Chapter 9
Incorporating Principles of Trauma-Informed Care Into Evidence-Based Sex Offending Treatment

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9.1 Introduction

Since the 1980s, well-conducted treatment programs for sex offending have been shown to help reduce recidivism by a moderate amount (Hanson et al., 2009; Schmucker & Lösel, 2015). In the USA, however, treatment programs have been very much about control, compliance, containment, and management, driven by presumptions of repetitive patterns, deviant sexual interests, multiple victims, and lifelong risk (see Chap. 2). The advent of strengths-based approaches such as the Good Lives Model (GLM; (Ward & Brown, 2004)) (see Chap. 3) encouraged greater consideration of the *why and how*—why do sexually victimizing behaviors develop, and how can we help our clients recognize the social and emotional needs they are trying to meet through sexual assault? Troubled pasts often pave the way to troubled adulthoods, and many people who have sexually offended are unable to find healthy intimacy and connections to others. Treatment programs, ideally, help clients to address these fundamental problems and learn to meet needs in healthy, non-victimizing ways.

People convicted of sex crimes have high rates of various child maltreatment and family dysfunction as youngsters (Levenson et al., 2015, 2016). Early adversity can create distorted thinking and maladaptive coping mechanisms (including violence).

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It can interfere with attachment and bonding, especially for children who see little modeling of healthy relationship skills (including empathy) in their families or communities. Criminal offenders have much higher rates of adverse childhood experiences (ACEs) than the general population, and such events change the neurochemistry of the brain, leading to poorer functioning in adulthood.

Knowledge about trauma and about sexual offending have grown, enhancing our understanding of these behaviors. Against a societal backdrop of sexual violence prevention emphasizing offense culpability and punishment, however, it is not surprising that professionals in the field have cautioned that people in treatment might embellish or fabricate stories of childhood abuse to deflect personal responsibility or to generate sympathy. On the other hand, several studies have confirmed that sexual offending treatment (SOTX) samples have higher rates of childhood sexual abuse (CSA) and other early adversities than the general male population (Hanson & Slater, 1988; Jespersen et al., 2009; Levenson et al., 2016; Reavis et al., 2013). With concerns about "abuse excuse," approaches to treatment have been highly risk-focused and confrontational and often neglected the principles of effective correctional rehabilitation and trauma-informed practices.

9.2 What Exactly Is TIC?

It is important to understand that trauma-informed care (TIC) is not the same as trauma resolution therapy, nor is it a specific treatment model or a structured program that is delivered in a standardized way. Likewise, it is not a reframing of clients' lives as victims with no internal locus of control, nor is it an excuse for offending. According to the US Substance Abuse and Mental Health Services Administration (SAMHSA), TIC is an overarching framework that takes a "universal precautions" approach to behavioral health services (SAMHSA, 2014). Trauma-informed practitioners understand that past trauma often manifests as presenting problems, and therefore they must integrate knowledge about the neurobiological, psychological, and social consequences of trauma into policies, procedures, and practices that guide a safe, compassionate, respectful therapy environment (Bloom, 2013; Giller et al., 2006; Miller & Najavits, 2012).

TIC is a way of conceptualizing and responding to problematic behavior and its sequelae through the lens of trauma. By conceptualizing cases through a perspective informed by trauma research, we can understand how past experiences may have contributed to sexually abusive behaviors. Trauma-informed practices guide the therapist to avoid repeating disempowering dynamics in the helping relationship. SOTX programs can use TIC to transform their interventions from primarily content-driven psycho-education to a more collaborative and dynamic, process-oriented approach that utilizes the therapeutic encounter as a corrective emotional experience and helps clients build healthy skills.

TIC is not intended to coddle clients, excuse criminal behavior, or condone victimization. Rarely have we seen clients exploit their "victimhood" to deny accountability or gain sympathy. More likely is that clients do not recognize their

own traumatic experiences or think about how those events might have shaped their perceptions and behaviors. The research suggests that men tend to underreport early adversity rather than exaggerate it (Dube et al., 2004; Hardt & Rutter, 2004; Najavits et al., 2009)—because they don't recognize it ("my dad was a raging alcoholic, but that was just normal in our family") and have distorted perceptions about it ("I deserved those beatings") or due to cognitive dissonance ("my mom did the best she could and I love her").

