subjects in the study is entirely voluntary (Nijhawan et al., 2013). Each participant was assigned a unique identifier to protect their confidentiality (Archibald et al., 2019). Participants in this study were aware that their participation is strictly voluntary and could decline to participate or withdraw from the study at any point. The U.S. Code of Federal Regulations (CFR) regarding voluntary withdrawal from research requires communicating withdrawal terms and that withdrawal requests will not affect the participant (Gordon & Prohaska, 2006). If participant withdrawal results in a few participants, the research will resume recruitment

procedures to obtain the necessary amount for saturation. The informed consent form will address all the preceding topics in the participant's language, which will be readily understood, minimize the possibility of coercion or undue influence, and give sufficient time to consider participation (Dunn & Jeste, 2001).

Once informed consent had been read and understood by the participant of this research's purpose, process, risks, and benefits, I obtained the original consent form signed, and a copy will be provided to the participant. To protect participants' confidentiality, I was responsible for enshrining this right by appropriately storing consent forms with names either in a locked filing cabinet or scanned and in a password-protected folder (Berkovic, 2023). Only the research committee and I had access to the raw data. Audio recordings were saved in a protected folder; only they can access them (Berkovic, 2023). Data will be securely stored for five years, as Walden University requires. After this period has elapsed, the data will be destroyed by commercially shredding all physical materials and deleting all digital material from the computer hard drive. I did not be conduct the research within my place of employment. I did not anticipate professional or personal relationships with any prospective participant.

Summary

In this chapter, I reviewed the purpose of this study, the role of the researcher, the research design, the inclusion criteria for sampling selection, ethical considerations, and the data collection procedures. This basic qualitative study aimed to explore the perceptions of the lived ACEs of clinicians, resiliency, and engagement of criminal offenders. The participant in this study consists of eight to 12 licensed clinicians currently

enrolled at a university who work or have worked with criminal offenders and are willing to discuss their experiences.

This qualitative study aimed to understand clinicians' perceptions of their ACEs, resiliency, and engagement with offenders. The research used semi-structured individual interviews to understand how these experiences shape their professional growth. ACEs can include traumatic events in childhood (0-17 years), witnessing violence in the home or community, having a family member attempt or die by suicide, growing up in a household with substance use problems, mental health problems, and instability due to parental separation or household member being jailed or prisoned. The research design was based on a basic qualitative methodological approach, which allowed participants to express their own lived experiences and gain a more comprehensive picture of everyone's experiences. The study used a phenomenological approach to add to the psychological literature on ACEs and clinicians by understanding clinicians' perceptions of their lived adversities, resiliency, and treatment engagements of criminal officers.

The primary instrument for data collection and analysis, using interview questions to guide data collection. Data was collected from individuals who do not know or knew the researcher, and the collected data was meticulously analyzed to develop comprehensive themes, categories, concepts, and observations. Acknowledgement of assumptions, interpretations, and preconceived notions about the research and strive to interact more objectively with the research. Member checking ensured that transcripts were accurate before beginning data analysis to minimize research bias. Furthermore, I

also subordinated their opinions, assumptions, and preferences to favor participants so that participant perspectives drove the conversation.

This study used purposive or selective sampling to select participants from the Walden Participant Pool, including individuals with professional licenses, ACE, work experience with criminal offenders, and university students. The Institutional Review Board (IRB) approval was obtained before data collection began. Participants identified using the Walden University Participant Pool and were contacted via email. Participants were contacted via email and provided with an informed consent form to initiate data collection. The sample size for this study consisted of eight to twelve participants, with additional participants chosen if saturation was not achieved. Data collection was conducted through individual interviews, aiming to elicit in-depth accounts of participants' experiences with ACEs, resiliency, and treatment engagement with criminal offenders. Interviews consisted of 45 to 60-minute individual semi-structured interviews, audiotaped and transcribed. The study also conducted member-checking to increase study credibility and confirmability. An interview guide was used to facilitate open discovery and capture the subjective point of view of the research participant. Open-ended questions were developed to promote positive interaction and stimulate discussion.

Thematic analysis is a method used to identify patterns or themes in data sets, providing new insights and understanding. It involves six steps: transcribing interviews, reading transcripts, generating initial codes, searching for themes, reviewing and refining themes, defining and naming themes, and producing an analysis report once themes are fully identified. The first step involves reading through interviews to identify possible

patterns. The second step involves generating initial codes, which are organized into meaningful units. The third step sorts codes into potential themes using a thematic map. The fourth step involves reviewing and refining themes, reworking themes if necessary, and defining and naming themes to identify central ideas. The fifth step involves defining and refining themes, writing a detailed analysis of each theme, and illustrating trustworthy themes to the reader. Trustworthiness is essential for a research study, and it is established through being upfront about analytic or ethical dilemmas, prolonged engagement, member checks, and audit trail methods. Credibility is crucial for a qualitative study, and it is rooted in honest and transparent reporting of how biases and other possible confounders were identified and addressed throughout the study processes. Triangulation, using identified data from multiple sources and methods to avoid error or bias, can increase credibility and confirmability. Member checking, also known as participant or respondent validation, is another method to increase study credibility and confirmability. It involves asking the research subject to verify the transcription of an interview, restating or summarizing participants for accuracy, and achieving saturation, where emerging themes emerge fully from the existing data (Halcomb & Davidson, 2006).

This study aimed to evaluate the applicability of research findings to other contexts and provide sufficient information for readers to interpret, contextualize, and assess their applicability. Thick description was utilized to describe the research population, sample, procedures, and accounts obtained from interview participants. Dependability refers to the stability of research findings over time, achieved through

credibility, triangulation, data splitting, duplicating analysis, audit trails, and member checking. Confirmability is the degree to which other research could confirm the study's findings. The study used audit trails to enhance its confirmability, providing detailed descriptions of methodological steps and notes on decisions made during the research process. This enhanced transparency, acceptability, and appraisal by others in research methodology and results. Ethical procedures include obtaining informed consent from participants, ensuring good communication of study risks and benefits, assigning unique identifiers to protect confidentiality, and obtaining original consent forms signed and provided to participants.

Chapter 4: Results

The purpose of this qualitative study was to address clinicians' perceptions of how their ACEs shaped their professional practices, resiliency, and engagement with criminal offenders. Most research focused on the impact of ACEs on physical and mental health outcomes. Research regarding counselors' trauma is still emerging.

The research question that guided this study was: How do clinicians describe their perceptions of how their ACEs shaped their professional practice, resiliency, and engagement of offenders? A comprehensive analysis of interview data was used to identify themes involving participants' lived experiences. Interviews helped to better understand this topic.

Chapter 4 includes the research setting, demographics of participants, data collection and analysis, evidence of trustworthiness, and results of the study. It concludes with a summary of research findings as they relate to the research question and transition to Chapter 5.

Research Setting

For this basic qualitative study, clinicians who had experienced ACEs and worked with criminal offenders in prisons or jails were recruited using purposeful sampling. Their participation in this study was voluntary and confidential. Participants were located throughout the United States. Interviews were conducted via phone at home using my iPhone 15 with audio recording. All recordings were done in a quiet and private environment to guarantee confidentiality. To guarantee there would be no interruptions or

outside interference with data collection, each participant selected a setting that was convenient and comfortable for them.

Participant Demographics and Profiles

This qualitative study involved using purposeful sampling. Participants were obtained through Facebook and LinkedIn. There was a total of 12 potential participants who met inclusion criteria, which included being over 18, graduate students, licensed social workers, psychologists, professional counselors, licensed psychological associates, or psychiatric nurse practitioners who worked or had worked with incarcerated offenders in prisons or jails and experienced ACEs before 18. Three of 12 potential participants did not reply via email after receiving informed consent forms electronically.

Participant Demographics

During interviews, participants were asked demographic questions (see Appendix C). Each participant was allocated a numeric pseudonym starting with the letter P followed by a number (see Table 1). Participants were located throughout the United States and included one male and eight females.

Table 1

Participant Demographics

Participant	Gender	Years Working with Population	ACE	Treat Offenders Differently
P1	F	10	Mother, Severe mental illness	Yes
P2	F	3	Father, Incarcerated	Yes
P3	F	2.5	Mother's boyfriend, Alcoholic	No
P4	F	3	Father,	Yes

			Incarcerated	
P5	F	14 (5 as LC)	Sister, drug dealer, gang member and a prostitute	Yes
P6	M	2	Father, Corporal punishment, workaholic	No
P7	F	4	Father, Incarcerated, Divorced	No
P8	F	1	Brothers, Incarcerated, unsafe home environment	No
P9	F	5 months	Father, Incarcerated	Yes

Participant Profiles

In this section, each participant is described in depth to provide context for their individual experiences. Each profile includes their time working with incarcerated individuals, reasons for working with this population, and relevant quotes that describe their ACEs. Some participants also described their roles and responsibilities.P1 worked with incarcerated individuals for 10 years. She began working with this population because, according to P1, = "my mom had some severe mental health issues growing up, so I was hoping I would be able to help people like her. She said she struggled with "multiple diagnoses […] there was emotional and physical abuse pretty consistently throughout my childhood." Due to this abuse, she explained there was significant CPS involvement.

In her current position and facility, P1 provided therapy and was, according to her, "in an administrative role over two buildings." In addition, she oversaw programing for patients. In her work with offenders, she said she decided "if somebody wanted to

change and be different, it was gonna be my job to be there and help them." In working with the offenders, she said she "trie[d] very hard to bracket and keep that information kind of separate from the individual that's in front of me. But occasionally [their offense] does have some impact."P2 worked with incarcerated individuals for 3 years. She began working with this population because, she said:

> My father was in and out of prison during my life. Having experienced this , I [did] not want other kids to experience having an absent father at home […] I [felt] like I just want[ed] the community and society to break the generational curses of the criminal justice system.

In her current position and facility, P2 provided therapy to incarcerated offenders. In her work with offenders, she said she viewed offenders differently based on their offense, especially those involving crimes against children. P3 worked with incarcerated individuals for 2.5 years. She began working with this population because her mom's boyfriend was a problem drinker and alcoholic, and she experienced parental separation and divorce, household members who wer mentally ill, and sexually assault. . She said having both her parents suffer from depression was hard after their divorce.

In her current position as a clinician, she said she "learned how hard life can be afterwards and the cycle of addiction… you can do good or not do good, just depends on what you do in the sport." P3 said, "struggling with depression or just a mental illness in general […] I am familiar with mental health and comfortable talking about it." In working with offenders, she viewed them differently based on their offenses and said "I think the biggest defensive tends to be more judgmental about is sexual abuse against

children is one that I have a hard time empathizing.P4 has worked with incarcerated individuals for three years. She began working with this population “to reduce recidivism rates. As a victim, as you know my dad being in and out of jail his whole life and then being killed.” Having experienced this, she explained, “I've always been very fascinated by why people do what they do, but I also have a great compassion and mercy for many in the system as a whole.”

