


The Ripple Effects of Post-Conviction Traumatic Stress in People Required to Register as Sex Offenders and their Families

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Abstract

Post-Conviction Traumatic Stress (PCTS) describes the cognitive, psychological, and physiological symptoms of trauma that result from a range of experiences with the criminal justice system. This pilot study aimed to empirically validate the construct of PCTS utilizing the Post-Traumatic Checklist (PCL-5), an existing measure of Post-Traumatic Stress Disorder (PTSD) according to DSM-5 diagnostic criteria. Using mixed methods, the survey asked about the traumagenic impact of arrests, court proceedings, incarceration, probation/parole supervision, and sex offender registration requirements in a sample of people required to register as sexual offenders (RSOs; $n = 290$) and their family members ($n = 126$). The PCL-5 was used to estimate the prevalence of PTSD and to explore the unique presentation of symptoms. Findings indicated that 69% of registrants and 62% of family members reported clinically significant indicators of PTSD. Examples of specific symptom presentations are illustrated through qualitative responses. Implications for clinical treatment, policy, and future research related to PCTS are discussed.

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Introduction

Hearing the word trauma might bring up associations with disasters, accidents, war, or being victimized. The notion of trauma rarely comes to mind when considering the psychosocial and legal consequences for someone who perpetrates an act of criminal victimization. A growing body of literature suggests that engagement in crime, the ensuing incarceration, and the process of community reentry can all generate traumatic stress (Badenes-Ribera et al., 2021; Crisford et al., 2008; Harris and Levenson, 2021; LeBel and Richie, 2018; MacNair, 2015; Maruna, 2001; Petersilia, 2003; Pettus-Davis et al., 2019; Roth et al., 2022; Steinmetz et al., 2019; Western, 2018).

Additional restrictions and systemic barriers for people required to register as “sex offenders” (RSOs)¹ create unique post-conviction challenges related to employment, safe and affordable housing, and social support (Levenson et al., 2016; Rydberg, 2018; Sample et al., 2018; Tewksbury and Mustaine, 2009). The psychological stress of reentry and the impacts of Sex Offender Registration and Notification (SORN) laws for RSOs and their family members are generally overlooked (Bailey and Klein, 2018; Jeglic et al., 2011; Kavanagh and Levenson, 2022; Ten Benschel and Sample, 2018; Tewksbury and Levenson, 2009). This pilot study aims to empirically examine the theoretical construct of *Post-Conviction Traumatic Stress* (PCTS; Harris and Levenson, 2021, 2022) using a validated tool designed to measure Post-Traumatic Stress Disorder (PTSD) as described in the 5th Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013).

Trauma Theory, Traumatic Stress, and Diagnostic Considerations

Trauma is commonly defined as direct or indirect exposure to an event that threatens one’s physical or psychological safety; the experience generates fear and helplessness, and overwhelms the ability to cope effectively (Bloom, 2013; SAMHSA, 2014). Trauma can involve a single event or a cumulative set of circumstances. Traumagenic conditions can include adverse childhood experiences (ACEs) such as abuse, neglect, and family dysfunction (Felitti et al., 1998), or they can occur within the larger social environment (for example, living in a violent community or a war zone, or a natural disaster). Trauma is characterized by a perceived lack of safety and a sense of powerlessness to protect oneself, escape, or change one’s circumstances (Bloom, 2013). Traumatic personal experiences can intersect with intergenerational traumas such as poverty, systemic injustice, and discrimination of marginalized groups. The complexity of trauma must be considered as we devise correctional programming (Jäggi et al., 2016; Maercker et al., 2022; Sotero, 2006).

Research about the neurobiology of traumatic stress finds that when people encounter dangerous or threatening conditions, the brain and body react simultaneously to activate what is known as the fight-flight-freeze survival response (Bloom, 2013; van der Kolk, 2006, 2014). Hyper-reactivity in the amygdala floods the body with stress hormones, causing emotional and behavioral dysregulation (Maeng and Milad, 2017; van der Kolk, 2006). Stress-induced hyperarousal can disrupt cognitive processing and memory, which increases the likelihood of impulsivity and poor decision-making (Holley et al., 2017; van der Kolk, 2014). Trauma can lead people to adopt distorted cognitive schemas and maladaptive coping strategies like addiction, aggression, self-harm, or criminal behavior (Bloom, 2013; Maschi and Gibson, 2012; Najavits et al., 2009; Young et al., 2003).

Four symptom clusters are outlined in the DSM-5 diagnosis of PTSD: intrusion, avoidance, negative cognitions and moods, and hyperarousal (APA, 2013). The clinical presentation of traumatic stress varies. According to the DSM-5, people commonly present with sub-threshold PTSD, meaning that they do not meet full diagnostic criteria but experience symptoms, distress, and impairment. A DSM-5 diagnosis of PTSD requires exposure to actual or threatened death, serious injury, or sexual violence; therefore many events perceived as traumatizing by the individual do not satisfy Criterion A (Zoellner et al., 2013). Criterion A was more broadly conceptualized in the DSM-III as a major, life-threatening traumatic stressor that would “evoke significant symptoms of distress in almost everyone” (APA, 1980, p. 238), but subsequent revisions narrowed the definition to reduce ambiguity in the differential diagnosis of PTSD. Including a wider set of events could dilute the diagnosis, but excluding “lower magnitude” events confounds the subjective perception of traumatic stress (Zoellner et al., 2013, p. 279). The term *complex PTSD* describes the collective effects of exposure to multiple, prolonged, or repeated traumas (Maercker et al., 2022).

What is Post-Conviction Traumatic Stress?

Harris and Levenson (2021, 2022) introduced the concept of PCTS to capture the syndrome of cognitive, emotional, and physiological symptoms associated with exposure to a range of criminal justice system (CJS) experiences. In studies of persons involved with the CJS, many researchers have observed behaviors and characteristics that are symptomatic of PTSD (Harris & Levenson, 2021, 2022; Harris & Levenson, 2022; LeBel and Richie, 2018; Liem and Kunst, 2013; Pettus-Davis et al., 2019). Drawing upon criminological theories of strain (Ackerman and Sacks, 2012; Agnew, 1992), labeling (Maruna et al., 2004; Mingus and Burchfield, 2012; Paternoster and Iovanni, 1989; Willis, 2017), and human needs (Maslow, 1943), Harris and Levenson (2021) applied PCTS specifically to RSOs, who are subject to considerable public stigma along with unique forms of monitoring and social exclusion.

Many scholars have agreed that CJS involvement and the stress of re-entry can induce trauma (Goff et al., 2007; LeBel and Richie, 2018; Liem and Kunst, 2013; Listwan et al., 2013; Petersilia, 2003; Pettus-Davis et al., 2019; Western et al., 2015).