TIC is a strengths-based and empowering framework that can be used within any treatment model or rehabilitation framework such as relapse prevention, risk-needs-responsivity, or Good Lives Model (RP, RNR, GLM) to focus on resilience and personal choice. It requires a professional who can build healing relationships with clients that are safe, respectful, non-shaming, and collaborative—these are the therapeutic alliance qualities that foster human connections, post-traumatic growth, and hope for future possibilities (Bloom, 2013). The key, in trauma-informed care, is to listen to the story from the client's perspective and not to project assumptions onto their narrative; rather, we can provide a safe space for the client to explore the meaning that has become attached to their experiences. TIC helps clients make sense of their lives, acknowledge the circumstances they have lived through, understand their choices and patterns of behavior over time, and identify areas for desired change.

TIC has many Rogerian themes, such as client-centered therapeutic encounters that offer warmth, non-threatening authenticity, and positive regard (Rogers, 1961). In practice it focuses largely on creating an empowering, collaborative, safe milieu in the treatment setting, with an aim to avoid re-creating dynamics that are similar to those in abusive and dysfunctional families. This is something that is often quite challenging for practitioners to do effectively in any nonvoluntary, forensic, correctional, or mandated treatment program. Indeed, treatment approaches that emphasize confrontation, control, and compliance are inconsistent with principles of TIC.

9.3 Why Are Trauma-Informed Practices Important in Treatment for Sexual Offending?

TIC recognizes the prevalence of trauma in contemporary society and especially how impactful a certain set of childhood maltreatments and family dysfunctions called ACEs—adverse childhood experience—can be (Anda et al., 2006; Felitti et al., 1998). There is little doubt scientifically about the neurobiological alterations to the brain that result from chronic toxic stress in childhood and that growing up in an adverse environment can affect behavioral and emotional self-regulation, social interaction, cognitive schemas, and self-efficacy. Early experiences shape expectations and interpretations of self, others, and the world (Creeden, 2009; Grady et al., 2016; Herman, 1992; Marshall, 2010). Not everyone who experiences traumatic events develops post-traumatic stress disorder, and many people flourish with

resilience even after dealing with adversity. However, ACEs can contribute to relational and psychosocial problems later in life.

A history of early trauma can set the stage for poorly executed interpersonal skills, which interfere with the capacity to build relationships with others. Sexual scripts resulting from early trauma can further limit opportunities for emotionally intimate relationships. Intimacy deficits have been correlated with sexual offense recidivism (Hanson & Harris, 2001; Hanson & Morton-Bourgon, 2005), but a trauma-informed therapy setting can mitigate the loneliness and alienation often felt by our clients. For some clients, the therapeutic relationship and the treatment group is the most emotionally intimate relationship they have ever had (Marshall & Burton, 2010; Marshall et al., 2013; Sawyer & Jennings, 2016). When SOTX clients engage in human connections with others who validate their experience, opportunities exist for building relational skills relevant to reducing recidivism risk (Levenson et al., 2017a).

The problems of people who have sexually abused manifest in different ways. For some, emotional identification with children protects them against perceived rejection from adults, while for others, hostility toward women is revealed through sexual violence. For some, sex becomes a coping mechanism like self-medication. Sexual abuse can be used as a maladaptive attempt to fulfill a need for attention, affection, or interpersonal connection. Conversely, some use it to avoid the risk and vulnerability of true emotional intimacy. Abusive behavior may not be antisocial per se, but may be learned in a hostile or deprivational environment and adapted as a survival or self-protection strategy. Treatment, then, should facilitate the development of new skills for clients to meet their psychological and social needs in ways that are neither victimizing nor self-destructive (Levenson et al., 2017a).

Dozens of studies document the linear and robust relationship between ACEs and problematic adult outcomes—including medical diseases, mental and behavioral health disorders, substance misuse, school dropout, and interpersonal violence (victimization and perpetration) (Anda et al., 2006). Notably, higher ACE scores are also associated with risky sexual behavior, such as early onset of sexual activity, higher rates of sexually transmitted diseases, unwanted pregnancies, higher numbers of sexual partners, being raped as an adult, and being a victim of sex trafficking (Dietz et al., 1999; Hillis et al., 2000; Levenson et al., 2017b; Naramore et al., 2015). Thus, maltreated children are vulnerable to revictimization, but they may also be at increased risk for engaging in behaviors that violate the sexual boundaries of others.

