TRAUMA-INFORMED CARE

Transforming Treatment for People Who Have Sexually Abused

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Introduction

Since the 1980s, sexual offending treatment (SOTX) programs have been very much about control, compliance, containment, and management, driven by presumptions of repetitive patterns, immutable deviant sexual interests, multiple victims, and lifelong risk. The piece that seems to be missing is the why—the understanding of how sexually victimizing behaviors develop, and how we can help our clients recognize the social and emotional needs they are trying to meet through sexual assault. As we spent time over the years really listening to our clients, it became clear that their troubled pasts had paved the way to troubled adulthoods, and that many were unable to find healthy intimacy and connections to others. Though they spent a lot of energy in treatment minimizing their culpability, we understood that they did not want to be living a life in which they harmed others.

People convicted of sex crimes inspire little sympathy. But the reality is that most of them were victims of various child maltreatments and family dysfunctions as youngsters. Early adversity shaped their distorted thinking, inspired maladaptive coping mechanisms (including violence), interfered with attachment and bonding, provided little modeling of healthy relationship skills (including empathy), and undermined their self-regulation capacities. The research is clear that criminal offenders have much higher rates of adverse childhood experiences (ACEs) than the general population, and that such events change the neurochemistry of the brain, leading to poorer functioning in adulthood. There is never an excuse for assaultive behavior, of course, but it is important for us to understand how interpersonal violence develops, so that we can inform our intervention strategies accordingly.

Knowledge about trauma and about sexual offending have both grown by leaps and bounds over the past 25 years, enhancing our understanding of our clients' behaviors. Clinicians are faced with an age-old dilemma, however: how best to apply research findings to their real-life clients. Keeping up with the emerging

evidence can be overwhelming, and it requires a willingness to leave behind unhelpful practices and implement new ones.

The field of treating people who sexually abused arose from different arenas, none of which involved a clear trauma-informed perspective. A recognition of child physical abuse in the 60s and 70s led to child protection laws and mandated reporting policies. Dialogue about sexual abuse emerged out of the women's movement, and many came to understand sexual violence as a misogynistic misuse of power and control (Prescott, Plummer, & Davis, 2010). The scientific study of sexuality also emerged in the twentieth century and helped us to assess men's sexual interest in children (Wilson & Freund-Mathon, 2007). Behavioral interventions for abusers developed after a wave of "sexual psychopath" laws intended to rehabilitate people viewed as sexually dangerous (Swanson, 1960). In the 1980s our field adopted a relapse prevention cognitive–behavioral model from the addictions field, and we attempted to develop manualized programming that lent itself to experimental research. Over the past twenty-five years, we have realized that sexual abuse represents a range of motivations across a spectrum of risk. Some abusers are motivated by sexually deviant interests, while others used sex in the service of power and control. Still others are making shockingly misguided efforts to connect intimately with others while minimizing their own risk of vulnerability. Despite the evolution of our theories and treatments, outcome studies still demonstrate weak effects on reducing recidivism.

Against a societal backdrop of sexual violence prevention emphasizing offense culpability and punishment, it is not surprising that the field of SOTX has been skeptical about the role of trauma in offending. 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, Hanson and Slater (1988) reported that about 28% of people convicted of sex crimes reported childhood sexual abuse, and other studies have confirmed much higher rates of CSA in SOTX samples than in the general male population (Jespersen, Lalumière, & Seto, 2009; Reavis, Looman, Franco, & Rojas, 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.

The principles of effective correctional rehabilitation include individualized assessment and case planning based on Andrews and Bonta's risk-need-responsivity (RNR) principles (Bonta & Andrews, 2017). Not all clients pose the same level of risk for reoffense, and not all possess the same risk factors. Each client has

strengths that can be harnessed in unique ways to build resilience. Counselors and group members who make clients feel valued and understood help strengthen human connections. It is these connections that help build empathy, which might influence clients to resist harming others. These connections also build new neural pathways in the brain which ultimately reinforce a new repertoire of interpersonal skills for clients who have suffered relational poverty. The attention to personalized risks, strengths, and needs is what maximizes responsivity, allowing us to engage each client in a way that enhances their ability to respond to our interventions.