LeBel and Richie (2018) reviewed the literature related to psychological consequences of CJS contact and described a persistent array of effects including dysphoric moods, ruminating thoughts, sleep disturbances, avoidance of reminders, fear or dread, anger or irritability, hyper-vigilance, and impaired cognitive processing. Symptoms were observed after allegations, arrests, charges, court appearances, sentencing, jail, prison, and parole or probation. Even one brief contact with police, courts, or jails can generate traumatic stress, negatively impacting mental health and psychosocial functioning (Fernandes, 2020). A distinct collection of PTSD symptoms after release from prison was described by Liem and Kunst (2013) as *post-incarceration syndrome*. Formerly incarcerated persons reported intrusive thoughts and nightmares, hyper-arousal, startle responses, avoidance of crowded places or overwhelming external stimuli, institutionalization, paranoia, and emotional detachment to protect against vulnerability (Liem and Kunst, 2013).

Guided by research noting the high prevalence of lifetime traumatic experiences and PTSD in CJS-involved populations, Pettus-Davis et al. (2019) devised trauma interventions to assist with the transition from prison to community. The challenges of re-entry can undermine protective factors (stability in work, housing, prosocial identity, and social support) (Andrews and Bonta, 2010; de Vries Robbé et al., 2015; Hamilton, 2017; Maruna, 2001). The CJS can be inherently criminogenic: negativity bias, stigma, exclusion, and condemnation can intensify personal stress, which can paradoxically increase dynamic risk and reinforce a self-fulfilling prophecy of criminality (Hamilton, 2017; Maruna et al., 2004). The phased intervention programs proposed by Pettus-Davis et al. (2019) were designed to improve coping and self-regulation skills before and during re-entry.

PCTS Related to Sex Offender Registration and Notification (SORN) Laws

SORN laws create formidable re-entry obstacles for RSOs in the USA, and they also have noticeable effects on family members who are directly and indirectly impacted by the same legislation. Originally designed for use exclusively by law-enforcement, registries have morphed over three decades into a complicated web of ever-changing (often lifelong) rules, restrictions, and collateral sanctions. Researchers have identified legal, practical, and psychosocial consequences associated with public registries and SORN laws. Registrants and family members confront the stress of employment constraints, housing restrictions, economic insecurity, harassment, invasion of privacy, relationship disruptions, public stigma, shame, vigilantism, and fear (Bailey and Klein, 2018; Harris et al., 2017; Jeglic et al., 2011; Kavanagh and Levenson, 2022; Levenson, 2016; Levenson et al., 2016; Mingus and Burchfield, 2012; Rydberg, 2018; Sample et al., 2018; Tewksbury and Levenson, 2009; Tewksbury and Mustaine, 2009; Willis, 2017).

Hamilton (2020) offered a framework for conceptualizing the collateral consequences of SORN laws, outlining the explicit barriers to re-entry along with the accompanying stigma and social exclusion. She noted a lack of empirical measures to

quantify the losses, discrimination, and emotional distress associated with SORN laws. While never actually using the word *trauma*, Hamilton (2020) identified shame, fear, stress, hopelessness, and hypervigilance as important effects of registration requirements. Housing and employment instability, fear of social rejection, a sense of futility about the future, and interactions with police and community supervision agents can generate an ongoing syndrome of traumatic stress for RSOs. The undeniable stigma and public shaming of the “sex offender” label creates a tarnished identity (Goffman, 1963; Hamilton, 2017), precluding a transformational narrative of desistance (Maruna, 2001). Daunting obstacles to goal attainment and even basic human needs (Maslow, 1943; Ward and Gannon, 2006) can produce chronic traumatic stress for registrants, causing emotional and behavioral dysregulation which can increase dynamic risk.

The ripple effects of a criminal conviction extend far beyond the person convicted, and the traumagenic impact is shared by family members. An arrest for a sexual offense is usually experienced by family members as unexpected (often shocking), creates life-altering changes over which they have no control, threatens their sense of well-being, and challenges their normal coping capacity. Family members have described ongoing intrusive thoughts and images; avoidance of people, places, and reminders; negative thoughts and feelings; emotional dysregulation; constant fear; and persistent hypervigilance (Bailey, 2017; Kavanagh and Levenson, 2022; Tewksbury and Levenson, 2009), all of which characterize PTSD.

Challenges in Using a DSM-5 PTSD Framework to Conceptualize PCTS

Researchers have recognized the limitations of the PTSD diagnosis when traumagenic conditions are ongoing. For instance, a conceptual model of *Chronic Traumatic Stress* was introduced to capture the experiences of refugees facing displacement and continual migration challenges (Fondacaro and Mazulla, 2018). Other scholars have noted the chronic nature of developmental trauma and ACEs (Maercker et al., 2022; van der Kolk, 2005), racial trauma and recurring microaggressions (Williams et al., 2018), social and economic stressors after a natural disaster (Galea et al., 2008), and the enduring trauma of a life-threatening medical diagnoses (Cordova et al., 2017). Furthermore, although some CJS experiences might not strictly meet Criterion A for PTSD in the DSM-5, being arrested without warning at gunpoint, or encountering dangerous conditions or lethal violence while incarcerated, would certainly represent life-threatening and life-altering experiences (Ellison et al., 2022).

Considering some of the issues described above, a wider conceptual framework may be needed to describe post-conviction trauma and the persistent stressors that might provoke it. LeBel and Richie (2018) observed that few researchers have utilized empirical methods to investigate PTSD in CJS-involved persons who report symptoms suggestive of the disorder. There is a need to collect data from CJS participants using validated empirical tools to measure PTSD symptoms and formulate an evidence-based construction of PCTS (Harris and Levenson, 2022; LeBel and Richie, 2018; Liem and Kunst, 2013).

Purpose of the Study

CJS involvement (e.g., arrest, court proceedings, incarceration, probation/parole, and appearance on a sex offender registry) is known to be potentially traumatizing. This study represents the first attempt to validate the construct of PCTS (Harris and Levenson, 2021, 2022) using an existing measure of PTSD criteria. The study also aimed to understand the prevalence of PCTS and its presentation of symptoms for RSOs as well as their family members.

Methods

This study collected quantitative and qualitative data through an online survey which launched on the SurveyMonkey platform in March 2021. To recruit RSOs and their family members, we requested assistance from several registry reform advocacy groups in the US.² These groups agreed to send our recruitment email and survey link to their email distribution lists and to share the link via their social media and networking partners, which allowed for additional snowball sampling. Any RSO or family member of an RSO who was eligible (over 18 and living in the USA) was invited to participate. The project was approved by the first author's University Institutional Review Board.

Surveys were completed online and were anonymous and confidential. IP addresses and other identifying information were not recorded. The survey was designed not to launch unless participants endorsed that they were over 18 years of age and clicked "yes" to consent to participate. Consideration was given to the potential challenges in studying hard-to-reach populations and avoiding duplicate or fraudulent responders (Teitcher et al., 2015). Because our recruitment was targeted directly through grass-roots advocacy groups made up of RSOs, their family members, and their allies, there was little risk of fraudsters randomly accessing our survey. We did not offer incentives for taking the survey and were therefore not especially concerned about fraudulent responding for personal gain. We adjusted the settings in SurveyMonkey to protect against multiple responses from the same IP address and added wording on the consent page asking participants to agree to only take the survey once.