The goal of TIC is not to excuse abusive behavior or to minimize client resilience. The goal is simply for treatment providers to think about maladaptive behaviors in the context of past trauma and help clients understand how their collective experiences shaped them and contributed to their relationship patterns and coping strategies. TIC encourages an understanding of how maladaptive behavior develops as a survival tool in response to fight-or-flight activation and is maintained over time through triggers and reinforcement. Trauma-informed practitioners respond to clients in non-threatening ways that aim to build adaptive behavior, an internal locus of control, and resilience.

Treatment aimed simply at stopping sexually abusive behavior without considering the past experiences and future well-being of the client may be insufficient. Trauma-informed care can help us in our challenge to develop the most relevant and successful programs and the best methods for delivering them. The principles of effective correctional rehabilitation include individualized assessment and case planning based on risk-needs-responsivity (RNR) (Andrews & Bonta, 2010; Hanson et al., 2009). Not all clients pose the same level of risk for re-offense, and not all possess the same risk factors. As a responsivity factor, trauma requires practitioners to understand how its legacy impacts the client's response to treatment (Giller et al., 2006; Miller & Najavits, 2012). Each client has strengths that can be harnessed in unique ways to build resilience, and these are best cultivated by attending to relational elements in the professional encounter (Giller et al., 2006; Knight, 2015; Levenson, 2017; Miller & Najavits, 2012). Trauma-informed care is a framework and a set of skills that transcends specific models of intervention and can be infused in any type of programming across agency settings and diverse populations. The goal is to create therapeutic spaces that are safe, empowering, collaborative, and corrective.

9.4 Is TIC Evidence-Based?

The role that research plays in designing empirically-informed treatment protocols goes beyond experimental testing in outcome or effectiveness studies (Levenson & Prescott, 2014). It also requires the merger of interdisciplinary and theoretical knowledge as a foundation for understanding client behavior, assessment of client needs, and development of appropriate case plans. It is challenging to "test" TIC in an experimental design, because its application requires an individualized and flexible approach that does not lend itself to the rigid implementation conditions that are required for research replicability. However, TIC rests on an extensive empirical foundation of research about the prevalence and impact of childhood adversity, along with decades of literature about therapeutic alliance, the common factors of psychotherapy, cognitive schemas, self-regulation, and client-centered principles. These areas of knowledge form the evidence base to shape our conceptualization of the importance of trauma-informed care and its application. Evidence-based practices require critical thinking plus an incorporation of research knowledge and best practices designed to address to the unique needs, risks, and strengths of each individual client (Grady et al., 2017).

Advancement in the efficacy of SOTX programs requires an acknowledgment of the role that early adversity plays in the development of sexually abusive behavior. Early trauma lays the groundwork for a range of interpersonal problems, maladaptive coping, relational deficits, and distorted cognitive schema about oneself and others (Adams, 2003; Bloom & Farragher, 2013). Intimacy deficits, which are often related to early adversity and attachment disruptions, have been correlated with sex offense recidivism and are therefore important treatment targets (Hanson & Harris,

2001; Hanson & Morton-Bourgon, 2005). By responding to aggressive and sexualized behavior problems in a more compassionate manner, the trauma-informed therapist creates a corrective emotional experience, fostering resilience and posttraumatic growth. By helping SOTX clients to recognize and change harmful interpersonal patterns, we create opportunities for them to learn new skills, enhance their relationships, and improve their general well-being. This type of personal growth can mitigate future potential to re-offend as the client builds healthy strategies for relating to others and meeting emotional needs in non-victimizing ways (Levenson et al., 2017a).