In her position as group facilitator and facility, she learned that “the things that they had been through really impacted my life and so that's kind of what led me to doing that.” In working with the offenders, she’s “met many murderers” and has viewed them differently based on their charge [murder]. She explained, “There was a man named Keith. He had a gun they did an armed robbery, and he was the one that got caught. The person was shot so he had been in [prison]… he just looked at me and he had tears and he asked for forgiveness and it was a moment of like as if we really were who we were asking forgiveness for you know what I mean like I looked at him like he killed my dad and he looked at me like I was the victim's family for real.” Having lived this experience, she was impacted as it was “such a therapeutic moment and cathartic for everyone involved.”P5 has worked with incarcerated individuals for 14 years and five years as a licensed clinician. She began working with this population because “my sister was a drug dealer, gang member and a prostitute and diagnosed with antisocial personality disorder, my dad was bipolar and hallucinate, and my mother was so paranoid she believes mafia, the FBI, and outer space aliens were stalking us.” Living with family members with multiple diagnosis she found that “I like working with very severe mental illness and it

just makes it more interesting." Due to this, she explained that she is "not intimidated by much."

In her past position working with criminal offenders, P5 provided therapy. In her work with offenders, she "refuses to work with pedophiles because of the manipulation and grooming… I just find it's so offensive that anybody would hurt a child." In working with severely ill patients, she can build rapport easily because she empathizes based on her experience with mentally ill individuals. However, when working with pedophiles, she explained "they are good at reading others, pushing boundaries constantly makes it very difficult to have that kind of rapport you need in order to make progress."

P6 has worked with incarcerated individuals for two years. He began working with this population as a "bachelor's degree internship requirement… I went beyond because I like the place. It was my master's internship… was a good fit and now that I have graduated, I'm staying." "Growing up my dad was old fashioned… and believed in corporal punishment, boy's don't cry. You know the whole macho, kind of thing"

In his work with offenders, P6 explained, [working with incarcerated offenders...] it's been a positive. I have found them to be humble and want people to just understand them." Through his experience "with them in summary, they [offenders] want the help. Most of them want to help themselves and they're willing to do the work." P7 has worked with incarcerated individuals for four years. She began working with this population because "I do personally have a high score [incarcerated parent, divorce, abuse] so a lot of what these criminals have been through or experience themselves is not foreign to me." Having experienced multiple ACEs "I can comfortably listen to some of their family

dynamics are there or their childhood history... not have a bigger reaction adverse reaction that others would that that maybe didn't grow up experiencing some sort of trauma."

In her current position and facility, P7 provides therapy and in her work with offenders, she explained "I'm okay with looking at them as a human being to help them get through their stay [prison]." In working with offenders, she explained"[have I viewed them differently] based on their offense? No, you know I thought I would. I thought I would have a hard time working with sex offenders specifically."P8 has worked with incarcerated individuals for one year. She began working with this population because "being brought up and out in a home where my siblings went through the correctional life was one of the reasons that I wanted to be a part of this." She further explained, "I was raised in at times unsafe home environment when I was young."

In her current position and facility, P8 provides therapy and explained "This population was in great need of treatment and counseling. It would be very beneficial for them just because of their past traumatic life experiences and them never getting an opportunity to be provided with treatment." She has not treated offenders differently based on their offense because offenders should be "provided with that opportunity on assisting and helping young offenders rebuild and hopefully you know redirect their lives into a life worth living."P9 has worked with incarcerated individuals for five months. She began working with this population because "my father was incarcerated for quite a few years." Having lived this, she "was curious to see how other children it affected them."

Living with an incarcerated parent as a child, she wanted to "see how I could work with these youths that I had at least a little bit of similarity [incarcerated parent] with them."

In her current work, P9 provides therapy to incarcerated youths and explained, "Yes [I have viewed offenders differently based on their offense], because when I would read over their cases their files because it was a very new experience for me." But occasionally their offense "such as them murdering individuals and then seeing the photos and their case of like how they did it." This has caused her to experience some biases based on their offense, "I'm being honest with myself, yes there were biases based on their history that did affect how I saw them at the beginning when I just met them."

Data Collection and Analysis Overview

I initiated data collection after Walden University's IRB granted research approval (11-22-24-1047683). This approval expired on November 21, 2025. I followed Walden University's IRB ethical guidelines to be certain the research was conducted in a manner which would not be harmful to participants.

Interested participants contacted me via my contact information on the flyer (see Appendix A). Twelve potential participants offered their time to take part in this research. To give their consent, each participant had to reply with "I consent" by email. However, only nine participants provided consent. Before the start of each interview, I provided a concise debriefing to ensure participants understood their rights (Ortiz, 2024). Participation in this qualitative research study was completely voluntary and confidential. Participants had the right to refuse participation, stop interviews, or withdraw from the study at any time without providing an explanation or facing negative consequences.

A semi-structured recorded interview was conducted over the phone with each participant using open-ended questions. I took minimal notes during the interview process due to the interviews being recorded and I was able to focus on the participants' lived experiences. If more clarification was needed on a participant's response, follow-up questions during the interview were asked to get more clarity for that response (Daniels, 2025). From these recordings, audio transcripts were subsequently produced. The sessions were planned for one hour each. The interviews were done in a controlled, calm, and private setting to make participants feel safe and at ease, which may have encouraged them to talk more freely. I transcribed participant responses to interview questions, storing each interview in a Microsoft Word document that was saved in a secure location. The audio transcripts were kept on my laptop in a password-protected folder.

Prior to the interview being concluded, member checking was conducted by summarizing the participant's responses, none of them requested any changes. No further verification was required because the transcripts were deemed accurate and comprehensive. This suggests that the participants agreed with the representation of their words and experiences, thus no changes or corrections were necessary to move the process further.

After each interview, participants were offered opportunities for any follow-up questions regarding the research. No follow-up interviews were needed because participants provided well- thought-out, reflective, and detailed responses during the interviews (Daniels, 2025). During the data collection process, no exceptional situations

were encountered. Prior to the interview's conclusion, each participant expressed gratitude for their enthusiasm and willingness to participate in this research study.

Braun and Clarke (2006) specify the six steps for conducting thematic analysis in qualitative research. These steps consist of a) transcribing interviews and reading the transcripts, b) generating initial codes, c) searching for themes, d) reviewing and refining themes, e) defining and naming themes to identify central ideas, and f) producing an analysis report once themes are fully identified (Braun & Clarke, 2006; Braun & Clarke, 2022; Riger & Sigurvinsdottir, 2016). Using thematic analysis to analyze the data to identify significant commonalities within the collected data enhanced the trustworthiness of the study by allowing common themes to be identified across all or most participants' responses, thereby minimizing the influence of individual biases or errors in the findings (Abiona, 2024; Braun & Clarke, 2006).

For this study, the transcripts included direct statements from participants to develop codes based on their perception of their lived adversities. Once an interview was transcribed, I checked the transcript against the audio to determine accuracy and corrected it as needed (Abiona, 2024). Once all interviews were reviewed for accuracy, I imported transcripts into NVivo 15, a computer-assisted qualitative data analysis software to code the interviews to develop themes.

Codes are defined as words or phrases repeated within a transcript and across all data (Kleinheksel et al., 2020). Coding interview transcripts helped identify categories that would help identify themes within the data (Williams & Moser, 2019). After the initial coding process, I grouped codes into a smaller category. By doing so, I could

inductively move from coded units to larger representations of themes (Abiona, 2024). This process was completed by comparing and clustering smaller coded units. Once I finished coding the transcripts into smaller units, I began comparing those units to each other to identify patterns or similarities.

Emerging themes within each interview suggested each participant had a specific unique viewpoint related to their adversities, resiliency, and treatment engagement of criminal offenders (Shulski, 2024). Once codes were developed, they were combined into themes. Themes emerged from understanding the codes associated with each participant's stories during their interview (Shulski, 2024; Williams & Moser, 2019). Throughout the theme refinement process, I revisited previously coded data whenever new material was added to a theme (Abiona, 2024). The themes were then reviewed to determine the significance of each theme and report the findings (Braun & Clarke, 2012).

A total of 69 initial codes were identified from the interview transcripts of the nine participants. The codes were then grouped into three main themes and seven sub-themes during the final stages of the coding process. The major themes that emerged from the data included (a) client interaction, (b) countertransference, and (c) resiliency.

Evidence of Trustworthiness

To guarantee and preserve the study's credibility, I followed the instructions given in Chapter 3 throughout the planning, data gathering, and analysis stages. To assure reliability, this study employed the measures of confirmability, dependability, credibility, and transferability. This study used many strategies, including member checking and data saturation, to establish credibility. To minimize bias, I ensured this study's results were

strictly based on the transcribed interviews used during the coding process. Furthermore, I mindfully asked questions that were approved for the study. I refrained from acknowledging or not acknowledging the information provided (Abiona, 2024).

Credibility

Credibility refers to the accuracy of the data or the participant's views and the interpretation and representation of them by the researcher (Lincoln & Guba, 1985). To demonstrate credibility in a qualitative study, I show evidence of engagement, methods of observation, and audit trails when reporting the research findings (Ravitch & Carl, 2016; Smith, 2024). In this qualitative study, member checking and data saturation was utilized throughout the study. Korstjens and Moser (2018) noted credibility is directly related to the truth value of a study. To ensure an accurate interpretation of the data analysis, member checking took place with the transcript being reviewed to verify participants accuracy (Garcia, 2024). During the interview, I restated and summarized the participant’s responses for accuracy (Patterson, 2024). Participants were also asked if the transcript was accurate. By doing member checking in this study led to clarifying responses of participants. Member checking was an important step in ensuring that the perspectives and views of participants were accurately reflected in the final interpretation of the data (Garcia, 2024). Saturation is another method by which I ensured credibility in this study (Hanson et al., 2011). Reaching saturation becomes a critical component of this qualitative research making data collection robust and valid (O’Reilly & Parker, 2013). When no new data was found, saturation had been achieved.

Transferability

Transferability as applicability relates to providing sufficient information for readers to evaluate the relevance of findings to other contexts. Thick description signifies highly detailed and rich description that provides enough illustrative detail to enable the reader to interpret, contextualize, and assess the applicability of the findings (Maher et al., 2018; Younas et al., 2023). This fundamental qualitative research study delves into the exploration, interpretation, comprehension, and description of the clinicians' perceptions of the lived experiences, resiliency, and treatment engagement of criminal offenders.

Dependability

Dependability ensures that the process is described in detail, allowing another researcher to repeat the work (Maher et al., 2018). Dependability is attainable through credibility, triangulation, data splitting, duplicating the analysis, audit trails, and member checking (Lincoln & Guba, 1986). To ensure trustworthiness, an audit trail was created by using NVivo 15, a qualitative coding software that allows researchers to code data in a way that leaves a clear audit trail (Patton, 2002). In this qualitative research study, I ensured that my data analysis included the examination, interpretation, description, and comprehension of the collected data to identify themes, subthemes, insights, and conclusions that are consistent with the findings of the data.

Confirmability

Confirmability is concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination but are derived from the data

(Korstjens & Moser, 2018). I utilized an audit trail which allows enhanced transparency, acceptability, and appraisal by others in research methodology and results (de Kleijn & Van Leeuwen, 2018). Member checking was utilized to increase credibility. Member checking, a common standard of rigor, is a practice to increase study credibility and confirmability that involves asking the research subject to verify the transcription of an interview (J. Johnson et al., 2020). During the interview, I will restate or summarize the participants for accuracy (Patterson, 2024).

Study Results

This basic qualitative study is grounded in the research question to understand clinicians' perception of their lived ACEs, resiliency, and treatment engagement of criminal offenders. The semi-structured interview questions provided answers to better understand how clinicians' adversities impacted their professional practice while working with criminal offenders.