Measures

The survey was developed by the authors specifically for this study. The survey began by asking about experiences related to the arrest for a sexual crime and the ensuing court proceedings, incarceration, probation/parole, and registration, which were considered to be potentially traumatic experiences related to the sex offense.³ In this section, participants answered dichotomously (yes/no) or provided a numeric response (e.g., to indicate "number of months in custody") (see Appendix A). Non-identifying demographic data were collected at the end of the survey to determine characteristics of the sample.

The Post-traumatic Checklist (PCL-5) (National Center for PTSD, 2022; Weathers et al., 2013) was used to measure PTSD related to the specific events asked about above (see Appendix B in supplemental online materials). The PCL-5 is a validated instrument that asks 20 questions measuring the severity of DSM-5 PTSD symptoms in the last month, using a Likert scale of 0 to 4 (0 = “Not at all,” 1 = “A little bit,” 2 = “Moderately,” 3 = “Quite a bit,” and 4 = “Extremely”). The 20 items correspond to the four symptom clusters defined in the DSM-5 (APA, 2013). Psychometric assessments of the PCL-5 indicated strong internal consistency ($\alpha = .94$) and good test-retest reliability ($r = .82$) (Blevins et al., 2015). A meta-analysis of 336 published articles using the PCL determined that the instrument had adequate psychometric properties when testing the reliability and validity of scores on three different versions used with veterans, civilians, and samples of people who had experienced specific types of traumatic events (Bressler et al., 2018). A provisional PTSD diagnosis can be made by identifying PCL-5 items rated as 2 or higher, which indicate clinically significant symptoms, and then following the DSM-5 diagnostic rules: one Criterion B item (questions 1–5), one Criterion C item (questions 6–7), two Criterion D items (questions 8–14), and two Criterion E items (questions 15–20). Research suggests that a PCL-5 cutoff score between 31–33 is indicative of probable PTSD across samples (National Center for PTSD, 2022). In our survey, the PCL-5 section also offered a series of open-ended prompts, asking participants to describe examples of symptoms in each PTSD cluster category (if applicable).

Sample

A total of 639 participants began the survey, but the current sample is comprised of the 290 RSOs and 126 family members (total $n = 416$) who completed all PCL-5 questions (68% survey completion rate). Seven of the RSOs indicated that they were not allowed to use the Internet and were being assisted by someone else to complete the survey. The demographics of the sample can be seen in Table 1. It is unknown how many (if any) of the RSOs and the family members who took part in the survey were related to each other. The participants lived in 38 different states, with almost half (45%) of the sample residing in Florida and California (see Appendix C in supplemental online materials).

This sample was 87% white, which is less diverse than national registry data indicating that minorities (non-whites) comprise between 28% (Ackerman and Sacks, 2018) and 33% (Ackerman et al., 2011) of the approximately one million registrants in the USA (and therefore, presumably, their family members). Because registries are managed and maintained by states, and because the composition of registries changes daily, it is difficult to obtain an up-to-date demographic snapshot of the national RSO population. A decade ago, the average USA registrant age was 45 years old (Ackerman et al., 2011) which is younger than the mean registrant age in the current study (mean = 53; range = 21–86). However, as the general population ages, it is likely that the average registrant age is increasing as well. Family members were slightly older (mean = 56 years; range = 28–90). In this sample, 6% of the registrants were female ($n = 16$),

Table 1. Descriptive Stats & demographics (RSO = 290; family member = 126).

Demographics		RSO	Fam
Current age	(Mean)	52.9	55.9
Gender	Male	93%	13%
	Female	6%	87%
	Trans/Non-Binary	1.5%	0
How would you describe your race?	White	87%	86%
	Black	5%	1%
	Other	8%	13%
Hispanic, Latino, or of Spanish origin	(yes)	8%	13%
Current relationship status	Married ^a	38%	68%
	Widowed	1.4%	7%
	Divorced	24%	7.8%
	Separated	1.8%	3.4%
	Partnered	13%	9.4%
	Single/never married	22.5%	4.3%
Current employment status	Employed full-time	41%	50%
	Employed part-time	14%	10%
Highest level of education completed	HS Grad	7.6%	6%
	College Grad	36%	45%
	Graduate Degree	24%	29%
Current income	<\$20,000	35%	12%
	\$20,000-\$49,999	38%	32%
	\$50,000-\$79,999	14%	25%
	\$80,000+	13%	32%

^aRSOs and family members are not necessarily married to each other.

which is an overrepresentation given that women are estimated to make up just 2% of the national registry (Ackerman et al., 2011). Most family members who participated in this study were women (87%). Family members described their relationship to the registrant in the following ways: 40% were a parent or step-parent; 33% were a spouse; 6% were a partner or significant other. Only one family member was a registrant's adult child, ten were siblings, and four were described as other relatives or close friends.

Table 2 contains the distribution of sexual offenses committed by RSOs. The majority were contact offenses (54%) and technology-assisted offences (48%). A small proportion (4%) of the crimes involved non-contact exhibitionistic acts.

Analytic Techniques

Quantitative data were analyzed using version 28 of the Statistical Package for the Social Sciences (SPSS). Quantitative analyses included descriptive statistics for the PCL-5 instrument, the clinically significant PTSD symptom clusters, and DSM-5 diagnostic criteria. The re-coding techniques used to calculate clinical significance for

Table 2. Types of crimes reported by respondents^a (*n* = 379).

	%	n
Child sex abuse material (CSAM) ^b	31%	119
Internet Solicitation (chatting with and/or traveling to meet a minor)	12%	44
Other internet related offense	5%	17
Exposing Genitals to adult	.3%	1
Exposing Genitals to minor	4%	16
Voyeurism/Peeping (adult or minor)	0	
Sexual contact crime- adult victim	6%	22
Sexual contact crime- minor teen victim	33%	124
Sexual contact crime- minor victim age 12 or under	22%	82

^aTotal does not add up to 100% because some people endorsed multiple categories.

^bCSAM is otherwise known as an internet-related child pornography offense: typically possession, distribution, or production.

the DSM-5 PTSD criteria are described in the Results Section. Chi-square and t-tests were used to compare groups of registrants and family members. Bivariate correlations and multiple regression techniques were used to examine the strength and direction of relationships between variables.

Qualitative data were subject to content analysis, and illustrative examples of each of the four DSM-5 PTSD symptom clusters are presented in narrative form. Different qualitative methodologies can be used for distinct purposes (Vaismoradi et al., 2013). Thematic analyses are used to search for emergent themes which are then defined, named, and elucidated with examples (Braun and Clarke, 2006). Content analysis is more suitable when the focus is on classifying narrative data with less need for thematic interpretation (Vaismoradi et al., 2013). In this study, the narrative questions prompted participants to offer *examples* of PTSD symptoms in each specific DSM-5 cluster, and therefore the answers required little thematic interpretation. Content analysis was used as a systematic approach for exploring, coding, and categorizing large amounts of textual information to determine trends, patterns, and/or frequencies of ideas or words (Vaismoradi et al., 2013).