Our treatment outcome research has produced mixed evidence about the ability of our interventions to reduce recidivism (Hanson et al., 2002; Långström et al., 2013; Marques et al., 2005; Schmucker & Lösel, 2015). We argue that trauma is an important responsivity factor (Bloom, 2013; Miller, 2011; Miller & Najavits, 2012) that SOTX providers should consider when delivering services. It is time to put the therapy back into treatment for sex offending. Though workbooks and treatment manuals can be helpful, any overemphasis on rigidly standardized programming can undermine the principles of psychotherapy, which require flexibility to respond to unique client needs as they present themselves in the therapeutic encounter (see Chap. 5). In this way, approaches that integrate interventions with empirically and theoretically supported principles of change may be most useful for promoting meaningful and successful SOTX practice—ultimately enhancing community safety (Levenson et al., 2017a).

9.5 CARES Model of Trauma-Informed SOTX

Using the acronym CARES (collaboration, autonomy, respect, empathy, safety) will help keep a clinician on track when translating trauma-informed concepts into SOTX practice (Levenson et al., 2017a). TIC moves away from the belief that we must actively restrict and manage client's behavior in order to prevent relapse of sexual assault. Our traditional treatment approaches have moved the locus of control away from the client and undermined the client's investment in change. Instead, TIC shifts from control to collaboration, and does not replace the evidence-based cognitive-behavioral interventions we are familiar with, but provides a framework for delivering those interventions in a way that potentially maximizes client responsivity.

Collaborative approaches allow clients to define their problems and goals and participate in devising strategies through which, together with a caring treatment professional, they can develop internal controls to make the self-improvements they desire.

Autonomy and empowerment honor a client's right to self-determination and allow a client to choose and prioritize his life goals and his pace in treatment in a way that is most meaningful to him.

Respect is crucial; by treating clients in ways that honor their humanity and dignity, we can help restore a sense of value and worth. By treating clients the way we all want to be treated, we reinforce and model the kinds of interactions we want our clients to imitate.

Empathy plays a role in helping clients to appreciate the perspectives of others. When we listen with curiosity and compassion, we model empathy and help our clients to feel connected with others.

Finally, treatment should feel *safe*. Many clients enter treatment with trepidation, shame, defensive denial, fears of judgment, and expectations of rigid authoritarianism. The burden is on treatment providers to create safe spaces for sharing openly and honestly about the sexual behavior problems (Really, safety comes first, but that acronym would be SCARE, which doesn't sound as therapeutic). Safe relationships are consistent, predictable, and non-shaming.

9.6 Translating TIC into SOTX Goals

TIC fits well within RNR, self-regulation, GLM, and RP models of SOTX (ideally, a combination of all). When applied to the common components of sex offending treatment, what becomes important is to utilize the treatment experience to reinforce new skills. In other words, what makes therapy different from a class is that in addition to psychoeducational information, clients have a chance to understand and alter their relational patterns with others in their lives, including group members and therapists. In this section, trauma-informed applications of traditional SOTX goals will be discussed (Levenson et al., 2017a).

9.6.1 Accountability

In our field, we have emphasized admission of offending and full disclosures of sexual history, often before any other treatment goals can be accomplished. While knowing the facts and circumstances around a client's offending behavior is certainly useful in formulating the assessment and treatment plan, the job of the therapist is not to decide whether the client is telling the truth, catch him in a lie, or prove him wrong. Counselors should provide an accepting and safe environment where, perhaps for the first time ever, there is more to be gained than lost by talking about shameful behaviors like sexual abuse. The therapeutic demeanor should say: "I want to listen to you and understand your experience, and I have no need to get into a power struggle or win a debate with you!"

Confrontational approaches to SOTX have historically been popular, and some clinicians fear that without confrontation clients will deceive and manipulate and obfuscate responsibility. However, these tactics may actually disempower and discourage clients from taking responsibility for personal change (Garland & Dougher, 1991;

Kear-Colwell & Pollock, 1997). By challenging and confronting clients in ways that may feel hostile, demeaning, or threatening, therapists may inadvertently reinforce resistance and cause a client to become further entrenched in his own unhelpful ideas (Jenkins, 1990). Negative process can affect group dynamics as well, and persistent, harsh, or adversarial confrontation by group members or therapists can inhibit clients from being forthcoming. On the other hand, respectful challenges from group peers can foster reframing of distorted thinking and lead to increased engagement. Therapeutic confrontation points out inconsistencies and inner conflicts without accusing, blaming, or shaming. It recognizes the fear that goes along with discussing abusive behavior and that people are often ambivalent about change. Utilizing more validating approaches can increase engagement by creating a non-threatening environment, which is less likely to trigger old trauma responses. Decreased defensiveness can lead clients to embrace the possibilities and benefits of change, tolerate emotional distress, and improve patterns of interacting with others (Kear-Colwell & Pollock, 1997; Willemsen et al., 2016).