We believe that a missing link in effective SOTX has been the absence of a trauma-informed perspective. Treatment aimed simply at stopping the sexually abusive behavior without considering the past experiences and future well-being of the client may be insufficient. John Morin and Jill Levenson tried to capture these ideas in our SOTX workbook *The Road to Freedom*, a strengths-based model that incorporated the construct of early developmental pathways to offending (Morin & Levenson, 2002). Trauma-informed care can help us in our challenge to develop the most relevant and successful programs and the best methods for delivering them. Trauma-informed care is a framework that transcends any model of intervention and can be infused in any type of programming across agency settings and diverse populations.

What exactly is TIC? TIC is not the same as trauma-resolution therapy, nor is it a treatment model, nor is it a structured program that is delivered in a standardized way. According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), TIC is an overarching framework that takes a “universal precautions” approach (SAMHSA, 2014a). A trauma-informed program, organization, or practitioner recognizes the widespread prevalence of trauma and its far-reaching effects across the lifespan. Trauma-informed practitioners understand that the signs and symptoms of trauma often masquerade as presenting problems, and that combative or resistant clients are, in actuality, most in need of trauma-informed responses. TIC integrates knowledge about the neurobiological, psychological, and social consequences of trauma into policies, procedures, and practices that guide a safe, compassionate, respectful therapy environment. Most importantly, TIC recognizes that social service interventions (especially those that are mandated) can be disempowering and oppressive, which can replicate traumagenic childhood conditions; TIC proactively seeks to avoid retraumatization in the service delivery setting.

By its very nature, TIC is tailored to the needs of each client within the context of his history and therapeutic goals. TIC is not intended to coddle offenders, excuse criminal behavior, or condone victimization. It is a way of conceptualizing and responding to problematic behavior through the lens of trauma.

In this book, readers will become well-versed in the cross-disciplinary research describing the impact of early childhood trauma on cognitive, social, emotional, and behavioral development. We will focus on two general skills: 1) case conceptualization and 2) trauma-informed responding. Readers will be able to define principles of trauma-informed care, identify its essential components, and conceptualize cases through a perspective informed by trauma research. We hope readers will learn innovative ideas for incorporating responses to clients that avoid repeating disempowering dynamics in the helping relationship. Finally, we hope to help SOTX clinicians transform their interventions from primarily content-driven psychoeducation to a more collaborative and dynamic, process-oriented approach that utilizes the therapeutic encounter as a corrective emotional experience. You will notice that we try not to use the term "sex offender," because, as Gwen Willis often reminds us, why would we want to label people as the very thing we don't want them to be?

We start with two simple questions: Do we want them to continue committing sex crimes or not? Assuming the answer is a straightforward no, the next question becomes: Then what can we do? Research findings have been clear: early adversity is very common in the lives of people who have engaged in crime. A history of trauma can set the stage for poorly executed interpersonal skills, which interferes with the capacity to build relationships with others. The deviant secrets of people who have sexually abused further limit their 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 model safe and healthy relationships while mitigating the loneliness and alienation often felt by our clients. For some clients, the therapeutic relationship is the most emotionally intimate relationship they have ever had. When they engage in the therapeutic process and experience an honest connection with others who validate their experience, opportunities exist for building relational skills relevant to reducing recidivism risk.

The problems of people who have sexually abused manifest themselves in different ways, but we think that a common thread is protection against vulnerability. Our clients use sexual abuse as one of many survival tactics rehearsed and per-

fected early in life, often in households fraught with physical or emotional danger. For some, emotional identification with children protects them against rejection by adults, while for others, hostility toward women is revealed through sexual violence. For some, sex becomes a coping mechanism like self-medication. We view sexual assault as a maladaptive attempt to fulfill a need for interpersonal connection, or conversely, to avoid the risk and vulnerability of true emotional intimacy. Treatment, then, can provide a new template facilitating skills for clients to meet their emotional needs in ways that are neither victimizing nor self-destructive.

