

# Hurt people hurt people: using a trauma sensitive and compassion focused approach to support people to understand and manage their criminogenic needs

Jon Taylor and Kerensa Hocken

## Abstract

**Purpose** – *This paper aims to argue that to address those factors that contribute to the probability of offending, the origins of such factors should be understood, and interventions that recognise the functional aspects of criminogenic capacities should be developed.*

**Design/methodology/approach** – *The paper provides a theoretical basis for trauma sensitive practice by providing an evolutionary understanding of human harmfulness alongside a summary of the impact of adversity and abuse on the developing child.*

**Findings** – *The paper proposes an overarching framework that uses compassion-focused therapy for risk reducing interventions with men who cause harm to others.*

**Practical implications** – *This paper encourages forensic practitioners to develop a trauma aware approach to intervention design and delivery. The paper provides an overview of a compassion-focused therapy as approach to intervention that conceptualises criminogenic capacities within a more holistic and functional framework.*

**Originality/value** – *Forensic interventions have been slow to assimilate evidence from adverse childhood experience research and have therefore been limited in their ability to address the functional origins of criminogenic need. This paper offers a framework that allows practitioners to address risk while also allowing individuals to process their own trauma and adversity.*

**Keywords** *Sexual offending, violent offending, intervention, Trauma-informed practice, Compassion-focused therapy, Evolutionary psychology, Formulation, Criminogenic need*

**Paper type** *Conceptual paper*

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## Introduction

Forensic practice has changed. In its infancy, understanding of offending behaviour was based on deviancy and disorder. Across a spectrum of interventions, methodologies were developed with the intention of removing or reducing faults. Aversion therapies were a popular way to address deviant fantasies (Laws and Marshall, 1990), cognitive-behaviour therapy was used as a template to challenge and prevent negative automatic thoughts and cognitive distortions (Salter, 1988), while psychodynamic therapies sought to rid people of their “perversions” (Welldon, 1996).

More recently, and perhaps stimulated by Tony Ward’s seminal work in rehabilitation and Good Lives (Ward, 2002) there has been a gradual shift from a deficit model to an understanding of offending based on human needs. Ward’s Good Lives Model (GLM) of rehabilitation proposes that offending is motivated by a drive to satisfy core human goals, such as competence, agency and relatedness (Ward and Maruna, 2007). Harmful

Received 14 August 2021  
Revised 14 August 2021  
Accepted 14 August 2021

behaviour is seen as an inappropriate mechanism for the pursuit of goals, but the goals themselves are considered legitimate. The GLM represented a shift in focus, from addressing *deviancy* to building skills, and similarly argues for the necessity of building affiliative relationships as the scaffold for therapeutic practice. At its essence, the GLM introduced the concept of common humanity based on the notion of universal human needs. However, while the GLM stimulated a positive shift for forensic practice, it did not address some fundamental aspects of human nature; our evolutionary imperative to survive and reproduce, our readiness to harm and our ability to adapt to our environment. In missing these aspects of human nature we would suggest that the GLM, for all its virtues, retains a somewhat deficit focus and we suggest that a more comprehensive view of human nature offers a functional understanding of harmfulness.

Our biological readiness to harm has been discussed in some detail elsewhere ([Malamuth, 1998](#); [Gilbert, 2005](#); [Taylor and Hocken, 2021](#)) and is therefore not repeated here. However, it is pertinent to note that the capacity to cause harm is very much part of our nature and not an anomaly. Human beings hurt human beings and always have done; albeit at different rates at different times in our history ([Pinker, 2011](#)). The presence of harmfulness throughout our history points to the adaptive value that sits in our readiness to harm. At its most basic level, our harmfulness is adaptive because it facilitates self-defence; we can address a threat by attacking the threat and removing it from our presence. From a broader perspective, the readiness to be harmful may generate a sense of safety by eliciting submissive cues from others and creating an in-group resource.

Our readiness to harm is complimented by our evolved capacity for epigenetic modifications, modifications that enable us to respond to our environment on a biological as well as psychological level (see [Walton, 2021](#)). Essentially, epigenetics means that the way we experience our DNA may change as a result of the environmental conditions that we experience; the influence of certain genes may be toned down if their impact is unhelpful, while others may be turned up. This readiness to respond; one of our evolved survival mechanisms; may offer some explanation for the relationship between the experience of adversity during childhood and later involvement in forensic services. This relationship has been widely documented ([Levenson \*et al.\*, 2017](#); [DeLisi and Beauregard, 2018](#); [Drury \*et al.\*, 2017](#)) and more recently a number of causal mechanisms have been proposed. In a detailed review of childhood trauma, [Nemeroff \(2016\)](#) identified key biological changes associated with ACEs including persistent changes in the endocrine and neurotransmitter system alongside changes in pro-inflammatory cytokines (proteins that can regulate cellular activity). Noting the differences that are apparent in the neural, cardiovascular, neuroendocrine and immune functioning, [Nusslock and Miller \(2016\)](#) developed the Neuro-immune network hypothesis to explain the multiple disadvantages that pursue a child through their adolescence and into adulthood. Furthermore, [McCloughlin and Sheridan \(2020\)](#) highlight the ways in which different types of adversity share common features that can be conceptualised along specific dimensions of environmental experience; those involving threat and others involving deprivation. Repeated threat experiences can alter neural pathways in ways that facilitate the rapid identification of further threat and simultaneously mobilise strong and adaptive emotional and behavioural responses. Ultimately, youngsters may be left unable to discriminate between threat and safety cues ([McCloughlin \*et al.\*, 2010](#)) – a clear survival strategy when growing up in a high threat setting.