Accountability should not just be about responsibility for sexually offending behavior. Rather, treatment should offer a more holistic approach to personal accountability in all areas of one's life. It involves a willingness to be honest with oneself and others about weaknesses, mistakes, and character flaws, and to identity the role one plays in contributing to conflict or unhealthy relationship patterns. It requires strength to admit the need for self-improvement in all areas of life, acknowledging truths about oneself that are hard to face. Therapists can model personal responsibility and willingness to admit mistakes and apologize. Therapists can also facilitate the safe and nonjudgmental environment required to recognize one's own human flaws and engage in personal growth. In summary, personal accountability is an important treatment target that goes beyond simply taking responsibility for one's offense. Its goal is to help clients live honestly and with integrity within their value system and be the kind of person they want to be.

9.6.2 Empathy

Empathy is the ability to understand the thoughts and feelings of another, and it seems to be a central reason why we resist harming others—because we can imagine how harm would feel. For our clients, the role of empathy in reducing recidivism is unclear (Fernandez, 2002; Marshall et al., 2001), but its importance may lie in the ability to take the perspective of others. To be able to help our clients with their own self-awareness and perspective-taking, we need to be able to model these skills. This parallel process occurs when the therapist conveys an understanding of the client's experience without judging and recognizes and validates client emotions. It also occurs when we acknowledge trauma and adversity, giving voice and recognition to clients' own inner wounds. Again, this is done not to excuse abusive behavior, but to connect with the feelings and thoughts and meaning attached to victimization experiences.

A lack of a secure attachment to a primary caregiver early in life may hinder empathy development (Adams, 2003; Grady et al., 2016; Marshall, 2010). Abusive or neglectful parenting in childhood fails to model sensitivity to the needs of another, inhibiting the development of skills allowing one to discern the perceptions of those around them. A major ingredient in the parental relationship early in life is a series of "serve and return" encounters between infants and their caregivers, by which parents smile, engage, giggle, coo, and talk, stimulating a reciprocal interaction of social responsiveness (National Scientific Council on the Developing Child, 2012). The absence of early parental responsiveness increases a child's risk for disorganized attachment styles, dependency, detachment, and intimacy deficiencies. Deprivational parenting can lead to narcissistic entitlement and self-centric thinking, with a schema of "get what I can when I can."

An adverse family environment can be a breeding ground for sexually abusive behavior. A lack of nurturing leads to mistrust, hostility, and insecure attachment, which then contribute to social rejection, loneliness, negative peer associations, or delinquent behavior (Hanson & Morton-Bourgon, 2005). "The form of sexuality that develops in the context of pervasive intimacy deficits is likely to be impersonal and selfish, and may even be adversarial… Attitudes allowing non-consenting sex can develop through the individual's effort to understand their own experiences and adopting the attitudes of their significant others (friends, family, abusers)" (Hanson & Morton-Bourgon, 2005, pp. 1154–1155). A trauma-informed therapist modeling empathy provides a new type of encounter and may help shape new awareness about the needs of others. This may in turn reduce criminal attitudes and distorted cognitions about the harmful impact of one's behavior on others. There are many opportunities in treatment groups to engage in trauma-informed responses that model and promote empathy.

In summary, helping clients understand and appreciate victim impact begins with validating their own experiences of being victimized. By giving voice to their own pain, clients can better see abusive actions through the eyes of those they've harmed. By modeling compassion and kindness, we implicitly teach clients to engage with respectful boundaries and non-harmful interactions. By eliminating power struggles, we remove the need for aggression and teach skills of shared power. Facilitating victim empathy is not about shaming, blaming, and confronting clients about how they've hurt people. It is about creating opportunities to practice and rehearse perspective-taking, neutralize power imbalances, and engage in mutual, collaborative decision-making that considers the feelings of others.