The units of analyses were the sentences contained within the participants' answers to each qualitative prompt. The two authors and two graduate research assistants read through the text responses and used different highlight colors to organize PTSD symptom descriptions within each cluster. Additional rounds of conferencing took place between the authors to choose the most salient and poignant examples of PTSD symptoms in each criteria cluster for inclusion in the qualitative results section. Table 3.

Table 3. Potentially traumatic events related to a sex offense.

Event	RSO (Self)%	FAM (Loved One)%	RSO (Self) Mean	FAM (Loved One)Mean
Arrest unexpected	77%	95%		
Arrested at home	53%	39%		
Arrested at work	15%	3%		
Search warrant	48%	37%		
Attended 1+ court hearings	97%	99%		
In jail pre-trial	64%	52%		
Jail Stay in months (range 0-50)			6.15	8.9
Sentenced to prison	58%	61%		
Prison Stay in years (range 0-39)			4.87	7.4
On probation or parole (P/P)	95%	90%		
Currently on P/P	30%	52%		
Total term of P/P in years (range 0-100)			12	12.5
How long on registry so far in years	0–5 years: 28% 6–10 years: 23% 11–20 years: 28% >20 years: 21%	0–5 years: 54% 6–10 years: 25% 11–20 years: 17% >20 years: 4%	13	7.3
Required to register for how long (in years)	<10 years: 2% 10–20 years: 18% +20 but not life: 12% Lifetime: 68%	<10 years: 3% 10–20 years: 23% +20 but not life: 13% Lifetime: 61%		
Can petition for registry removal	No: 28% Yes: 31% Not sure: 41%	No: 35% Yes: 18% Not sure: 47%		

Results

Quantitative Findings

PCTS was assessed using the PCL-5 (see [Appendix B](#)). First, the PCL-5 items were calculated to view total scores by summing the raw Likert scale answers for each item (range = 0–80). Cases with missing data on any PCL-5 item were excluded. The mean score (valid $n = 416$) was 42.2 (SD = 18.97, median = 45, mode = 51; see [Table 4](#)). In the research literature, PCL-5 threshold scores indicating PTSD range from 28–38 ([Ashbaugh et al., 2016](#)). Using the “average” cutoff score of 33 ([Ashbaugh et al., 2016](#)), 66% of our participants might meet criteria for PTSD using the PCL-5. The most

Table 4. PCL-5 scores.

PCL-5 Item (Scored 0–4) ^a	Mean	Std. Deviation	% yes (>0)
1. Repeated, disturbing, and unwanted memories of the stressful experience?	2.70	1.13	83
2. Repeated, disturbing dreams of the stressful experience?	1.81	1.39	55
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	2.05	1.36	64
4. Feeling very upset when something reminded you of the stressful experience?	2.76	1.15	84
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	2.30	1.34	69
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	2.34	1.20	74
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	2.35	1.25	74
8. Trouble remembering important parts of the stressful experience?	1.12	1.29	34
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	2.30	1.41	68
10. Blaming yourself or someone else for the stressful experience or what happened after it?	2.41	1.36	72
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	2.64	1.25	78
12. Loss of interest in activities that you used to enjoy?	2.23	1.43	66
13. Feeling distant or cut off from other people?	2.55	1.34	74
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	2.09	1.42	62
15. Irritable behavior, angry outbursts, or acting aggressively?	1.41	1.25	43
16. Taking too many risks or doing things that could cause you harm?	.84	1.17	23
17. Being "super-alert" or watchful or on guard?	2.39	1.40	70
18. Feeling jumpy or easily startled?	1.87	1.40	58
19. Having difficulty concentrating?	2.01	1.30	61
20. Trouble falling or staying asleep?	2.24	1.41	67
PCL-5 total score	42.4	18.97	

^aScore of 2 or more on each PCL-5 Item = clinically significant.

Valid n for each item ranged from 437–447.

Table 5. PTSD symptom clusters & diagnostic criteria.

	N	Range	Mean score	% yes	Std. Deviation
DSM-5 symptom clusters based on PCL-5 items: Mean # of Symptoms ^a					
Intrusion	438	0–5	3.53		1.666
Avoidance	439	0–2	1.48		.793
NACM	430	0–7	4.55		2.270
Arousal reactivity	433	0–6	3.20		1.983
DSM-5 PTSD symptom clusters: % meeting DSM-5 criteria					
Intrusion	438			84%	.363
Avoidance	439			81%	.392
NACM	430			86%	.344
Arousal reactivity	433			75%	.436
DSM5 PTSD DX	Valid n = 416			67%	.472

^aScore of 2 or more on each PCL5 Item = clinically significant.

NACM = Negative Alterations in Cognition or Mood.

rigorous range for PTSD is 35–38, with an average cutoff score of 37 (Bressler et al., 2018). Using the more conservative threshold of 38, 60% of our sample indicated a diagnosis of PTSD.

Next, formulas were created to assess whether each participant met diagnostic criteria for PTSD as described in the DSM-5. Each PCL-5 item was originally scored on a 5-point Likert scale (0–4) and scoring instructions designate a score of 2 or more as clinically relevant. Each item was recoded into a dichotomous variable: clinically relevant (scores of 2, 3, or 4) and not clinically relevant (scores of 0 or 1). The DSM-5 categorizes PTSD symptoms into four clusters: intrusion, avoidance, negative alterations in cognition and mood (NACM), and arousal/reactivity (APA, 2013). The dichotomized scores were then calculated to give a total score for each cluster. For instance, if a participant endorsed a score of 2 or more for three intrusion items, their intrusion cluster score was 3. Each of the four DSM-5 symptom clusters were then dichotomized to determine if each participant met criteria for each symptom cluster. Clusters were coded “yes” if the participant received scores of 2 or more on at least one re-experiencing symptom, one avoidance symptom, two symptoms of NACM, and two arousal/reactivity symptoms (Ashbaugh, et al., 2016). If a participant met DSM-5 criteria in all clusters, they were then coded “yes” as meeting criteria for PTSD in the DSM-5. In our sample, 67% met criteria for PTSD in the DSM-5 using this formula (Table 5).

Group comparisons were conducted to determine if there were significant differences between RSOs and family members when considering clinically meaningful symptoms of PTSD. The comparisons were conducted using both the PCL-5 symptom cluster scores and the DSM-5 diagnostic criteria formula score (see Table 6). The independent samples t-test was used to compare means in the PCL-5 cluster scores, and chi-square analysis was used to compare proportions of each group meeting diagnostic

Table 6. Group comparisons: RSO & Family Members.