Each participant was asked to describe why they decided to work with criminal offenders, have they viewed offenders differently based on their offense, engagement techniques, identifying countertransference, and how they each achieved resiliency. Each participant was allowed to describe the impact of their lived adversities and working with criminal offenders. Words, concepts, expressions, and accounts directly relating to clinicians' perceptions of their lived childhood experience, resiliency, and treatment engagement of criminal offenders as a way for coding and themes were established based on the codes from the interview transcripts (Daniels, 2025). I gathered each clinicians' perceptions were gathered and analyzed to create themes. I asked all the interview

questions in the same sequence with all participants. The themes highlighted in this section are based on the interview data with the nine individuals.

RQ1 referred to how clinicians describe their perception on how their own ACEs shape their professional practice, resiliency, and engagement of offenders. This section is divided by the categories of the prominent themes and subthemes which answered the study's research question. The following themes emerged after the data was analyzed: (a) client interaction, (b) countertransference, and (c) resiliency. Table 2 provides a breakdown of the categories and subcategories identified with participant interviews.

Table 2

Themes and Subthemes from Data

Theme	Subtheme
Client Interactions	
	Client engagement techniques
	Life impact from client interaction
Countertransference	
	Awareness of Effects of ACE
	Signs of Countertransference
Resilience	
	Client Engagement
	Support System
	Ways of Thinking
	Coping Strategies

Theme 1: Client Interactions

The first theme that emerged was client interactions. Interview question that prompted responses from participants for RQ1 was "How would you describe the therapeutic engagement techniques used when working with an offender?" Participants each expressed different interactions with offenders within their capacities which prompted different engagement techniques. Within the exploration of clinicians' perception of lived ACEs and client interactions distinct subtheme emerged within this section includes (a) engagement techniques and (b) impacts of client interactions on life. In each section, I provide the data relevant to each subtheme according to the meaning conveyed in the data.

Subtheme 1: Client Engagement Techniques

Each of the participants had a unique way of interacting with offenders and the techniques utilized to build rapport. The topics within client engagement techniques include person-centered strategies and more formal therapy-based strategies. The data in this subtheme show the willingness of the participants to adapt to client needs. For example, participant one reported, "It's focused on the building of the rapport with the client… and talking about client issues."

In the person-centered strategies, the participants described being genuine and authentic, which includes four topics. These four person-centered strategies are (a) being direct, (b) developing rapport through trust and safety, (c) listening to their story, and (d) validating the clients and their experiences. Overall, the data presented illustrate that the participants wanted to convey their growth as clinicians despite their lived adversities.

Being direct and intentional was a common technique utilized by clinicians to address resistance in therapy with offenders. To establish a strong therapeutic relationship, it is necessary to talk about incongruence in behavior.

P5 stated:

> I use radical honesty because they can usually, they're [pedophiles] very good at reading if somebody is being fake… I will also be more direct with them than with a client who has never been incarcerated. I'll ask them did I do something to piss you off because we need to talk about it if I did. So, you have to push back [in terms of establishing your territory as a professional clinician]. Anytime you give in they will push that boundary further and further. And so, if you are respectful and hold the boundary consistently, then you get respect back."

P5 spoke about directness through awareness of client behaviors:

> Partly it is to not allow even one boundary to be pushed with me. I'm very aware of for example they'll show up late to discussions or they will not look at me while they're talking to me. I will call them out on it hey, your eye contact isn't really good today. What's going on? What are you not telling me? What do you need to share that you're not?

P1 addressed directness through talking with clients about issues they were picking up on:

> A lot of the times, I try to be as genuine and as real as possible so when I present to my patients, it's I mean I talk about it [resistance]. We bring that resistance out into the open you know why don't you wanna engage in this? What? What

> purpose does your does your resistance serve? Is it protecting you from something? We try to dive into it and explore it and see what's going on. Sometimes, I will try to weave my way in the backdoor to some emotional content.

Most participants reported an importance of building rapport by developing trust first when working with criminal offenders which leads to them feeling comfortable and safe. Mistrust is often a result of negative past experiences with authorities of healthcare providers, leading to hesitancy in sharing sensitive information (Suggs-Crudup, 2025). Establishing a strong therapeutic relationship with offenders should consists of being intentional in listening, validating feelings, and creating a safe space for expression.

Participants 1, 3, 6, 7, and 8 had a different way of describing the need for establishing rapport and trust. P1 explained the importance of rapport building. I provide "quite a bit of rapport building. It's all focused on the building of the rapport and does that patient trust you which is extremely difficult for offenders to do there's no reason they should trust me." P3 explained their alternative to generate rapport, "I do utilize safety, installing safe places and safe people and that kind of stuff for these individuals." P6 responded, "The first thing I do is pretty textbook create that rapport. I'm trying and build trust." P8 responded, "[due to my ACE of not being in a safe home environment] an option for counseling is to have somebody that you could feel safe with and speak with."

P7 discussed alterative topics to generate rapport:

> With resistant clients, it's typically just trying to kind of come through another door instead of sitting there and trying to get them to tell me you know what their

issues are and what's going on. Typically, I'll ask them about you know dynamics in the pod, dynamics with staff. We'll talk about you know what are some of the things that they're looking forward to so I can see if they're in future-oriented talk.

P1 spoke about their use of intentional listening:

I generally try to go very person centered and meet them where they're at, including if they're angry. I mean a lot of the times working with offenders, they don't have a choice to be there, so this is not something that they're coming in for voluntarily. It's usually mandated or in my case they're in a residential setting, so they're locked up in there and their schedule is dictated to them. They can either lay in the day room and skip out on classes or go, so they're not always happy to be there, so I try to meet them where they're at with how they're doing right in that moment.

P6 also spoke about intentional listening:

If they have a story to tell, I let them talk I don't go immediately into the bio psych and doing other assessments. They just wanna talk they just wanna tell a story so I sit there. I just let them tell their story and I don't interrupt unless someone wasn't clear. And then based on that [their story], I'll go back to them later once they're more comfortable and we'll start getting into more of the details.

P1 said:

It's perfectly OK that you don't wanna be here I get that-that is understandable and. Honestly, that's most of us would feel the same way if we got shoved into something like that. I try to validate their emotions.

P3 said, “But I also I mean my framework in a person-centered therapy you know, providing an unconditional positive regard and empathy and validation.” P6 said, “But above anything else it's all unconditional positive regard.” P9 said, “So, it's a lot of also treating them you know in a holistic and a humanistic way too. We have to also remind them we are human. We make mistakes. We let our emotions get the better of us.”

In the trauma-based processing and therapy strategies, the data resulted in clinicians identifying therapeutic techniques that help them with treating offenders such as Adlerian, Cognitive Behavioral Therapy, and Dialectical Behavioral Therapy which has led to growth in understanding strategies, life impacts from client interactions, and coming to realization.

Participants elucidated their therapeutic methodology with offenders and the rationale for its application. Most participants articulated, in diverse manners, the process of enabling the offender to derive meaning from their trauma and conduct, while cultivating and executing constructive behavioral responses. Most of the participants theoretical approach was Cognitive- Behavioral Therapy (CBT), Dialectical-Behavioral Therapy (DBT), while others opted for the use of Eye Movement Desensitization and Reprocessing (EMDR). P3 responded, “If they're in a good spot right like they have and they're not experiencing addiction, I might broach some more trauma processing, but I usually don't get that far.” P1 responded, “I just feel like it [CBT] since it focuses so much on the patient that it lets them tell you how they need to be treated, and I can learn a lot from my patients on how they want to move forward or how they don't want to move forward within their treatment.” P3 shared, “I'd say toss it between DBT and CBT I

borrow a lot from DBT. I'm not super rigid as far as like you know you'll have to have the coaching our response and we have to go through this manual." P6 responded, "Others are 'I don't understand why this happened.' Or they can't accept you know? 'This didn't happen. This isn't happening.' We will start with some reality, but it's all really kind of CBT. A lot of DBT as well." P8 mentioned, "I do, the main one would be the cognitive behavioral therapy approach that is in combination in regards to the humanistic perspective…and the dialectical behavioral therapy, which is the DBT therapy that we also implementable we provide them with the necessary tools in order for them to make that cognitive behavioral change into a positive one." P9 responded, "So, a lot of the main techniques we use is CBT and DBT so it's a lot because even within the correctional facility…, while we're making progress with them, they do regress and the engagement behaviors that we have worked towards and avoiding [poor behavioral responses] with the CBT and the DBT skills."

Participants conveyed their experiences with each therapeutic technique employed in the treatment of offenders, along with the rationale for their application. Clinicians reported that the offenders with whom they engage have been profoundly affected by their traumas and may not completely comprehend the current implications for their mental health. By employing these strategies, they have improved their abilities in treating criminals with trauma. P3 shared, "Yeah, I'd say my primary is CBT and DBT that I use. I have utilized some EMDR with clients; however, I'm really apprehensive of you've seen that primarily because a lot of these individuals are in a state of like de-stabilization and I do not want to disrupt that when they don't have a safe place to go." P4

responded, “You know at the time I didn't really understand the approach the way I do now of course of like what you know CBT and DBT…a lot of the time we were using a lot of cognitive behavioral interventions in the sense that our thoughts and the way we think the way we see the world a lot of the core beliefs. They had core wounds. We would tackle those little by little and not even realizing that it was CBT.” P7 responded, “CBT with the adults there's no real allowance for using any other type of therapies although I am trained in in DBT and EMDR [Eye Movement Desensitization and Reprocessing], but I'm not able to use those with the adult prison in the juvenile prison, I was able to use those a lot more with the with the juveniles.”

Clinicians offer tailored support by teaching how to manage stress, anxiety, and trauma through therapeutic methods such as mindfulness, cognitive-behavioral strategies, and emotional regulation exercises (Suggs-Crudup, 2025). Participants concentrate on instructing offenders in strategies to navigate challenging life circumstances, sustain emotional regulation, empowerment, and awareness. P2 responded, “The therapeutic techniques that are used primarily like motivational interviewing, I try to use a lot of open-ended questions to encourage like expression and sharing their own perspectives to their behavior, reflective listening is another one.” P3 responded, “Then motivational interviewing is also another key one that I used to.”

P3 also mentioned, “I'm also just bring in the skills and the mindfulness and in our personal effectiveness, how do we communicate to people more proper? We need to get our needs met. Experience, mindfulness, and emotion regulation that kind of stuff I use quite a lot.” P9 spoke about client empowerment through emotional regulation and

awareness, “We always try to empower them, even though they might have not done some of the skills that we had showed them. It is important to remind them that it's okay if you didn't do it this time.” P4 and P9 shared their insight of emotional regulation skills with offenders. For example, P4 said:

> [We] taught them how to do breathing techniques because you know prison is not a safe place and they still feel all these emotions in there, but you can't show them and so. To teach emotional regulation was a key thing, and for them to be able to regulate themselves, not only to not hurt somebody else or like react, but learn how to respond differently to the conflict around them, but also for them to learn that they're feelings matter and what they're feeling in and is valid but on ways to you know journal it out instead of crying in front of everyone because that's really hard to do in there.

P9 also spoke about emotional regulation with offenders:

> So, it's a lot of making them kind of realize "OK do you see what you could have done differently? Do you see how this response affected you emotionally and how you lead your emotions to act on your behaviors and then the behaviors escalated into this sort of consequence?" you know?”