9.6.3 Reconstructing Relapse Prevention as Self-Regulation

Traditional relapse prevention approaches emphasize complicated models of cycles and triggers that may not be applicable to all clients. Instead of thinking of relapse prevention as an offense-specific phenomenon, it may be more helpful to focus on self-regulation deficits that create a spectrum of risk factors in clients. Chronic early

adversity can alter the architecture of the brain by the overproduction of stress hormones (fight-or-flight responses). The amygdala rules, and the executive functioning of the frontal lobe may be less developed, creating self-regulation deficits in three main areas: *general, sexual, and affect regulation* (Levenson et al., 2017a). These areas are consistent with the items in the Sex Offender Treatment Intervention and Progress Scale (SOTIPS), an empirically designed assessment of improvements in treatment targets (McGrath et al., 2013). Some clients may experience difficulties in multiple categories in all three spheres, while other clients may have problems in very specific areas. It is important for therapists to help each client identify those most applicable to salient behavioral, sexual, or emotional regulation goals.

Children who grow up in chaotic home environments may not get a lot of instruction or modeling in how to be organized, set goals, structure time, or plan ahead. Without a chance to cultivate those skills and practice them early on, their adult lives may mimic the chaos that was so familiar to them in childhood. They may have lacked adult caretakers who created external controls in the environment that restricted the ability to act on impulse. There may have been few chances to learn a decision-making process by which we explore many alternatives and weigh the pros and cons of potential outcomes in order to make a well-reasoned choice. Thus, clients may need help with learning to manage impulsivity, creating routine or structure, becoming organized, managing their time or budget efficiently, and thinking through cause and effect. SOTX counselors should recognize these issues, help clients understand their connection to early life experiences, and coach skills that assist clients to navigate the adult world more successfully.

SOTX programs have typically focused primarily on sexual self-regulation. Obviously this is important, but sexual regulation problems may, for some clients, be representative of other related patterns—in particular, a mechanism to meet emotional or intimacy needs. Some sex offenses occur because a person has a paraphilic interest such as pedophilia, or sexual preoccupation, or an excessive sexual appetite. Sexualized coping may be a way of soothing distress and/or meeting needs for intimacy, affection, attention, power, or control, and this may be especially true for clients with a childhood history of abuse. Molestation in childhood can make a unique contribution to sexually abusive behavior. Sexually abusive behavior may reflect compensation for feelings of powerlessness, social learning by which individuals model their own abuser's behavior and distorted thinking, or the association of sexual arousal with adult-child sexual activity (Seto, 2008). Witnessing violence in the childhood home can contribute to a distorted sense of power dynamics in relationships as well as inaccurate ideas about gender roles, male privilege, respect, and consent. In some cases, sexualized acting out (particularly noncontact offenses like computer-related crimes, exposing, or voyeurism) may be a way of creating distance in interpersonal interactions and avoiding the emotional vulnerability of true intimacy. Clients may have different types of sexual self-regulation issues that differ from paraphilic disorders, such as compulsive masturbation, pornography use, infidelity, sexually harassing behavior, promiscuity, or purchase of sexual services.

Affect regulation is also a prominent theme for many SOTX clients and may manifest in irrational anger, overreaction to environmental stress, "chip on the shoulder," or volatile moods. Interventions can include building skill sets for self-monitoring, de-escalation, distress tolerance, mindfulness, and self-awareness. Addressing conflicts and unhealthy interactions that occur here and now in group therapy sessions are ideal to coach interpersonal skills by creating experiential opportunities for compromise, negotiation, conflict resolution, assertiveness training, and active listening skills. Group therapy is also ideal for helping clients with reality testing, interpersonal competence, and perspective-taking with trusted others. Dialectical behavioral therapy (DBT) can be a helpful supplement for some clients with extreme emotional dysregulation (Linehan, 1993; Stinson, 2016).

Self-regulation skills are crucial in helping people develop a strong sense of self-efficacy, defined as belief in one's own capacity to achieve goals, accomplish tasks, and respond competently to challenges (Bandura, 1977). Emotional competence and self-regulation are important pathways to self-efficacy. Learning how to observe one's own inner experience and become more proficient in managing thoughts, emotions, reactions, relationships, and impulses are essential skills and strategies for preventing re-offense and creating a good life.