PCL-5 (0–4)	Respondent	Valid N	Mean	Std. Deviation	t	Sig
PCL5_Intrusion	RSO	303	3.65	1.643	2.171	.030
	FAM	135	3.27	1.695		
PCL5_Avoidance	RSO	304	1.55	.765	2.612	.010
	FAM	135	1.33	.836		
PCL5_NACM	RSO	298	4.66	2.249	1.575	.116
	FAM	132	4.29	2.303		
PCL5_ArousalReactivity	RSO	298	3.32	2.007	1.879	.061
	FAM	135	2.93	1.909		
PCL5_Total	RSO	290	43.92	18.922	2.490	.013
	FAM	126	38.91	18.680		
DSM-5 criteria	Respondent	Valid N	% Yes	Df	Chi-square	
DSM5_Intrusion	RSO	303	85%	1	.340	.550
	FAM	135	83%	1		
DSM5_Avoidance	RSO	304	83%	1	2.926	.087
	FAM	135	76%	1		
DSM5_NACM	RSO	298	87%	1	.770	.380
	FAM	132	84%	1		
DSM5_ArousalReactivity	RSO	298	76%	1	.779	.377
	FAM	135	72%	1		
DSM5_PTSD Dx	RSO	290	69%	1	1.781	.182
	FAM	126	62%	1		

Independent samples t test. Bonferroni Correction:
Significance level was set at $p < .01$ ($.05/5 = .01$).

criteria. The Bonferroni Correction was used because when multiple comparisons are tested, the chance of observing a rare event increases, and therefore, the likelihood of incorrectly rejecting a null hypothesis increases (i.e., a Type I error). The Bonferroni correction compensates by testing each individual hypothesis at a significance level of $p = .05$ divided by the number of tests. In this case the significance level was set at $p < .01$ using 5 tests, which included four symptom clusters and one total score ($.05/5$ tests = $.01$).

Across both measurements of PTSD, the experience of trauma was prevalent among all participants. The average PCL-5 scores were 44 for RSOs and 39 for family members. Further, 69% of the RSOs and 62% of family members met the DSM-5 diagnostic criteria for PTSD. No statistically significant differences were found between the groups on either test (PCL-5: Cohen's $d = .266$, 95% CI [.056, .475]; DSM-5: Cohen's $d = .142$, 95% CI [-.067, .352]).

Associations Between PCL-5 Scores and Other Variables

A two-tailed Pearson correlation matrix was devised to explore the strength and direction of relationships between the PCL-5 total score and the events listed in [Appendix A](#). For the registrants, the only variable showing a significant correlation was “when I was arrested, it was unexpected” ($r = .25$, $p = .000$). For family members, the only significant correlation was with attending court hearings ($r = .19$, $p = .03$), however there was almost no variation with only one “no” answer to that question.

A multiple regression equation using the full sample of RSOs and family members assessed whether demographic characteristics were associated with PCL-5 scores. The model was significant, $R = .30$, Adjusted R square = .077; $F(5, 374) = 7.349$, $p = .000$, 95% CI [57.030, 83.259]. Age (continuous), income (ordinal), and education (ordinal) were all significantly and inversely related to PCL-5 scores (higher scores for younger people with less education and lower income). Race (white = 1/nonwhite = 2) and relationship status (married, cohabitating, or civil union = 1; widowed, divorced, separated, never married = 0) did not show statistical significance.

A multiple regression equation model was then constructed for the RSOs to assess whether being currently on probation/parole (0 = no, 1 = yes), registration duration so far (years), and the five demographic characteristics listed above were together predictive of higher PCL-5 scores. The model was significant: $R = .284$, Adjusted R square = .056; $F(7, 259) = 3.234$, $p = .003$, 95% CI [49.962, 82.386]. The significant predictors were age ($p < .01$) and income ($p < .05$) and they were inversely associated with PCL-5 scores. In other words, registrants who were younger and had less income indicated more traumatic stress. The same model was constructed for family members. The model was significant: $R = .418$, Adjusted R square = .113; $F(7, 94) = 2.841$, $p = .010$, 95% CI [42.889, 102.458]. The significant predictors were education ($p < .05$) and income ($p < .05$) and they were inversely associated with PCL-5 scores. Family members with less education and income indicated more traumatic stress.

Narrative Responses

Open-ended survey prompts invited participants to share specific examples of PTSD symptoms within each criterion cluster. Content analyses were used to categorize symptoms. Some particularly illustrative examples from both RSOs and family members are described in the sections below.

Intrusion/Re-experiencing. Registrants described physiological responses such as “panic attacks,” rapid heartbeat, heart palpitations, loss of breath, dizziness, and stomach pain. Physical reactivity was often triggered by seeing police, hearing sirens, unexpected phone calls or knocks at the door, movies or TV shows depicting arrests, courtrooms, or prison scenes, news stories about sex crimes, seeing their probation officer, and attending their regular registration appointments. Several described distressing memories, “recurring flashbacks,” or “obsessive” thoughts that

interfered with sleep. One described feeling “paranoia every day, not knowing why [a] person is looking at you.” Intrusive thoughts were described by one RSO in this way: “I keep re-running thoughts and words in my mind. My concentration is interrupted by these thoughts.”

One respondent described how “sometimes a particular word or smell will remind me of jail. Those moments usually cause me to panic and hyperventilate.” Another recounted walking into a public restroom “and the cleaner there smelled like the stuff used in the prison. I immediately felt a sense of panic like the door was going to lock behind me.” One said, “When George Floyd was murdered, I saw the man in prison get murdered again and again,” and another said, “I dream that I’m fighting for my life in prison.” Registration also triggered intrusive thoughts: “Every time I have to register (every 90 days) I worry I will be arrested for something. Going in makes nervous, antsy, sweaty.” And finally, this poignant description was given of re-experiencing symptoms:

I relive this in my mind every single day of my life. That is not an exaggeration. EVERY time I hear a loud noise I freak out - heart pounds, sweating starts, I get the shakes, sometimes I am completely frozen. EVERY time I hear anything that sounds vaguely like “pedophile”, “sex offender”, “registry” - all these negative feelings and emotions rush back and interfere with life.

Family members described re-experiencing and intrusive thoughts as well, including one who said “I relive seeing my son taken from us. It is deeply disturbing.” A nurse described working with people who have been incarcerated: “It brings about feelings of stress and anxiety when I read about their cases or just learn that that has been their life.” Other narratives revealed intrusive memories and physical reactivity after reminders:

If I hear a certain song or two from the many road trips we took to see our son...every bit of everything is right there; the temperature of the air, the ‘worry’ bracelet I kept on my wrist, the clothes my son was wearing, the food we ate.

Recently a car pulled up to the front of my house with 2 guys in suits, who I did not know. I panicked and felt my knees buckle under me, thinking they were detectives coming to get my husband or search the house. They were Jehovah’s Witnesses. After they left, I locked myself in the bathroom, sat on the floor and cried.

I have many triggers - going into a supermarket I am afraid I’ll see someone I know; someone asking me personal questions; talking about our lives before the incident; These triggers affect me physically. My stomach hurts and sometimes I get a bad headache.