Subtheme 2: Life Impacts from Client Interactions

In working with offenders, the second subtheme that emerged was the life impacts from client interactions. The interview question that prompted responses from participants was “How would describe your experience working with an incarcerated offender?” and “How would you describe working with this population has impacted

your life?" The topics within this section include two topics (a) coming to realization and (b) emotional responses.

Two participants shared their positive experiences working with offenders. Their interactions allowed them to come to realization that positive outcomes can occur even in a controlled environment. Within the theme of client interactions, the participants highlighted impacts from working with criminal offenders. For instance, participants 1 and 4 spoke of the general positive experiences they had while working with offenders. P1 responded, "It [client engagement] has been a positive thing overall." P4 responded, "Of those three years…, I genuinely loved it! It was life-changing!"

Participants 1, 2, 3, 5, 6, and 8 recounted their experiences collaborating with offenders. The variables that led to their unfavorable experience were the environment in which they gave treatment, as well as stagnating or lack of progress. P1 responded, "As counselors, it's up to me to exist to be here to offer support to hold the flashlight be a tour guide point things out that I see it's not my job to do all of the work and so as long as I'm showing up in the ways that I am professionally ethically meant to. Then that is, it." P8 responded, "Another negative experience has been the milieu of providing the treatment to the incarcerated offender. A lot of the times the offenders do not feel safe, so therefore mentally they're not able to be in a place where they can accept or completely understand the therapy aspect." P2 shared, "[Working with this population] It's impacting. Sometimes I feel like I want to save them, right? But I know that it's not my responsibility." P5 responded, "Yeah, I also think that they catch the games better that that criminals tend to play. They're better able to read the signs than I am." P8 responded,

“I would have to say my experience have been both--[negative and positive]. Unfortunately, after several sessions working with offenders for about you know 8 to 10 months that I have not noticed a change in their behavior or their cognitive ability to understand and take accountability that could be some of the negatives.” P8 continued to share their experience,

> You know, after so many so much time working with them, they struggle in actually acknowledging that they did wrong and taking accountability that they have you know injured someone else or they have caused a significant amount of trauma towards others. Their mentality in regards to not taking accountability. That has been a negative experience.

P3, P6, and P8 highlighted how working with offenders has been a positive experience. For example, some participants stated that their profession has made them more conscious of their privilege, the resource they have become as a result of their career choice, and the benefits of counseling. P3 responded, “I have worked with many clients who struggle with their basic needs like homelessness, food, and security, addiction things like that and it's definitely just humbling. It's been humbling like you know how much I have available to me, and you know that basic needs that I have met that I barely expressed gratitude for.” P3 shared how they have become a source to others, “I would say after becoming a clinician I kind of put myself on a spot of [being a source of] knowledge about mental health and provide support and talk about it a lot more than my other family members like I had.” P6 expressed her experience, “There are too many variables to make judgment on anybody for what they're doing so going

through the mental health now profession learning what I have I've learned like so many and listen to these people talk to them learning their various backgrounds and how things happen and why things happen in the brain and what not I see a whole different side." P8 shared her experience working with offenders and the success she has seen through counseling. P8 responded, "There has been positive [experiences] as well." She continued to explain: "I believe I have had like two successful outcomes where I have visually, you know experienced the positive change in them…implementing the techniques, implementing the skills that have been talked to them by me and them pretty much graduating."

Secondary traumatic stress (STS) exhibits symptoms that are similar to post-traumatic stress disorder (PTSD) without having direct exposure to trauma (Bryan, 2019). Also, when clinicians work directly with clients, STS can happen faster after a single exposure to trauma, whereas vicarious trauma results from a gradual process of repeatedly being exposed to clients sharing their stories of trauma (Bryan, 2019). Participants discussed how their work with criminals elicited emotional responses. Secondary effects reported by participants were nightmares, hypervigilance, safety concerns, tension, heightened anxiety, difficulty trusting others, and personal responsibility. P1, 8, and 9 shared how working with offenders has led to increased anxiety or dreams causing fear. P1 shared, "I do sometimes dream about work and that's ranged from like full on nightmare. I've had dreams where patients have shown up to my house, which hasn't never happened, but I've had dreams about it before and it was quite frightening." P8 reported, "So my anxiety has been a little elevated in regards to that. My

anxiety has been elevated as well and it has really changed my mind, my thinking in regards to the capabilities that a young person can do." P9 mentioned, "So it does put me a little bit on edge you know or even with a children in public that I start to see kind of have like little outburst or behaviors." P7 explained how working with offenders has led to fear for family:

> With my daughters, I also found myself being a lot more scared about her care when it when it came to her, not being around me and I couldn't see her. It would make me I would guess I would say more like a helicopter mom, and it just made me much more stressed out because I had to be on-call for them and it was just like this consistent 24-7. It's impact on my life, I never really felt like I got a chance to disconnect from.

P1P1, P5, P8, and P9 shared how working with offenders has resulted in being more vigilant. P1 shared her experience when working with aggressive offenders, "There are occasional instances where a patient is behaving like hyper, aggressive behavior, and you know they're threatening to hurt staff…but they're a little more kind of alerting to the senses. "P8 mentioned, "I have to make sure that my doors are locked in my vehicle when I'm walking towards my car. I'm very vigilant as to anyone's walking behind me. I'm very vigilant in regards to who's around me. What are they doing?" Furthermore, P8 has also had conversations with her children about vigilance, "Not only within myself, but also for my children, I do have those discussions with them and how they cannot be so naïve and so trusting with other people." P9 expressed an increase in her anxiety which has also resulted in increased vigilance, "So, it has definitely you know made me a

little bit more on edge and I guess also kind of more vigilant to behaviors, especially aggressive behaviors in children I see those outburst and behaviors." P5 shared,

> Assault for example: One of the people I worked with was an MS 13 gang member. While I was working with him, I made sure I had changed how I scheduled because I was working with him. I always made sure there are other people in the building. I'm in private practice. I double checked him. When I would walk out to my car at the end of the day or even in the early morning, I was more careful to have my keys between my fingers and walk with the purpose and check my surroundings. When I came back to my car, I would look under my car. I would make sure nobody had been tampering with it. I would bring everything inside with me instead of leaving it in my car because I didn't trust him. Not to plant something on me and call the police and call the board. I was very cautious. And it that's a way of living that I don't. I don't normally live that carefully. Not usually that paranoid.

P3, P7, and P8 described how they have experienced greater stress, personal responsibility, and burnout. Through their work, they have recognized signs that they have been personally affected. P3 responded, "There's some positive but a lot of challenges I would say I wouldn't say it's negative, but it's definitely a burnout inducing career." P7 responded, "There would be a while where it was all I thought about and a lot of that stress I would take home so I was being less presence at home. I'm a single mother so at times I found myself getting frustrated a lot easier." P8 expressed how their increased anxiety led to stress and personal responsibility:

> For me, I can definitely say that my level of anxiety has progressed and the amount of pressure also as a counselor as a clinician, I have felt like this amount of pressure in responsibility of making sure that they are receiving the correct treatment so that way once they are let out into the community in a way I would not, and if they continue committing other crimes that it you know it doesn't fall back on me in regards to having that amount of pressure it's like did I do enough?

Participants explained how their work with offenders has led to either positive or negative outcomes. Although they all expressed that their trauma has helped with meeting offenders where they are at therapeutically it has impacted their personal lives by noticing changes in their behavior, increasing their awareness and hypervigilance, and having meaningful conversations with their families about safety.

Theme 2: Countertransference

The second theme that emerged was unconscious emotional reactions. Interview questions that prompted responses from participants for RQ1 included “In your clinical opinion and experience, have you viewed offender differently based on their offense?” and “How do you believe your childhood experience affects your professional practice?” Another critical questions that allowed participants to express the impact of their ACE and their professional practice was “How do you identify when you are experiencing countertransference in your professional practice?”

Subtheme 1: Awareness of the Effects of ACEs

In this theme, I explained the impact of clinicians’ adverse childhood experience with offenders. This theme is supported by two subthemes (a) awareness of the effects of

ACEs and (b) signs of countertransference. The data is supported by the participants responses of consisting of choice of clients, perspective gained of compassion and empathy, creating a safe space, developed thick skin, and understanding the world differently.

P4 and P9 discussed how her ACE has influenced their work with offenders. Their personal experiences have improved therapeutic abilities and professional practice. P4 asked, “How did it [ACE] not [affect my professional practice]? My dad was in prison, a majority of my adolescence and early adulthood. My trauma from my past when I was a child, I was very neglected, emotionally and physically abused and emotionally abused. It impacts my professionalism in a way that I understand the world I think I said that a minute ago I under, and that's just gonna be my main answer. I understand the world in a way that others don't if you've never had ACEs in your worst trauma is like a root canal.”

P4 also responded, “You can't possibly connect with inmates. You can't connect with a lot of different people’s walk of life. And it helped me see the world in a different way. Granted some of that is this world's evil and it makes me sad, and it's broken, and I wish it wasn't. There's a lot of injustice and there's a lot of children that I went through what I'm going through are going through what I went through and there's no justice for them right now.”

P9 responded, “That [my ACE] helps me within my profession again to try to alleviate my biases. I mean, I do have biases as I had stated earlier, but I feel like when I meet a youth or an individual that has something similar to what I went through. It does

kind of. I do open myself up a little bit more because I want to understand, and I let them know that I understand them as well because I went through something similar so I kind of like enhanced my profession in that sense through that personal experience."

The data illustrates that the P5 ACE influenced her selection of clients that she works with. P5 shared they like working with those who suffer with severe mental issues. "Well, I work with the most severe cases, I possibly can get my hands on because after growing up the way I did. People in private practice work with depression anxiety may be a little bit of bipolar, adjustment disorder, relationship problems...and all seems very mundane to me, and I don't want my work to be mundane." P5 further elaborated, "I want it to be interesting and so working with people with schizophrenia working with people who are criminals. That keeps it relevant meaningful and interesting because I'm always learning every single day from my clients. It [these experiences] shape the therapy that I do with a client."

Compassion and Empathy

P4, P8, and P9 shared how their ACEs has helped them understand offenders struggles. All three-participants shared that their adversities have also increased their level of empathy towards offenders. P4 expressed, "I do best and that's connecting with people and that's how it impacts who I am as a counselor because I understand that connection and empathy and compassion or ultimately gonna be the three characteristics that I need to uphold any type of professional practice in the counseling field." P8 indicated, "So having experienced that [not being in safe environment] as a child I believe has made me way more empathetic in regards to providing my counseling

towards you." P9 mentioned, "I believe because one of my parental figures was not present when I was younger. I do feel very empathetic with individuals that come across in my profession that also have absent parents, and it does make me empathize with them, and I sympathize as well."

Safe Spaces

Through her work with offenders, P7 is mindful of creating a safe space for others in therapy. Trauma survivors are disorganized from within (Van Der Kolk, 2014), so when reliving these experiences individuals feel a sense of powerlessness and need to learn healthy coping skills to manage the intensity of their emotions (Su & Stone, 2020). P7 explained how her ACE has helped her professionally, "It helps me be more--how can I say I'm able to incorporate maybe trauma-informed techniques better cause I have a better understanding as far as like nonverbal cues of like safety, right? How I talk; how I how I look offering seating, you know? I'll let them pick a chair. You know if it's appropriate for them to sit down first. And I guess kind of what I've been through you know being able to create like this little space of safety is really important something I think I do very well."