9.6.4 Thinking and Cognitions

In most SOTX programs, identifying and restructuring distorted cognitions about offending are common requirements for treatment progress. Offense-related distortions take the form of rationalizing, justifying, and excusing behavior, as well as victim-blaming and denial of the impact of abuse on others. Confrontational approaches are often used in group therapy to address offense-related thinking errors, and clients are often required to "correct" distortions in a cognitive restructuring process. However, trauma-informed approaches suggest that distorted thinking about offending is often tied to larger cognitive schemas about self, others, and the world in general (Levenson et al., 2017a).

Beck defined "cognitive distortions" as "idiosyncratic thought content indicative of distorted or unrealistic conceptualizations" (Beck, 1963, p. 324) that often originate from underlying negative *schemas* or "core beliefs" through which people view themselves, others, the world around them, and the future. Core beliefs reflect "truths" formed in childhood based on experiences that shaped expectations of others and interpretations of events.

Distorted cognitions presented by SOTX clients often reflect entrenched patterns of thinking across many domains of a person's life and relationships. A trauma-informed approach focuses on understanding the origins of maladaptive schemas and exploring the validity of these cognitions in a safe environment. For clients with extensive ACE histories, cognitive treatment targets linked to sexual offending are best conceptualized as symptoms rather than problems, and maladaptive rather than distorted or erroneous (Levenson et al., 2017a).

Offense process work can help clients explore the origins of maladaptive cognitions and identify themes and patterns of expectations about boundaries, adult-child relationships, problem-solving, conflict resolution, sexuality, intimacy, gender roles, power and control, and other relevant relational issues. Often, maladaptive cognitions are connected to early trauma. However, it is important to recognize and acknowledge that other factors, including societal values and cultural norms, can influence the development of offense-related cognitions. These include messages about male privilege, sexualization of youngsters, and the pliable interpersonal boundaries fostered by electronic communication. Rather than simply challenging clients to "correct" their "thinking errors," therapists can promote thoughtful discussions in group that explore harmful social norms as well as individual schemas resulting from personal adversities. In this way, we can empower clients to rethink their own flawed assumptions, enter into a process of self-exploration, and take responsibility for altering their thinking and behavior in healthy ways.

9.6.5 Relationship Skills and the Power of Group Therapy

Relational improvements may be the most important aspect of sex offending treatment, and this begins by modeling within the therapeutic encounter. An important principle of TIC is that respectful language, boundaries, and use of power are crucial to the enactment of safe spaces (Levenson et al., 2017a). Modeling respectful interactions with clients can establish safe and appropriate limits without replicating the oppressive dynamics of other authority figures in their lives (Harris & Fallot, 2001). Safe relationships are consistent, predictable, and non-shaming (Elliott et al., 2005; Marshall 2005; Marshall et al., 2013; Willemsen et al., 2016). The historically confrontational approach of many SOTX programs may inadvertently reproduce disempowering dynamics like those in abusive families (Blagden et al., 2016). This can easily create a parallel process that reactivates trauma and prompts a client's need to respond with old coping skills that were rehearsed over and over in a dysfunctional home. Trauma-informed SOTX can facilitate important changes in relational patterns that might improve self-efficacy and decrease dynamic risk for re-offense.

Erik Erikson proposed that trust in our earliest relationships with caretakers is fundamental to establishing a healthy personality (Erikson, 1993). Maslow's hierarchy advised that all humans have basic needs for survival, physical and psychological safety, social connection, self-esteem, and actualization (Maslow, 1943). Carl Rogers talked about unconditional positive regard, as well as therapist authenticity, as foundational elements of the therapeutic alliance (Rogers, 1961). These core foundations of psychotherapy apply to all clients, including people convicted of sex offenses, and are perhaps even more important in highly dysfunctional patients. When a client's basic need for safety and acceptance in the helping relationship is acknowledged, an atmosphere of trust can be established (Elliott et al., 2005). There are stages of intimacy that all relationships go through, and by allowing the consumer to manage risk-taking at his own pace in the counseling program, the clini-

cian actually models a healthy process of establishing trust based on evidence that another person is listening and responding in a truly reliable and genuine manner.