Avoidance. Participants described actively avoiding people, social situations, places, and other cues or reminders of the arrest, incarceration, or RSO status. Some registrants said they avoided showing affection to their own children, fearing what others might assume about their parental nurturing. One registrant said: “At times, I will self-isolate for days and avoid personal interactions,” and another reported: “I avoid people, don’t

want to make new friends.” Many avoided driving past places like the courthouse or jail, and one declared: “I have built my life around avoiding stressors and reminders related to my arrest, conviction, and treatment.” One described being so good at avoidance that he avoided the survey question:

This may sound odd, but I am very good at avoiding thoughts or feelings that cause me stress. So, if I start thinking about the horrible events and those places or people or smells or feelings, I won’t let them go from my mind, so I’m not going there today.”

Family members also gave examples of avoiding stores that they used to frequent before the arrest and taking pains to avoid “bumping into someone we knew.” One noted that they no longer attend any public events for fear of encountering others who knew of the offense, and another described evading “friends who I know judge me for his mistake, and I feel my circle of friends is much smaller than ever. I feel very isolated and lonely.”

Negative Alterations in Cognitions and Mood (NACM). Persistent negative thoughts and feelings commonly described by registrants were self-loathing, guilt, shame, sadness, despair, the stigma of the RSO label, and hopelessness for the future. Several described shame with words like “dirty” and one had resigned himself to being an “outcast” who felt like a “leper. That’s how I see myself these days. And that’s how I anticipate others seeing me.” One said he feels “like I am unfixably flawed,” and another felt like he is “unlovable and a monster for my offense and what I did.” Many used the word “stigma” and one added “that makes it hard for me to feel like a whole person sometimes.” Other phrases described feeling “stupid and broken” and “disgusting and infected.”

Several described thoughts of suicide, and one said he felt “like I’m already dead just floating through a world that I’m not a part of.” One described despair “every morning when I realize that I am still living this nightmare and that I’m not dead yet.” A common theme was regret over the loss of how life used to be: “Any chance of me having a home and family of my own is essentially evaporated. Even of finding a companion who can live with all of my baggage.” A sense of hopelessness was prominent: “I can’t manage to locate ‘desire’ for anything anymore. I can’t think of a single goal, or hope, or plan, or expectation of anything changing or getting better.”

Other similar sentiments stood out:

Although I dream of a day when I can put this all behind me and my family, I feel hopeless that I will ever be able to. I also feel that I am forever stigmatized and will never fully be treated as an equal human being.

I’ve gone from a guy who had a good sense of humor to someone who has no energy in doing more things in life and typically just eats because I know I need to; not that I’m really hungry.

I used to give the shirt off my back to blatant strangers. I would stand up for other kids all through high school because no one deserves to be bullied and yet I was popular. I wasn't afraid to stand up for others or myself. I was truly selfless and altruistic. Now I'm a petrified hermit with nothing but shame and hate towards myself.

Family members also offered heart-wrenching thoughts and feelings of hopelessness, self-blame, stigma, isolation, and despondence. One described feeling abandoned by others: "I chose to stand by him because I believe in him. Now, being almost completely ostracized by my family, I feel worthless most days, and unloved." Parents of registrants suffered in unique ways, with one stating "I think of myself as failure of a parent." Other parents described relentless worry and lost dreams: "My heart is broken. My son's life is worthless now and he had so much to give. I'll never be happy the way I used to be ... I worry he will kill himself in his motel room. I worry someone will kill him or torture him."

Another family member described the forgotten children of registrants:

I feel alone, like no one can understand or cares about what my children and I have gone through ... I feel we can never have a normal life. I don't know how to help our children ... I feel isolated and have fear of (others) finding out about my husband.

Family members also expressed anger and broken trust that lingered long after the crime. Some were directed at the registrant:

I can't trust anyone. I certainly don't feel like I can trust my husband. I know in my heart he would never do anything like this again but how can I be certain. I never thought he would do something like this to begin with. If he can hurt me, so can everyone else.

I think of myself as someone who stands by Loved Ones. But I am forced to confront the fact that I am swayed by societal opinion and legal authorities, rather than allowing myself to embrace the pain of my Loved One.

Others directed their anger and mistrust at a system perceived to have failed them, with one saying "I was once far more understanding of social justice issues until I was forced to live under the cloud of the registry with my husband." Another also described disillusionment:

I used to think that everything happened for a reason. I have believed in a higher power all my life. I no longer do, I don't trust anyone. I think everyone is bad. The world is a horrible place. I have always been a believer of justice and fair. I no longer do... A person's life should not be written on the one worst thing he ever did...I don't believe in anyone or anything.

Arousal and Reactivity. Many registrants described trouble falling asleep, staying asleep for “more than a couple hours at a time,” or getting “deep sleep.” Many described problems with concentration, with one saying, “I can’t concentrate for very long; thoughts are constantly interrupted by fear and terror about what people are saying/thinking,” and another fearing “constantly” that distraction would cause him to “accidentally do or not do something that will get me in trouble.”

Hypervigilance, irritability, and startle response were commonly described in various ways, with words like “quick to anger,” “always hyper alert and have many guards up,” “constantly on edge.” One was particularly hyper-aroused by his “hopeless situation of being homeless... feel like I’m going to die every second of the day.” Another described being “constantly on guard. I watch and listen for what I consider to be threats. I can’t sleep.”

Many of the narratives were characterized by a fear that they (or their loved one) would inadvertently violate one of the complex and frequently changing registration laws or a rule of community supervision, leading to a new arrest, sanction, or incarceration. Another common fear was being “exposed” publicly and “constant worry” about vigilantes: “I can’t leave my back to an open door...I put furniture between me and the street side wall of my house in case someone shoots at my house.” One registrant summed it up this way: “The only times I feel any sense of relief is when I am not at home. Home is where the ‘sex offender’ tag exists the most.”

The ripple effect of trauma was clear in the experiences shared by family members that were characterized by fear: “Everything frightens us. Every sound we hear,” and hypervigilance described as “a heightened level of awareness.” Family members also described how “worry for my son interferes with sleep and daytime concentration & general sense of contentment.”

Family members also noted that they couldn’t feel safe even in their own home:

Honestly, most people would probably say they feel safest when they’re home...my hyperarousal comes when I’m in my own house, because of my fear of vigilantism (someone using the registry to find us and hurt us/my husband because of what he’s done/ what they think he’s done).

Discussion

About two-thirds of RSOs and family members had clinically significant indications of PTSD following the sex offense conviction, suggesting that the construct of PCTS has validity. The mean PCL-5 score in this sample was 42.4, and 60–67% of our sample reported symptomatology compatible with DSM-5 diagnostic criteria for PTSD. Comparatively, in a recent study of first responders (Morrison et al., 2021), the mean PCL-5 score was 38.7, with 61% of the sample meeting criteria for PTSD. Perhaps most striking is that scores did not differ significantly between registrants and family members. The traumatic stress examples in all four DSM-5 clusters underscored the wide-ranging ripple effects of the offense and its aftermath.