Thick Skin

P3 and P5 both indicated that their exposure to an adverse childhood experience has helped their professional practice in a positive manner by having a strong resistance skill. For example, P3 reports how being in stressful situations she is able to maintain composure and calmness. "I think it has allowed me to be ... in stressful situations be more levelheaded to be able to deal with like people yelling at me saying fuck you. I have

pretty thick skin. I don't tend to take personal offense." P5 shared her experience, "I grew [up], and then of course, my psychopathic sister. My childhood, actually my entire childhood until I moved out, was full of fear. Ordinary life seems very boring to me. In my work I'm very comfortable working with really severe stuff because it very little of it actually matches up to the way I grew up."

Subtheme 2: Signs of Countertransference

According to Straussner et al. (2018), many social workers choose specific specialization that mirror their problems experienced over many years, which may result in transference and countertransference issues during clinical sessions with clients. The data shows that clinicians had difficulties with boundaries, perception of offenders, emotional impact, and emotional reaction.

P1P1, P3, P4, P7, and P8 shared their experiences with how they struggled with boundaries which resulted in emotional reactions. P1 responded, "They [strong emotional reactions] would feel on the inside like either a heavy, heavy frustration or repulsion." P3 responded, "I [have] worked with individuals that have like talked about those crimes. I just felt very disturbed by comments about. The victim I think in one case was like 13 and one was 14 something like that, asking for it or saying that it should've been legal because she initiated it things that They placed accountability on a child and it was disturbing to me." P4 indicated her experience working with a sex offender who had sexually abused his 14-year-old daughter, "We did a sexual offender group as well, and that was probably my hardest offense I mean. This man discussed Having sex with his 14-year-old daughter that was probably the hardest group I've ever done or the hardest

session I ever had to listen to somebody be so open with that." P7 responded, "Difficult working with the juveniles. The ones that were engaging on regular self-harming--that I did find difficult to process cause they're just children. They're just kids and to see them in that kind of pain and doing the things that they were doing to themselves. Day after day, there was a point where it was pretty consistent that that was pretty hard for me to deal with that. You know it made me very sad. It made me very upset, and it made me very scared. At times, I don't know what I was gonna walk into work there. Yeah, I would say that." P8 responded, "I have struggles. I have noticed that I have struggled in regards to placing boundaries in regards to when I'm providing the counseling a lot of the times I do feel because these are very young offenders. I feel that they kind of see me as their mother and I have to build those boundaries."

Perceptions of Offenders

The attitudes and perceptions that some clinical professionals may exhibit toward their patients can have a significant impact on treatment delivery and outcomes (Bryant, 2006). P3, P5, and P8 shared their experience how they have perceived offenders differently based on their offense. For example, P3 reported, "I think the biggest defensive tends to be more judgmental about is sexual abuse against children is one that I have a hard time empathizing with a reason if I'm presented with someone with that charge." P5 responded, "They'll [pedophiles] always be pushing for territory if you think of it as a territorial fight. And that territory in prison is emotional and physical." P8 shared her experience and how she has viewed offenders differently; however, it has not hindered her therapeutic engagement skills. P8 said:

> I will view I do deal with offenders that have been there for murder as well as sexual assault towards children and things like that, so their felonies have been. I mean, I have [viewed offenders differently based on their offence], but at the same time it has not played a significant role, or it has not prohibited me to provide them with the therapeutic engagement or therapeutic counseling that I can still give them, but it has.

Inward and Outward Emotional Signs

Participants shared their experience in recognizing when they are experiencing countertransference. The sign that participants identified when they experience countertransference were strong emotional reaction. P1 responded, “So any strong emotional reactions that I have is a really giant red flag for countertransference. They [strong emotional reactions] would feel on the inside like either a heavy, heavy frustration or repulsion.” For example, P1 shared an example, “On a personal level, it's [lack of patient buy-in/commitment is] frustrating because it does it kind of engages us at that counter transference and it reminds me of my mom not wanting to be any different so on a personal level at frustrates me.” Another example provided by P1 when she experiences strong emotional reactions is having the urge to end treatment immediately. She explained, “[when having strong emotional reactions] I want to. I want to get away and in this session immediately like I want to I don't wanna talk to this person anymore. I don't wanna hear anything that they have to say I want out of the room.” P2 indicated, “Well, when I start to notice that I'm feeling upset, or I spend a lot of time on this psychoeducation how their decisions are impacting their children. I observed myself

feeling disappointed and upset because the offender places their needs above their children's." Additionally, participants may experience strong emotional reactions when their views do not align with the views of offenders. For example, P4 shared her experience when a client's views did not align with hers. P4 indicated, "You know I just had a recent client who's getting an abortion, and I just feel so bad for the situation whether they're pro-life or not it's I felt so strong for her, but I also felt so strong for the baby and that was a really weird torn feeling to have and I could feel that anger and frustration coming up of like if she only knew she could get through this and so I don't know if we could count that as countertransference right now." P5 responded, "I look at I'm just trying to think how to quantify that I look at whether my emotional reaction is stronger than what it normally is." P5 shared an example of a strong indicator for countertransference, "I start feeling resentful toward a client in the session, but I can't really pinpoint why. I'm just I don't wanna go in that day. I don't wanna have to deal with them. I don't wanna hear the story again."

P6 indicated identified her signs of countertransference, "I get really confrontational with authority, and I don't want anything to do with watching movies or films about jail and incarceration, but I don't have a problem talking to people face-to-face if that makes any sense." P7 shared how working with young offenders who often engaged in self-harming behavior caused strong emotional reaction. P7 responded, "Difficult working with the juveniles The ones that were engaging on regular self-harming--that I did find difficult to process cause they're just children... Day after day, there was a point where it was pretty consistent that that was pretty hard for me to deal

with that. You know it made me very sad. It made me very upset, and it made me very scared. At times, I don't know what I was gonna walk into work there. Yeah, I would say that." P8 responded, "It triggers me and makes me very confrontational, so I will immediately address it in a very confrontational and at the same time defensive approach where I have to kind of take a step back." P9 responded, "A lot of how I identify it is with my thought process, I would say so when I catch myself kind of thinking about myself and not so like not so much about the youth and how they might be feeling, and I start to feel it within myself."

Past Connections

As clinicians expressed their emotional reactions when working with offenders, they were able to associate who their countertransference is associated with their ACEs. For P1, "A strong emotional reaction or if like any patient who remind me of my mother are I just stay on guard just even that thought of oh this is like my mom like even that just that single thought by itself I'm like oh so then I watch out for countertransference with any patient that reminds me of my mom." For example, "So anyone who is engaging in repeated, and Kind of ostentatious non-suicidal self-injury so kind of big non- suicidal self-harmed gestures repeated manipulation anything that kind of anything that smacks of a borderline personality disorder or history on a personality disorder trait. Usually who tends to lead me to think of my mom." P4 indicated, "It's pretty obvious when I'm feeling that because I work with a lot of survivors. But I would say even in the prison system in groups before knowing the term countertransference that would happen because I was so

connected to who they were as in it was like my dad was there [prison]. They reminded me of my father a lot and so there's always this this moment of."

However, through their work with offenders, clinicians have increased their awareness of their purpose in treatment and addressing incongruence in treatment. P4 responded, "I have to remind myself of why I'm there what we're there for, So I think countertransference is extremely healthy for clinicians. How could it not be? We are human." P4 responded, "But I hide it so when I when I know that something's happening internally for me, I tell myself that I have to remind myself that it's about them, not me and so to kind of flip the emotion." P5 responded how she addresses incongruence in treatment, "It's very often it's unconscious pressure by the client to test and see if I'm going to back off. If I'm feeling uncomfortable in session to call it out and say, 'hey, I have this weird feeling today and I'm wondering if there's something more you wanna talk about or something else or if you're having a problem with me and I'll I call it kicking the elephant in the room and usually that's when the client starts making progress."

Triggers

P8 said:

> I do identify there's a lot of triggers that occur in regards to my own feelings in the environment that I work with. I do work under a lot of at times a lot of stress; a lot of loud noises, banging constantly on the windows on my office window on my door. So, I immediately when I hear that because of my ACEs and because of my past childhood home I guess home environment.

Theme 3: Resilience

The third theme that emerged was resiliency. Interview question that prompted responses from participants for RQ1 was "How do you identify when you are experiencing countertransference in your professional practice, How often do you engage in supervision or consultation, How do you manage and/or work through your childhood experiences, and In your opinion and experience, how do you achieve resiliency?" Participants each expressed different ways that they manage through their childhood experiences to achieve resiliency, identifying countertransference, and engagement in supervision or consultation. There were four subthemes that emerged from the data (a) client engagement, (b) support system, (c) ways of thinking, and (d) self-care.

Subtheme 1: Client Engagement

The data analysis reveals clinicians can become desensitized through their work with criminal offenders. For example, P1 responded, "It's [working with this population] desensitized me to a lot of things in the real world my coworkers and I often joke. I mean I'm sure you know dark jokes are common in this field, but we often joke that we won't know what to do if we're ever threatened in the real world because I mean, verbal threats are constant where we work... It's desensitized me too quiet a lot."

Through their work with offender's P2, 3, and 8 shared that they are more empathetic in their professional practice. P2 responded, "I kind of try to be Bible-focused so you know no judging others and just you know one bite I kind of start I kinda you know I try to I could switch back and try to put myself in their shoes." P3 responded, "Empathizing is understanding like... we all have life situations that can get us to a place

where committing crimes...Understanding that you know, we're all humans and we all make mistakes." P8 said:

> These are children right so having said that. I manage my interaction with the youth and then I always kind of think back and continue to remind myself of the importance of being you know very empathetic putting myself in that situation. Okay, how would I react? What would I think? No wonder you know this youth is very defensive and does not have good trusting relationships.

Self-Awareness

P1, P3, P5, P6, P7, and P8 shared how their work with offenders has increased their self-awareness of emotions when interacting with offenders. P1 responded, "If I noticed that I'm having a particularly strong emotional reaction." P3 responded, "I will also say it like self-awareness." P3 responded, "I'd say really I look at my body sensations like if I'm noticing anxiety or if I'm like going into the session or seeing them on my schedule if I'm starting to hope that they don't come in or I start to feel unwell or you know get really Just say just anxious really that kind of tells me there's something going on with the client." P5 responded, "It's very often it's unconscious pressure by the client to test and see if I'm going to back off. And so I've learned to use that as a guide if I'm feeling uncomfortable in session to call it out." P6 responded, "Based on things I've read and studied and learned, I've either come to learn what I thought about it was wrong and I've read. I've changed my thoughts about it or I confirm that was right because I've always kind of self-psychoanalyze why did I do this? Why did this happen? Why is this happening? My own stuff is making sense of what did happen and knowing. I was right

wrong about it." P7 responded, "I use mindfulness a whole lot like I said learning DBT trained help me really understand why mindfulness is so important you know what's happening with my thoughts and my body and my emotions in the moment." P8 responded, So just me kind of being very you know self-aware and in regards to like my counseling I have to practice a lot of meditation a lot of you know mindfulness so that way I can proceed you know in providing a good therapy relationship."