Most SOTX programs utilize group therapy modalities, and there is growing support for the value of an experiential framework that utilizes interpersonal process in group psychotherapy (Blagden et al., 2016; Gunst, 2012; Levenson, 2014; Marshall & Burton, 2010; Marshall et al., 2013; Sawyer & Jennings, 2016; Willemsen et al., 2016). Relational disturbances can be at the root of sexual offending for many clients, and group allows them to share and process emotions in a safe environment. Being more in touch with feelings can help facilitate emotional and behavioral regulation, as well as deeper intimate connections and improved interactions with others (Blagden et al., 2016; Gunst, 2012; Willemsen et al., 2016). Therapists can foster a group climate in which members establish norms regarding peer support and confrontation, model compassionate interactions, and practice effective communication skills (Macgowan, 2003; Marshall, 2005; Marshall et al., 2013; Marshall et al., 2003; Sawyer & Jennings, 2016). When members see honesty and disclosure being rewarded with support and encouragement, it reduces anxiety and threat, thereby decreasing the need for defensive posturing. A TIC model attempts to employ a respectful and accepting encounter in the group room, maintaining a nonjudgmental atmosphere and avoidance of negative labels (Willis, 2017). Group therapy is an opportunity for strategic process-oriented relational interventions, creating opportunities for clients to relate to others in a meaningful and healthy fashion (Levenson et al., 2009; Levenson & Prescott, 2009).

The power of group cohesion and mutual aid is realized when acceptance and sharing from peers facilitate willingness and ability to interact with others more deeply and honestly (Yalom, 1995). Sexual offending can be a manifestation of having had few opportunities for emotional connection with others (Seidman et al., 1994) due to limited interpersonal skills as well as a desire to hide their sexual interests. Yalom (1995) contended that de-isolation and cohesion results from the discovery that others have similar thoughts and feelings; it is the sharing of one's inner world and subsequent acceptance by others that is a healing force. Group therapy also provides ample opportunities to develop and practice new social skills and constructive conflict resolution in the treatment setting itself (Jennings & Sawyer, 2003). The interactions between group members, and between client and therapist, allow relational patterns to be addressed in a non-threatening way as they present themselves in the therapeutic encounter (Jennings & Sawyer, 2003; Marshall & Burton, 2010; Sawyer & Jennings, 2016; Teyber & McClure, 2011). Therapists can coach clients to engage in effective communication with one another.

9.7 Summary and Conclusions

The success of treatment in reducing recidivism for people who sexually abused remains a subject of controversy (Långström et al., 2013; Levenson & Prescott, 2014), and empirical studies have demonstrated mixed results and small effect sizes.

SOTX treatment exists primarily to prevent future victims. Levenson and Prescott (2014) pointed out, however, that SOTX studies have focused almost exclusively on measuring recidivism rates, while other measures of client improvement have often been ignored. By conceptualizing a broader range of treatment goals, and including various measures of client change, SOTX can foster relational improvements that reduce someone's risk of reoffending (Levenson & Prescott, 2014).

The existing literature in the areas of general psychotherapy, neuroscience, and psychosocial impacts of early adversity have much to offer in our understanding of sexually abusive behavior. TIC brings the therapist back into therapy while incorporating best practice principles of risk-needs-responsivity as well as the strengths-based Good Lives Model of rehabilitation. Areas of focus for trauma-informed SOTX should include the common factors of psychotherapy, attention to the life narratives of clients and the meaning attached to them, awareness of the role of adverse childhood experiences in the development of self-regulation difficulties and maladaptive schema, and use of the therapeutic process to foster a corrective experience and meaningful relational changes.

The definition of evidence-based practice involves using clinical expertise informed by research in the context of unique client strengths and needs. Trauma-informed case conceptualization fosters trauma-informed clinical responses, which creates emotionally safe treatment settings and promotes change through corrective experiences and human connections. TIC empowers clients to define their own goals and make meaningful change that reduces future risk to harm others. Using the acronym CARES (collaboration, autonomy, respect, empathy, safety) will help keep a clinician on track when translating trauma-informed concepts into SOTX practice (Levenson et al., 2017a).

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