Interestingly, being on supervision and length of time registered were not statistically significant predictors of traumatic stress in either direction for either group. This is a curious finding, since RSOs and family members poignantly described PTSD symptoms that were connected to supervision and registration. We expected less symptomatology following release from supervision, with desensitization or adaptation effects after longer durations of registration.

It is necessary here to acknowledge the (perhaps obvious) dilemma of studying the trauma experienced by people who have themselves caused so much trauma. There are surely some readers who believe that giving voice to the trauma of people who offend diminishes the anguish and suffering of sexual assault survivors and their families. For many survivors, their pain never ends, and some might argue that people who offend should not escape the same destiny. It has indeed been a thought-provoking journey for us as researchers. We recognize that registrants' own choice to victimize others has led to the traumatizing conditions in which they now find themselves. We make no excuses for people who cause sexual harm, nor do we question whether they should held be accountable. Nevertheless, contradictory things can co-exist: the consequences of a criminal conviction are no less traumatizing simply because someone is guilty and deserves to be punished.

Nonoffending family members, however, are the hidden and unrecognized victims of the ripple effects of crime. They must confront the shock, stigma, betrayal, and shame experienced upon discovering that a loved one has committed a sex offense. Family members of RSOs often encounter judgmental or rejecting reactions within their communities, from friends and relatives, and even from professionals when seeking counseling for themselves (Bailey, 2017; Kavanagh and Levenson, 2022; Sample et al., 2018). They too are impacted by the collateral sanctions of sex crime sentences and SORN laws, and their PCTS should be acknowledged.

Implications for Practice

Post-traumatic stress, by definition, implies that the traumatic event is in the past. However, unlike some other traumatic events, registration as a sex offender (usually) does not end. Prison, probation, or parole can create ongoing traumagenic conditions. These findings suggest a need to re-conceptualize PTSD when traumatic stressors remain ongoing and persistent in real time. Even when formal system involvement concludes, the collateral sanctions of a conviction and subsequent re-entry obstacles can be daunting and stressful in ways that feel threatening to one's ability to survive.

The DSM-5 states that post-trauma environmental risk factors for PTSD include "subsequent exposure to repeated upsetting reminders, adverse life events, and financial or other trauma-related losses" (APA, 2013, p. 278). These factors were often described in the narratives of our participants. Anticipatory traumatic stress is stimulated by ongoing concerns about one's safety and security (Hopwood et al., 2019). The neurobiology of persistent traumatic stress can continually trigger PTSD symptoms, causing distress and impairment (van der Kolk, 2006).

Given these realities, professionals working with people convicted of sex crimes and their family members should be trauma-informed (Grady, Levenson, Glover, & Kavanagh, 2022a; Grady, Levenson, Glover, & Kavanagh, 2022; Harris and Levenson, 2022; Kavanagh and Levenson, 2022; Levenson et al., 2020). Practitioners should consider trauma as a possible explanation for dysregulated emotions and behavior, and deliver trauma-specific interventions to address trauma narratives and reduce PTSD symptoms. Research evidence shows high rates of ACEs and lifetime trauma among prisoners, and trauma contributes to the intergenerational cycle of violence. However, trauma treatments are not routinely incorporated into correctional programming or sex-offending treatments (Gajewski-Nemes and Messina, 2021; Grady et al., 2022a; Pettus-Davis et al., 2019). Recognizing and treating trauma plays a crucial role in self-regulation, which can reduce treatment dropout and dynamic risk for re-offense (Willis and Levenson, 2022).

Trauma-specific and trauma-informed treatments can help clients to transform negative self-narratives into beliefs that foster self-regulation and desistance (Maruna, 2001). Resilience and post-traumatic growth are then reflected in positive changes like self-management, healthier relationships, and flexibility in coping with life's challenges (Tedeschi et al., 2015). Addressing trauma is perceived by CJS clients as helpful in processing past adversity, as well as enhancing coping skills, self-control, self-awareness, and empathy for others (Gajewski-Nemes and Messina, 2021).

Implications for Policy

Paradoxically, the trauma of CJS involvement can have a criminogenic effect on cognitions, coping styles, and personality patterns (LeBel and Richie, 2018). Estrangement from family, unstable housing, reduced employability, anxiety, social isolation, and economic insecurity all provoke significant stress after a criminal conviction (Pettus-Davis et al., 2019; Western, 2018; Western et al., 2015). These barriers to successful re-entry are simultaneous risk factors for recidivism, supervision breaches, and registration violations (Andrews and Bonta, 2017; Hamilton and Fairfax-Columbo, 2022; Pettus-Davis et al., 2019; Uggen et al., 2004; Western et al., 2015). A history of trauma can intersect with current stressors, triggering dysregulation which increases dynamic risk. Thus, it is in the interest of public safety and recidivism prevention to understand the traumagenic nature of criminal sanctions.

Criminal justice reform should include supportive re-entry services and access to trauma-informed mental health care to reduce dysregulation, minimize risk, and promote successful reintegration and desistance from crime. Sex offender management should be evidence-based and individualized based on risk factors: policy-makers should avoid housing restrictions that legislate people into homelessness, and registration durations could be shortened based on longitudinal data informing recidivism and desistance trends (Hanson et al., 2018). Unfortunately, people with a criminal background are highly stigmatized, and there is more public support for disenfranchisement and punitive policies than for rehabilitation and reintegration (Shi et al., 2022). Mass incarceration and

re-entry obstacles have disproportionately blighted minority communities, leaving in their wake more single-parent households, economic depression, and heightened risk for countless social problems (Pettus-Davis and Epperson, 2015; Western et al., 2015).

The principles of *quaternary prevention* are widely recognized in the medical world as a movement to “do no harm” by protecting patients from over-treatment or invasive procedures (Sadeh and McNiel, 2015; Welsh and Rocque, 2014). By balancing risks and benefits of interventions, quaternary prevention models improve outcomes through re-appraisal and refinement of service delivery based on individual needs. In the CJS, unnecessarily restrictive policies and one-size-fits-all treatments can compound iatrogenic effects (Harris and Levenson, 2021; Sadeh and McNiel, 2015; Welsh and Rocque, 2014; Western et al., 2015). In turn, dynamic risk may increase, undermining desistance goals. Clinicians, corrections professionals, and policymakers should consider quaternary prevention concepts and avoid re-traumatization in the re-entry process.

Implications for Research

Measuring PCTS as a type of PTSD has important challenges. As noted elsewhere in this article, qualifying events may not fit perfectly with Criterion A in the DSM-5. Precipitating traumagenic condition(s) persist in the present time (e.g., registration or probation), intersecting with past trauma and further confounding manifestations of distress and impairment. Thus, distinct characteristics of *chronic traumatic stress* might be better captured by alternative measures (Fondacaro and Mazulla, 2018). Inmates serving life sentences suffer psychologically due to the permanence or indeterminacy of their situations (Liem and Kunst, 2013), and the hopelessness of many registrants seems similar to this phenomenon. Future research might also explore future-oriented anxiety as it applies to CJS involvement, possibly using the *Anticipatory Traumatic Reaction Scale* (Hopwood et al., 2019). This tool measures negative feelings and intrusive thoughts related to future threats, preoccupation with preparatory ideas and actions, and disruption in daily functioning. As well, PTSD symptoms can emerge from crime commission itself (Crisford et al., 2008), and the *Perpetration-Induced Distress Scale* might be useful for further study of this phenomenon (MacNair, 2015; Steinmetz et al., 2019).