If there has ever been a time to reconstruct principles of treatment for people who have sexually abused, it is now. We have kept doing the same things, and we have kept getting the same results. Clearly, content-driven treatment that focuses primarily on relapse prevention, delivered in a psychoeducational format, has not demonstrated its effectiveness as robustly as we'd hoped. Jill, Gwen, and David have come to see our RP approaches metaphorically like a Band-Aid on wounds that continue bleeding internally. We thank you in advance for reading this book. We hope we can persuade you to transform your practice to become more trauma informed. For us, this book represents the culmination of how we have come to understand the complexities of the clients we serve. Our own ideas, however, are continuously evolving as we listen to and learn from scholars and (mostly) from our clients. By understanding the role of early adversity on neurobiological, psychological, social, and cognitive development, we hope you will be better equipped to play a vital role in the prevention of sexual victimization.

About the Authors

Jill Levenson, PhD, MSW, LCSW is a professor of social work at Barry University in Miami, Florida. She is also a licensed clinical social worker with 30 years of experience working with victims, survivors, and perpetrators of interpersonal violence, child maltreatment, and sexual abuse. She is a SAMHSA-trained expert in trauma-informed care (TIC), and has published extensively about adverse childhood experiences (ACEs) and TIC. Her groundbreaking research about the link between childhood adversity and adult criminality has paved the way for innovations in sexual offending rehabilitation programs that now utilize a trauma-informed framework. She uses a scientist–practitioner model to inform both her research and her work with clients. As a well-known international expert on sexual abuse and TIC, Jill is frequently quoted in the media and has been invited to speak across the United States and around the world. She is a strong advocate for human rights and social justice, highlighting the need for trauma-informed care and primary prevention efforts that recognize the role of early adversity in the development of psychosocial problems and sexually abusive behavior. Jill has served on the board of directors of the Association for the Treatment of Sexual Abusers (ATSA) and sits on ATSA's adult clinical treatment committee.

Gwenda Willis, PhD, PGDipClinPsyc, is the founder and director of the Advancing Sexual Abuse Prevention (ASAP) research group at the University of Auckland, New Zealand, and clinical psychologist in private practice. Gwen has worked in clinical and research capacities with adults who have sexually abused in New Zealand, Australia, and North America. Her research and clinical interests focus on understanding and preventing sexual offending and strengths-based approaches to rehabilitation and reintegration. Gwen provides training and consultation to

sexual offending treatment providers internationally, including in the application of the good lives model of rehabilitation. Gwen has received numerous awards and accolades for her research, including a Fulbright Senior Scholar Award (2010), and a 5-year Rutherford Discovery Fellowship to research desistance and protective factors in individuals who have sexually abused (2016). Gwen is an executive board member for the Australia and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA), a board member for Rape Prevention Education (RPE), a member of ATSA and the ATSA prevention committee, and serves on editorial boards of several international journals.

David Prescott, MSW, LICSW, is a current fellow and past president of ATSA. He is also the 2014 recipient of that organization's Distinguished Contribution award, one of only a handful of recipients. Previously, he received the Bright Lights award from the National Adolescent Perpetration Network in 2007; he has since become a member of that organization's board of elders. David is a senior associate and certified trainer for the International Center for Clinical Excellence and a member of the Motivational Interviewing Network of Trainers. He is also a consultant, supervisor, and invited trainer for the Romanian Association for Brief Therapies and Strength-Based Solution Focused Consultancy. David has lectured around the world and has served on the editorial boards of numerous journals. He is also co-editor of the NEARI News, which is read by thousands of professionals each month.