Awareness of Responses

The data analysis revealed that participants increased their awareness of own responses by reflecting on what they are feeling and their interactions with offenders. Participants 1 and 5 spoke about their awareness of own responses. For example, P1 responded, "I take more stock of my own personal like reactions to them so that I can keep an eye on what's going on within me. I'm just very much more careful of how I interact with them." P3 spoke about increasing her awareness to her own needs:

> Recognizing when I need to take a break or when I need to rest so like I imagine with my grandpa dying by suicide, I tried to go back to work like three days after. I was not OK. I talked to a client who was contemplating suicide, and I was like I have to save this person, and I can't. I need to take some time because that's not my role. I'm not here to save this person. I'm here to support and work alongside them and so yeah recognizing when you need to take a step back or when you need help and support.

P5 responded, "Let's say that I start feeling resentful toward a client in the session, but I can't really pinpoint why. I don't wanna go in that day to deal with them. I

don’t wanna hear the story again.” P6 responded, “I'll see some dumb commercial that was a little bit sad or something. I know I feel emotional about it. It's like 'What in the world is wrong with me?' So, I'd start thinking about it. So, after a while of thinking about it, he was like okay well, how we work at that have come from then I'll trace steps backwards.” P7 responded, So I constantly try to check in with myself and check in with you know how my thoughts are sounding, what my emotions are, and then I try to do either some deep breathing or I'll do some of the DBT techniques.”

Subtheme 2: Support Systems

This qualitative research study examined how clinicians perceive how they achieve resiliency and professional growth. Within this subtheme we gain an understanding of how personal therapy, supervision, and peer consultation contributes to participants resiliency and professional growth. P3 shared her social support plays a significant role her professional practice. P3 responded, “I would say the biggest thing [to achieve resiliency] is social support on having understanding people that you can talk to whether it be a therapist or friends or family members.” P7 responded, “I make sure that I have a really good support group around me. That's there for me if I need any sort of emotional support, I think that's really important.” P9 responded, “I find that support in wherever whoever it might be finding that support of within my mother within my siblings, my peers, professors that I once had you know during my academics...but I feel like the positivity and the support came hand-in-hand with having a good support system.”

Participants 1, 3, 4, and 5 engage in personal therapy which has helped them maintain overall well-being and resiliency. P1 responded, “Personal therapy is a big one personal therapy and a very good support network at work is able to point out if I'm off the mark [or something related to ACE]. No, not really, I just personal therapy.” P3 expressed, “[to work through my childhood experience] Well, I do therapy and I've been in and out of therapy for like 10 years or so maybe a little bit last so that's been the primary thing. Yeah, really therapy. I can't really think of much else.” P4 responded, “Therapy I've been in therapy since I mean, I went to therapy when I was a child because I was probably a problem child not you know. My parents weren't aware that they were the problem”. P5 responded, “Let's see I have done. I can't tell you exactly how much therapy I've done because it's been on and off through the years but if you weren't at it altogether, it would have to be at least 10 years’ worth of. Individual therapy to work through it plus medication.”

Other factors that participants shared has helped with professional development includes supervision and peer consultation. In clinical supervision, all participants reported receiving weekly guidance, support, and feedback from their supervisor or peers. P1 responded, “I'll usually go debrief it with my supervisor or a colleague and kind of talk through it to figure out if I can't figure out on my own, what's going on to figure out what it's what it's pulling up for me.” P2 seeks consultation when she feels upset about a certain offense or situation, “I can talk weekly with other members of my team to discuss the cares that the cases I'm sorry that have caused me to feel upset on their offense Like the sexual abuse of a child, you know, The pornography. All those types of cases out

there.” P3 responded that they did engage in supervision or consultation “very often. I'm in the last week actually of my second internship so I have back supervision my supervisor and I also have. Administrative supervisor that I meet with all of them weekly so lots of supervision. At least twice.” P4 responded, “Well, I don't have supervision anymore, but I miss it. I'd love it. I wish we could still do it but now I am one so, but I do consult. I have close friends that are clinicians, and we talk probably once or twice a day. Whether it's about an insurance issue or it's a client that it was a tough one like that abortion one I had to go and talk that out with somebody.” P5 responded, “At least once a month [I engage in supervision or consultation]. I've gone in up to once a week for periods of time because. My cases were so challenging. For example, let's say I start working with a client and find out after I start working with them that they have thoughts of hurting a child.” P6 reported, “Once a week. We consult on PTSD and its coordinated comorbidities.” P7 responded, “For myself I genuinely try to attend monthly trainings as far as supervision that's kind of as needed. It's not something that's like on a rotation or anything like that.” P8 mentioned, “I believe once minimal has been once a week as far as my like my supervision, a consultation, maybe two to three times a week because I do have the support in the facility where I can go and just consult about different situations that I have experienced there in with other youth in the within the facility. Yes, supervision would be at least minimum once a week consultation between two to three times a week with my peers.” P9 shared the frequency of supervision, “About once a week, it's about a group revision, and we discussed all the cases whether we make progress or have not with our supervisor.”

Subtheme 3: Ways of Thinking

Data analysis demonstrates a consistent emphasis by participants to remain honest with themselves about resiliency, maintaining a positive outlook, practicing gratitude, and focusing on the positive impact they make with the offenders they treat. P4 responded, “You know the hard work through resiliency was actually allowing myself to feel what I was feeling, but honesty is my key characteristic that I hold onto an integrity to make it through and be honest about things I've done things I've been through and where I am today where I wanna be.” Participants 1, 3, 7, and 9 share how they maintain a positive outlook on life. P1 responded, “Having hope [and] a positive outlook, I guess that things can get better.” P3 responded, “Resiliency-I'd stay It's too fold. It's bouncing back after challenges.” P7 responded, “By making sure that I focus on my successes and not so much on where I don't get failures and failures, I just look at them as places where I need to do better learn more you know where I can improve.” P9 responded, “I feel like we have come where I currently am right now like even having gone through my ACEs just a lot of it has as cliché as it might sound a lot of it has to just not give up.” P9 further explained, “I was able to think positively and push myself to keep going forward you know and not stay stagnant. You know because of my ACE and not have that kind of handicap me into not being able to achieve the things you know that I want to like achieving a higher education and in the future, you know achieving licensure for my doctorate.”

P5 engages in daily gratitude to help her maintain resiliency. For example, she shared, “Daily frequent gratitude. I'm sitting here looking out my window watching the

birds come to my birdfeeder in my cat. Watch the birds and I'm grateful for that those simple things. Or I'm grateful for the mountains I can see out in my window, you know, and I find these little tiny things that I noticed in life all the time to be grateful for And I also look at ways in which I've survived in the past and how I can put that to you in the future."

P1 shared her positive impact in stabilizing offenders to return to court is a strong contributor to her resiliency. P1 responded, "Our unit has made some real differences. We've been able to get people competent so they go back in and handle their charges that we thought would never be able to be competent. I consider that not only good for the patient themselves and that they need to go get their charges and get their life handled, but also good for any potential victims as in that enables justice to move forward." P2 responded, "There's been multiple occasions that I have been able to help these offenders take accountability for their actions and commit to make to make positive changes." P3 responded, "When there is success, though it is a bigger success." P3 shared an example, "Traditional outpatient counseling it feels like there's more hurdles that you overcome it's more meaningful because when people like I have a client for example that was facing prison time and she went to treatment and now she's doing exceptional and so having that experience and feels a lot more rewarding because I can see how rewarding it is for her and how well she's doing." P4 responded, "As a clinician, yeah you know it is it was life changing. I loved it. I miss it every day. I have a picture on my refrigerator right now with me and some inmates from a group we did, and I have a banner and where they

signed you know little going away things to us when the group ended, and those things means so much to me in a lot of my a lot of my core memories."

Subtheme 4: Coping Strategies

The data reveals that clinicians who have experienced an ACE and work with offenders use different coping strategies to handle their professional roles. Under the subtheme coping strategies, participant shared how each of their skills contributes to their resilience. P1 responded, "I prize my hobbies. I love I love to read, and I love to play video games and so my kids and I play video games and board games together and that's one of the big things that is like top of self-care routine is to play with my kids." P2 responded, "I'm in school right now so just schoolwork." P6 responded, "There's just a number of things I can do. I've got a lot of hobbies and stuff." For example, P6 discussed their drive home helps with maintaining work-life balance. He explained, "Coming home I got a 30-minute drive home. I listen to the radio or whatever and it doesn't. It just doesn't come home with me." P9 shared how she sets calendar reminders that remind her to not focus on work after 5PM, "I have you know these little have a little signal for myself so excuse me, I'll have like a note on my calendar saying OK like don't focus on work... I like to see a lot of kind of encouraging and inspirational posts as well specifically within individuals who have gone through trauma…blog posts that are related to you know, therapist and counselors and encouraging one another."

P2, P6, P8, and P9 shared how they engage in self-care which includes participating in activities with their family. P2 responded, "I try to just be the best mom I can be the mother that that I need to be to my kids. I have them in every sport you can

think of, so I keep busy. They're in it so just keeping busy." P6 responded, "When some things do get to me, I have my dog, I have instrument to play. My wife is a really good person to talk to." P8 responded, A lot of the things that I do again, you know I am I ensure that at least one day one whole day I get to spend with my family, with my children, and I am very present with you know with what they have to tell me once I get home." She further explained, I'm present physically and also emotionally mindfully and we do take you know short trips here and there." P9 responded, "As well and being with my family too, I would say it has to be like a really important part of it and again brings me to my center and spending time with my pets and especially being mindful when I'm with family, I would have to say it."

Other examples of self-care practices included praying, yoga, mindfulness, and physical self-care such as massaged. For P2, maintaining a connection with her faith and children helps with achieving resiliency. P2 responded, "I've have to spend a lot of time praying. I do attend bible study. I believe that I achieve resiliency by being connected to my faith, my children, and just you know it's really, really big on faith I try to live by the word of God and that's it." P4 responded, "I'm just learning radical acceptance and how to emotionally regulate and then obviously my faith God has healed me, and he's made so many things new it's unreal and so." P8 responded, "I do get my massages. I am very into the holistic therapeutical massages as well as my pedicures my nails. I do a lot of facials, so that is how I would practice a lot of like self-care." P8 responded, "Again a lot of self-care massages a practicing yoga you know things like that word's kind of more. Tied into nature just because my environment isn't a facility once I get home, I like to take long

walks with my pads a lot of times with my kids as well and be reconnected with nature." P9 responded, "I do a lot of I do a lot of self-care I have gotten into the habit of once I am done with work."

Summary

This basic qualitative research study aimed to understand clinicians' perspectives of their lived childhood adversities, resiliency, and treatment engagement of criminal offenders. Chapter 4 describes data gathering, collection methods, and a summary of themes for this basic qualitative research study. All participants shared their lived experiences and the impact it has had on their professional practice while working with criminal offenders. Three themes that emerged from the raw data were the following: (a) client interactions, (b) countertransference, and (c) resiliency. The findings of this study reveal that clinicians who experience ACEs seek a helping profession driven by curiosity and motivation to break generational cycles. Furthermore, findings reveal that participants have had their own experience with childhood experiences that allows them to have higher level of empathy and connectedness with offenders. However, they each explained how their work has impacted their lives in a positive and negative manner. They all gained some awareness of how their work has resulted in becoming more vigilant, mindful in their therapeutic engagement skills, and working on maintaining resiliency. Also, these findings show the importance of continuous support, self-care practices, and mindfulness practices to lessen the effects of personal trauma, particularly as shared in relation to reactivated personal trauma (Ortiz, 2024). In Chapter 5, I defined

explanations of the findings, study limits, future study recommendations, implications, and the study's conclusion based on the findings of Chapter 4.