Of course, there are risks to trauma research, which is why protections for human participants need to be approved by institutional review boards. A meta-analysis of nearly 74,000 participants in trauma research found that most felt positive after the research procedure, but some perceived distress was not uncommon (Jaffe et al., 2015). Noteworthy is that after our survey was conducted, we received about two dozen direct emails. A few asked for (and received referrals to) counseling resources after being triggered with feelings about past traumatic events. But most expressed gratitude, not only for acknowledging the real trauma faced by people who sexually offended and their family members, but for finally putting a name to something they have lived with for years. One respondent emailed:

“I filled out the survey this morning, not thinking that PTSD has had any significant effect on me. I came to realize I have for 36 years been suppressing some things which would seem to point directly at PTSD effects... I never put this together until today.”

Just asking people about their perceptions of trauma seems to be helpful. We need to be willing to hear and believe what people convicted of sex offenses tell us about their experiences if we want to advance treatment effectiveness, risk reduction, and sexual harm prevention (Grady et al., 2022b; Waldram, 2007). Evaluations of CJS services in the USA usually focus on outcomes rather than personal experiences in the system itself (McCartan et al., 2021). Lived experience and service user voices can augment quantitative research; personal narratives elucidate the process by which desistance occurs (or not), thereby enhancing correctional and rehabilitative programming (Copes et al., 2020; Harris, 2017; LeBel and Richie, 2018; Maruna and Liem, 2020; Waldram, 2007). The far-reaching ripple effects of CJS involvement and mass incarceration extend to families and communities, especially marginalized and impoverished groups (Pettus-Davis and Epperson, 2015). Future research might involve refinement of the PCTS construct for other types of justice-involved persons and families, for SORN-specific traumatic stress, for exploration of temporal factors when traumatic stressors remain ongoing rather than situated in the past, and to distinguish between acute and long-term PCTS.

Limitations

The most glaring limitation is that this sample is not representative of the general RSO population and their families. By recruiting participants via grassroots registry reform groups, we reached more affluent and educated people who have intentionally sought self-advocacy and support resources. There is a clear lack of minority representation, including those from disadvantaged communities. There are barriers to reaching marginalized groups, who may be unaware of advocacy and research efforts, or who may distrust those processes and their actors. Only one adult child of a registrant participated in the survey, so there is much to learn about the intergenerational nature of PCTS. This unique area of study would be informative given the literature about the trauma suffered by children of incarcerated parents.

Attention to self-selection bias is worthwhile for several reasons. First, we reached only a certain sampling frame of people of relative privilege, with literacy and computer devices, who are able and allowed to use the internet, and who have the cognitive ability to concentrate and answer questions requiring time, personal reflection, and insight. The findings may not be generalizable to the larger population of people convicted, incarcerated, and/or registered for sex offending. Thus, it is necessary to consider this study and the PCTS phenomenon through a culturally relevant lens, recognizing the intersection of disparities such as racial, economic, gender, and sexual minority injustice (Bryant-Davis, 2019; Williams et al., 2018). We might speculate that PCTS would be even more prominent in representative CJS groups, who are typically less

resourced and more disempowered in many ways. On the other hand, it is possible that registrants and family members with more to lose through the legal process are more inclined to join advocacy groups to seek support and allies for change. Marginalized groups who are more “desensitized” to oppression might see little point in joining these groups and simply carry on as best they can in their lives post-conviction.

As noted previously in the research implications, there are inherent challenges with the measurement of PCTS using the current diagnostic criteria for PTSD. There are also limits to self-reported data. It is possible that respondents embellished symptoms to gain sympathy or to offer seemingly desirable responses. Conversely, it is possible that participants under-reported symptoms which have a subtle presentation and go unrecognized as trauma-related. Though people in the CJS often have more ACEs and traumatic life experiences than the general population, we chose not to ask about other past traumas to avoid confounding the construct of PCTS. It may be impossible to distinguish between PCTS and pre-existing PTSD symptoms that stem from old trauma, even though we asked specifically about traumagenic experiences related to the CJS.

We do not know how the construct of PCTS applies to groups of people with nonsexual criminal convictions. Further analyses of the qualitative responses might shed light on unique specifiers of SORN-specific traumatic stress that are distinct from arrest, conviction, and incarceration. Future research might examine PCTS in general criminal samples and compare differences between them and people convicted of sex crimes. Such studies might clarify whether special post-conviction mandates pertaining to sexual offenses (e.g., SORN and residence restrictions) have additional traumagenic impact.

Summary and Conclusions

While PCTS has been described conceptually in the literature ([Harris and Levenson, 2021, 2022](#)), this pilot study measured traumatic stress in RSOs and their loved ones using an empirically validated tool. PCTS appears to exist in people required to register and their families. Future researchers and practitioners should consider the complexities we encountered, including the limitations of Criterion A in the DSM-5 PTSD diagnosis and the presence of ongoing traumagenic conditions. Clinicians working with registrants and their loved ones can incorporate trauma-informed practices, recognize trauma symptoms, and avoid oppressive dynamics which can re-traumatize service users ([Levenson et al., 2020](#)). Integrating trauma knowledge into sex-offending treatment interventions might help reduce dysregulation, which can contribute to dynamic risk and recidivism. Treating the ripple effects of trauma within a risk-needs-responsivity model ([Jung, 2017](#)) might improve treatment outcomes and help prevent reoffending.

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Supplemental Material

Supplemental material for this article is available online.

Notes

1. We subscribe to the use of person-first language but use the acronym “RSO” to refer to a person who is required to “Register as a Sexual Offender.” The acronym reflects the legal designation of “sex offender” and helps to distinguish registrants from family member participants.
2. Recruitment emails were sent to organizations such as National Association for Rational Sex Offense Laws (NARSOL), Florida Action Committee (FAC), and Alliance for Constitutional Sex Offense Laws (ACSOL), as well as to attorneys and clinicians known to work with registrants and their family members. Recruitment emails encouraged recipients to share the link with other potential participants (snowball sampling).
3. The PCL is typically paired with the *Life Events Checklist for DSM-5* (LEC-5), a self-report measure designed to screen for potentially traumatic events in a respondent’s lifetime [Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). The Life Events Checklist for DSM-5 (LEC-5) is available from <https://www.ptsd.va.gov/>]. The LEC-5 serves as a proxy for PTSD Criterion A in the DSM-5. It begins with the instructions: “Listed below are a number of difficult or stressful things that sometimes happen to people.” For our purposes, we developed a series of questions designed to assess exposure to several CJS-related experiences speculated to potentially result in distress. See [Appendix A](#) in the supplemental online materials.

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