Chapter 5: Discussion, Conclusions, and Recommendations

ACEs are a daily crisis that U.S. societies face, impacting individuals, families, and future generations. As a result, it is crucial to gain a deep understanding of personal stories and perspectives of adults who have lived through these experiences, as they can provide valuable insights regarding how these events continue to affect their lives in adulthood, informing more effective support and intervention strategies.

The purpose of this qualitative study was to explore clinicians' perceptions of how ACEs influenced their professional practices, resilience, and engagement with criminal offenders.

A purposeful sample of nine clinicians who experienced ACEs and worked with or had worked with criminal offenders participated in this study. The sample of participants included licensed professional counselors and social workers. Each theme and results were analyzed to answer the research question: How do clinicians describe their perceptions of how their ACEs shaped their professional practice, resiliency, and engagement of offenders?

Three main themes emerged: client interactions, countertransference, and resiliency. Furthermore, eight subthemes emerged from data analysis: client engagement techniques, life impacts due to client interactions, awareness of effects of ACEs, signs of countertransference, client engagement, support systems, ways of thinking, and coping strategies. This chapter includes interpretations of findings, limitations, recommendations, implications, and a conclusion.

Interpretation of Findings

In the United States, 60% of individuals have experienced at least one ACE, which has deleterious effects on physical, psychological, and mental health of children and adults (Clunis, 2023; Lee et al., 2022). Results of this study were consistent with similar studies addressing clinicians as wounded healers, survivors of trauma, and working with criminal offenders. Many clinicians who have experienced ACEs are drawn to working in the profession to help others heal (Cahak, 2021; Ortiz, 2024; Straussner et al., 2018). P4, P8, and P9 shared how their ACEs helped them understand the struggles offenders face, which increased their empathy towards them.

Brown et al. (2022) found mental health clinicians have higher rates of ACEs, with 93% to 95% of counselors reporting at least one to eight traumatic experiences in their lifetime. Participants in this qualitative study expressed their perceptions of their vulnerability to countertransference. They shared signs of countertransference and were aware about how their ACEs influenced their work with offenders. P3, P5, and P8 shared their experiences involving how they perceived offenders differently based on their offenses. When participants came to realize their vulnerability to countertransference, they sought supervision or consultation.

Findings of this study include insights regarding the role of clinicians who have ACEs and the importance of establishing supportive measures to address vulnerable population such as criminal offenders. Participants reported they entered the helping profession due to their personal experiences. The three main themes that emerged were client interactions, countertransference, and resiliency.

Theme 1: Client Interactions

Prevalence of female practitioners who experienced ACEs was a common theme, and they are more likely to enter the clinical profession to help others heal. This theme confirms what Straussner et al. found in their study, indicating that clinicians with a history of ACEs are attracted to the counseling profession to help others heal. For example, Eight of the nine participants were females, and they reported significant ACEs compared to the one male participant.

Moulden and Firestone (2007) reported therapists who experienced emotional hardening tended to have difficulty engaging in effective therapeutic relationships, showing empathy for their clients, and believing change is possible. Data demonstrated clinicians can engage in effective therapeutic relationships and show empathy for their clients. P4, P8, and P9 shared how their ACEs have helped them understand the struggles of offenders. They shared their ACEs also increased their level of empathy towards offenders. P4 expressed, "I do best and that's connecting with people and that's how it impacts who I am as a counselor. I understand that connection and empathy and compassion are ultimately gonna be the three characteristics that I need to uphold in any type of professional practice in the counseling field." P8 said, "having experienced [not being in safe environment] as a child I believe has made me way more empathetic in regards to providing my counseling towards youth." P9 stated, "I believe because one of my parental figures was not present when I was younger, I do feel very empathetic with individuals that come across in my profession that also have absent parents, and it does make me empathize with them, and I sympathize as well." Clinicians with childhood

traumas are more empathetic towards female sex offenders (Bryant, 2006; Stapleton, 2022).

Ortiz (2024) and Cahak (2021) found that therapists who had been wounded were ideal professionals who could provide their clients with empathy, compassion, patience, and acceptance. Zerubavel and Wright (2012) noted that wounded healer's own lived experiences involving suffering can help clients heal. As indicated by the findings in this study, the majority of participants reported being more empathetic and compassionate with criminal offenders because of their lived childhood experiences and the difficulties survivors face. P4 confirmed what has been previously reported in the literature by Ortiz, 2024; Cahak, 2021; and Zerubavel and Wright, 2012). P4 stated, "as a victim, as you know my dad being in and out of jail his whole life and then being killed." Having experienced this, she explained, "I've always been very fascinated by why people do what they do, but I also have a great compassion and mercy for many in the system as a whole." P5 also confirms what has been previously found in the literature on being empathetic with others.

Furthermore, the outcomes of this qualitative research study confirm Warmke's (2025) conclusions, which were that post-traumatic growth played a role in the career decisions of participants in the form of learned helping skills, increased empathy, enhanced therapeutic traits, therapy attendance, increased desire for social justice, and increased curiosity about human behavior. P9 confirms clinicians' decision to work in the field is driven by curiosity of human behavior. For example, P9 began working with this population because "my father was incarcerated for quite a few years." Having lived this,

she "was curious to see how other children it affected them." Living with an incarcerated parent as a child, she wanted to "see how I could work with these youths that I had at least a little bit of similarity [incarcerated parent] with them."

This theme of client interaction confirms what has been previously identified in the literature regarding clinicians as wounded healers and being effective in their role as clinicians. However, they are vulnerable to transference and countertransference, which continues to be a growing interest in identifying interventions for managing the risks associated with past trauma.

Theme 2: Countertransference

The findings of this theme confirm previous research. Adverse childhood experience does place clinicians at a higher risk of vulnerable to triggers, resulting in emotional responses such as avoidance and countertransference.

According to Pearce et al. (2019), when clinicians have experienced ACEs, they may be more susceptible to triggers that can interfere with their ability to provide adequate care for their clients. These triggers can lead to emotional responses, such as anxiety, anger, or avoidance, which can compromise the clinician's professional judgment and effectiveness in therapeutic interventions. The results demonstrate that clinicians who have experienced ACEs are vulnerable to triggers, resulting in emotional responses such as avoidance and countertransference. The responses from P1, 2, 3, and 5 who are judgmental, strong emotional responses, or avoidance of specific offenders based on their offense confirms what Straussner et al. (2018) found in their study on countertransference by clinicians in clinical practice. P1 responded, “They [strong emotional reactions] would

feel on the inside like either a heavy, heavy frustration or repulsion." P2 shared that they have viewed offenders differently "especially the ones against children, and it's just honestly disgust at times." P3 mentioned, "I think the biggest defensive tends to be more judgmental about is sexual abuse against children is one that I have a hard time empathizing." P5 reported she "refuses to work with pedophiles because of the manipulation and grooming… I just find it's so offensive that anybody would hurt a child." The response from participants 1, 2, 3, and 5 confirms what has been reported in the literature by Bernard (2021) which emphasizes on the need for supervision to treat offender effectively while clinicians manage the challenges associated with working in a correctional environment.

Theme 3: Resiliency

This theme of resiliency disconfirms previous research, such as Warmke (2025) and Elliott and Guy (1993), who reported that clinical psychologists experienced higher levels of trauma impacting their ability to provide adequate mental healthcare services, and significant psychological distress in their adult lives because of their dysfunctional family dynamics growing up. During all the interviews, participants did not express significant psychological distress resulting from their ACEs or their inability to provide adequate mental healthcare services. On the contrary, participants 1, 3, 4, and 5 engage in personal therapy which has helped them maintain overall well-being and resiliency. P1 responded, "Personal therapy is a big one personal therapy and a very good support network at work is able to point out if I'm off the mark [or something related to ACE]." P3 expressed, "[to work through my childhood experience] Well, I do therapy and I've

been in and out of therapy for like 10 years or so maybe a little bit last so that's been the primary thing. P4 responded, “Therapy I've been in therapy since I mean, I went to therapy when I was a child.” P5 responded, “Individual therapy to work through it [ACE] plus medication.” Furthermore, the responses from the participants in this study confirm what Symister (2023) found in his study of mental health clinicians playing a pivotal role in assisting the public with managing the effects of trauma and mental illness. Nevertheless, they are not immune to its effects. As evident in the interviews, clinicians were forthcoming about sharing their mental health challenges and how they maintain resiliency.

The findings from this study expands on the previously published results of Rosenberger (2023) and E.M. Brown et al. (2022) findings of the need for attention to be given to the traumatic experiences of counselors and professional resilience. This study focused on paying attention to how clinicians achieve resiliency based on the need for further understanding how clinicians achieve resiliency in their personal and profession. Within the interviews, participants discussed how they overcome their childhood adversities and their healing process. For instance, P2, 6, 8, and 9 shared how they engage in self-care which includes participating in activities with their family. P2 responded, “I try to just be the best mom I can be the mother that that I need to be to my kids. I have them in every sport you can think of, so I keep busy. They're in it so just keeping busy.” P6 responded, “When some things do get to me, I have my dog, I have instrument to play. My wife is a really good person to talk to.” P8 responded, A lot of the things that I do again, you know I am I ensure that at least one day one whole day I get to

spend with my family, with my children, and I am very present with you know with what they have to tell me once I get home." P9 responded, "As well and being with my family too." The participants discussed in their interview their childhood adversities, such as being exposed to alcohol abuse, drug abuse, mental illnesses, physical, or sexual abuse by parents, relatives, or primary caregivers. As participants began their healing process, they reported successfully continuing their resilience through the identified self-care strategies, despite what had been previously published about the lack of effectiveness in resiliency, treatment services, and overcoming past adversities.

Findings Relevant to the Theoretical Framework

The current study guided by resiliency theory developed by Garmezy (1991), a pioneer in resiliency research who formulated the theory to identify the protective factors that allow individuals to navigate life stressors successfully. Resiliency theory focuses on positive contextual, social, and individual variables that interfere with or disrupt developmental trajectories from risk to problem behaviors, mental distress, and poor health outcomes (Zimmerman, 2013). Zimmerman (2013) postulates that resiliency comprises resources composed of outside individuals, such as parental support, adult mentors, and youth programs that provide opportunities to learn and practice skills. The theme of resiliency confirms what has been previously published by Zimmerman (2013). For instance, Participants 1, 3, 4, and 5 engage in personal therapy which has helped them maintain overall well-being and resiliency. P2, 3, 5, 7, 8, and 9 all reported engaging in peers, mentors, or supervisors when confronted with complex cases. For example, P5 responded, “At least once a month [I engage in supervision or consultation]. I've gone in up to once a week for periods of time because. My cases were so challenging.” P9 shared the frequency of supervision, “About once a week, it's about a group revision, and we discussed all the cases whether we make progress or have not with our supervisor.” Mesman et al. (2021), coping skills are essential to resiliency. All the participants identified their unique coping skills as factors that help them achieve resiliency, which supports the published literature on resiliency. P1 responded, “I prize my hobbies. I love I love to read, and I love to play video games and so my kids and I play video games and board games together and that's one of the big things that is like top

of self-care routine is to play with my kids." P2 responded, "I'm in school right now so just schoolwork." P6 responded, "There's just a number of things I can do. I've got a lot of hobbies and stuff." For example, P6 discussed their drive home helps with maintaining work-life balance. He explained, "Coming home I got a 30-minute drive home. I listen to the radio or whatever and it doesn't. It just doesn't come home with me." P9 shared how she sets calendar reminders that remind her to not focus on work after 5PM."

The data analysis results illustrate how clinicians'' perceptions of resiliency, including therapy, family support, and adult mentors, empower them to overcome adversity through therapies. Furthermore, the attributes of developing resiliency, which include skills, strength, support, and trust (Ellis et al., 2017), are known as protective factors. Throughout the interviews participants were able to identify protective factors which are vital in them maintaining resiliency and achieve positive personal mental health outcomes.

Limitations of the Study

This study consisted of only nine participants, making it challenging to represent the general population. The study's inclusion criteria and scope should be evaluated when determining the study's transferability to the broader field of human services practice (Nowell, 2024). Other professionals, such as probation officers, correctional officers, and substance abuse therapists, may have been interested in sharing their perspectives on their work; however, the inclusion requirements prevented them from participating, making the findings difficult to apply to a larger field of human services practice, settings, or populations. The chief limitation of a small study was that the results were not

generalizable beyond the small sample (Beverly, 2020). I identified this limitation during the study's planning, and it is a common issue in qualitative research in general. The number of research participants was only nine, which may be insufficient to represent the general population. The second limitation is related to subjectivity, where the interpretation of data could have been influenced by my personal biases working with criminal offenders, potentially affecting the validity of the findings (Ortiz, 2024). However, it is crucial to emphasize that I was mindful of my biases while evaluating and interpreting the data, focusing on recurring themes and patterns, and adhering to established data analysis procedures. The final limitation is related to participants underreporting the impacts of their ACEs on countertransference and personal impact based on their gender.

Recommendations

In this section, I offer recommendations for future research based on the implications and limitations of this study and the literature review in Chapter 2. This basic qualitative study focused on understanding the perception of clinicians lived ACEs, resiliency, and treatment engagement of criminal offenders. Although I gained a greater grasp of each of their difficulties, which had a positive and negative impact on the clinician's personal and professional progress while working with criminal offenders.

The findings of this study support that there is not enough research available on female clinicians and their willingness to engage sex offenders in treatment. Therefore, future researchers should consider conducting interviews with female clinicians to investigate their treatment engagement of sex offenders. Research should investigate

further their perception of the severity of the offense and the age of the victim. A comparative analysis with other clinical roles such as social workers, licensed psychologists, licensed professional counselors, licensed psychological associates, and psychiatric nurses yields different engagement patterns. The result from this study suggests that attention should be given to female clinicians based on their response of having a strong emotional reaction or avoidance to sex offenders. Future research should also consider exploring how clinicians' training status influences their treatment services with offenders. Furthermore, future research should focus on clinical psychologists who have experienced an ACE and work with criminal offenders.

I recommend that future researchers focus on male clinicians who have experienced an adverse childhood experience and work in corrections to determine whether there is underreporting of the personal impact of their lived adversities based on gender role expectations. In this study, there was one male participant who denied countertransference or perceiving offenders differently based on their offense.

Another recommendation for future researchers is to explore further the personal impact of their work with criminal offenders on family dynamics. The results highlight the personal impacts of working with criminal offenders on clinicians and their families. Strong consideration should be given to the severity of clinicians' hypervigilance from their work with criminal offenders based on their offense and the setting of treatment services. For instance, do clinicians experience higher levels of hypervigilance when working with specific offenses, gang affiliation, and services being offered in a prison versus an outpatient clinic.

A recommendation for future research is to explore clinicians' perceptions of their emotional reaction to criminal offenses based on the offender's gender. The participants in this study all worked with male offenders; therefore, there is no information suggesting that there is a variation in emotional responses based on gender. It would be beneficial to explore whether clinicians are more empathetic and supportive of female offenders than male offenders based on the severity of their offense.

Another recommendation based on the results of this study and previous literature is the frequency and intensity of significant emotional distress working with incarcerated offenders with clinicians who have experienced childhood adversity. Although there is previous research, such as Warmke (2025) and Elliott and Guy (1993), who reported that clinical psychologists report experiencing higher levels of trauma impacting their ability to provide adequate mental healthcare services, and significant psychological distress in their adult lives because of their dysfunctional family dynamics growing up. There is no indication that this has been explored with the population in this study.

A recommendation that should be further investigated based on the findings of this study is the effectiveness of consultation and supervision of clinicians who experience countertransference exacerbated by the nature of the offense of criminal offenders. Future researchers need to investigate whether supervision and consultation can help treatment engagement of offenders and treatment outcomes. Furthermore, future researchers should pay close attention to clinicians' gender and frequency of consultation. For example, in this study, females expressed frequent consultation and supervision compared to the one male participant.

Future researchers may also benefit from having a higher number of participants exploring clinicians' perception of violent offenders (i.e. murders, high profile offenses, or rape) and treatment outcomes. Although this study reached saturation, interviewing more clinicians may have revealed additional information on clinicians' own biases and treatment outcomes of violent offenders.

Implications

This research study deepened the understanding of the impact of ACEs on clinicians and the impact it had when providing treatment services to criminal offenders and resilience. The results indicate that clinicians can overcome their adversities; however, their personal biases and adversities influence the selection of their clients.

An implication of this study would be on an organizational level and possibly a policy and societal level. The majority of participants in this study expressed strong emotional reactions and viewed offenders differently based on their offense. For instance, clinicians expressed viewing sex offenders differently or being unwilling to work with such a population; therefore, there is a need for more supportive interventions and treatment policies. This could lead to policy development in the criminal justice system, as there is a need to address clinicians' personal biases towards this population.

Additionally, this study can influence positive social change for the criminal justice system to develop protocols for clinicians to engage in a minimum number of hours of supervision and case consultation for novice clinicians working with criminal offenders. Implications for constructive societal transformation on an individual level. Having information on what clinicians have experienced may help inexperienced

clinicians working with offenders understand treatment engagement approaches and overcome trauma. This knowledge may assist higher education institutions in implementing educational methods that promote training in counseling approaches, services, resilience, and resources for treating this group (Melton, 2023).

An implication for positive social change is that, on the organizational level, female clinicians experience different symptoms of countertransference than male clinicians. This is significant for criminal justice stakeholders to develop protocols to continuously monitor emotional distress, countertransference, and burnout among those in a clinical role. It would be beneficial for organizations to develop self-care protocols and incentives to help those in the helping profession maintain resiliency and reduce the risk of countertransference and vicarious trauma.

This study offers new insight and expands the existing literature on clinicians and ACEs. The implication from this study is expansion from a theoretical approach of resiliency theory. The study expands previously published findings of the effectiveness of personal therapy to achieve; however, there is no information on the resilience of clinicians who experience an adverse childhood experience and work with diverse criminal offenders involved in the justice system.

At the research level, the results from this study may lead to positive social change in reducing the stigma surrounding clinicians as wounded practitioners. In this study, clinicians spoke freely about the adversities that led to their career selection and the impact of their lived adversities in their personal and professional lives. This will help

to normalize the discussion of traumas and increase the effectiveness of personal therapy, self-care, and work-life limits.

Conclusion

In this study, I sought to determine the perception of the lived childhood experiences of clinicians and their professional practice when working with criminal offenders and fostering resilience. The findings of this study show that clinicians who have experienced an adverse childhood experience are an asset to the field based on the desire to help others and perseverance to maintain resilience. The participants in this study are an admirable representation of the power of healing to overcome their adversities and the dedication to the clients that they serve.

The data collected from the nine clinicians showed that their career decision was driven by their childhood adversities and the desire to heal others. The themes convey the positive outcomes when working with criminal offenders despite having had a traumatic experience prior to the age of 18. Clinicians agreed that creating and sustaining family and peer support, personal treatment, establishing boundaries, religious faith, and positive thankfulness were the most effective ways to create resiliency. The findings provide more insight into how trauma shaped their clinical practice and client engagement. The results also show professional growth through increased empathy, a desire to help others, enhanced clinical traits, an increased awareness of countertransference, attending their own therapy, and searching for meaning were all identified as factors influencing their choice to become clinician. The findings shed new light on how childhood adversity can

influence therapists' professional and personal development through self-care and therapy.

In conclusion, the findings of this study may lead to advances in graduate clinical programs aimed at developing well-trained, resilient, and skilled practitioners who may help to alleviate the clinician shortage. This information may be useful to novice clinicians working with offenders, employers, supervisors, and future clinical students interested in entering the helping profession.

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Appendix A: Recruitment Flyer

A qualitative study seeking licensed clinical workers with experience working with criminal offenders. I am conducting a study to understand how clinicians describe their perception on how their own adverse childhood experiences shape their professional practice, resiliency, and engagement of offenders. Your participation can provide a deeper understanding and insight of how past adversities impacts practice, resiliency, and treatment engagement. This study is part of the doctoral study for Aaron Omar Pena, a Ph.D. student at Walden University.

About the study:

- One 5-minute demographic questionnaire.
- One 45–60-minute phone interview.
- To protect your privacy, no names will be collected.

Volunteers must meet these requirements:

- 18 years old or older.
- Be a licensed social worker, psychologist, professional counselors, psychological associates, or psychiatric nurse practitioner.
- Works or has worked with incarcerated offender in a prison or jail.
- Experienced an adverse childhood experience (ACE) before the age of 18.

Appendix B: Interview Protocol

I plan to facilitate the notetaking by audio recording our conversations today to make taking notes easier. The release form needs to be signed. For the participants' information, the tapes will be accessible only to me as the researcher working on the project and will be finally discarded after being transcribed. The participants must also sign a document to satisfy our human subjects' criteria. This agreement states that (1) all information will be kept private, (2) The participants are welcome to withdraw at any point if you find the activity uncomfortable, and (3) I have no malicious intent. I appreciate you deciding to take part. This interview is expected to last no more than one hour. I want to address several questions during this time.

Appendix C: Demographic Questions

Prior to consent you may only ask questions that seek to confirm they meet the inclusion criteria.

Demographic Questions:

- Are you over the age of 18?
- Are you a graduate student?
- Are you a licensed social worker, psychologist, professional counselors, licensed psychological associates, or psychiatric nurse practitioner?
- Have you worked or currently work with incarcerated offenders in a prison or jail?
- Have you experienced an adverse childhood event?

Appendix D: Primary Interview Questions

- What led you to work with this population?
- In your clinical opinion and experience, have you viewed offender differently based on their offense?
- How would describe your experience working with an incarcerated offender?
- How would you describe working with this population has impacted your life?
- How would you describe the therapeutic engagement techniques used when working with an offender?
- How do you believe your childhood experience affects your professional practice?
- How do you identify when you are experiencing countertransference in your professional practice?
- How often do you engage in supervision or consultation?
- How do you manage and/or work through your childhood experiences?
- In your opinion and experience, how do you achieve resiliency?