The combination of an innate propensity for harm and the ability to learn and hard-wire learning and learned responses creates an increased readiness for harmfulness when the right conditions prevail during our developmental period. In light of the growing evidence of the presence of adversity and trauma in the histories of people who offend, it would seem reasonable to suggest that interventions should take account of the research on trauma, attachment and developmental processes ([Levenson and Grady, 2016](#); [Taylor, 2017](#)). These studies highlight the need to explore and recognise the underlying origins of

dynamic risk to support individuals to understand how trauma and adversity shaped their lives, how defensive strategies are inevitably used to promote safety and how these strategies may inadvertently culture harmfulness. In essence, criminogenic capacities need to be understood functionally rather than pathologically.

Aligning this knowledge to forensic services has stimulated a proposal to move towards trauma informed models (Levenson *et al.*, 2017). While a trauma informed model can provide the architecture for service design, we feel this stops short of a holistic intervention. Building on the foundational work by Levenson and colleagues, we have proposed an approach that embraces the potential for change (optimism), alongside sensitivity to process and a trauma-informed methodology for both support and interventions (Taylor, *et al.*, 2020). We have also suggested that compassion-focused therapy (Gilbert, 2010), as an integrative form of psychotherapy may offer this potential (Taylor and Hocken, 2021) to create trauma-informed and compassion-focused practice as a model of intervention for those who commit serious harm.

The remainder of this paper provides an overview of a trauma sensitive and compassion-focused intervention framework. To provide a context, a brief overview of CFT is provided.

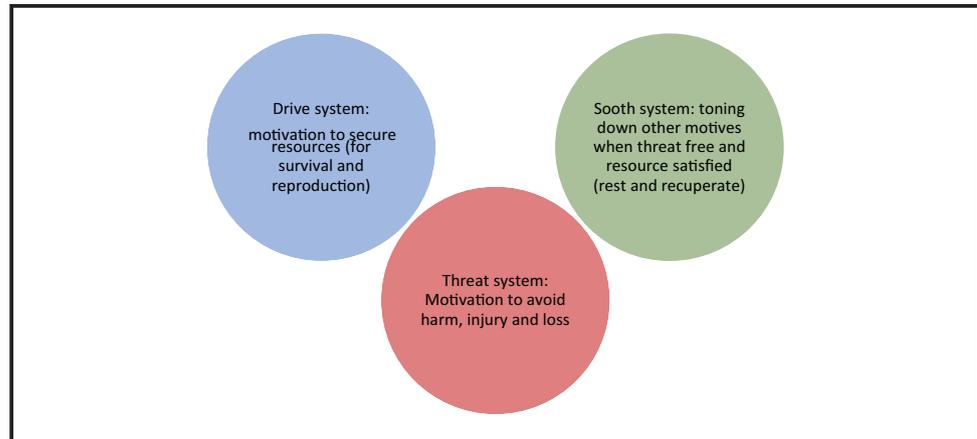
### Compassion-focused therapy

CFT was initially described as a third wave cognitive-behavioural therapy that supported clients to explore the emotional tone of their inner dialogues (Gilbert and Irons, 2005). Recognising the disparity between the content of “alternative thoughts” and the experience of these thoughts, Gilbert drew attention to self-conscious emotions – shame, embarrassment, guilt, humiliation and pride – and their role in organising self and social relating. Highlighting the intent (that is to shame, to humiliate to instil pride) that sits behind (alternative) thoughts, CFT recognises the influence of tone on the experience of our thought – a compassionate tone contrasting somewhat sharply with a contemptuous or sarcastic tone. Try saying “yeah you’re a good therapist” in these differing tones and experience them for yourself.

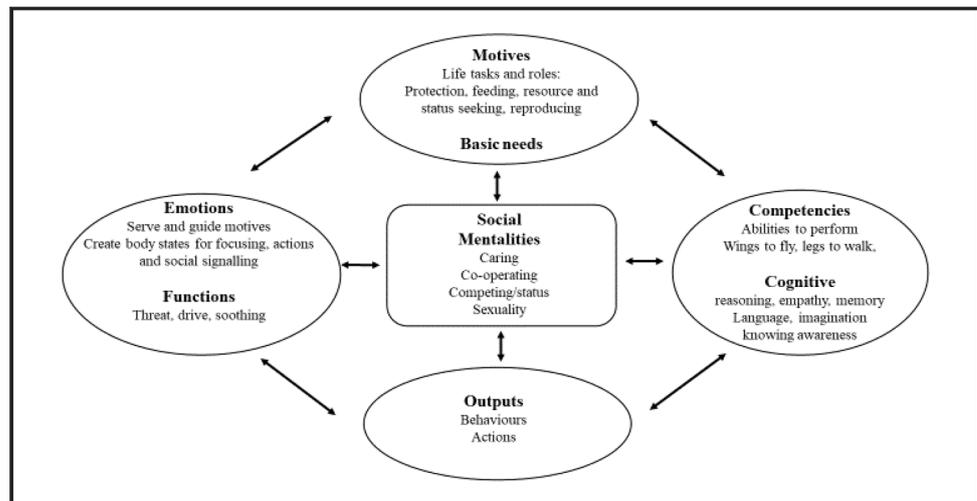
Rather than being conceptualised as a third wave CBT, CFT is more accurately understood as an integrative form of psychotherapy that assimilates ideas from a range of theoretical approaches. Drawing on evolutionary science, CFT places the role of brain architecture and the nuances that are a product of our evolution at the centre of our understanding of human nature. The role of the new brain - the advanced human cortex – enables us to reflect, remember and reminisce, think ahead and predict, gives texture to our experiences and enables us to feel. In contrast, CFT recognises that we also share a rudimentary brain architecture with our ancestors that facilitates the evolutionary need to survive and reproduce. In essence this architecture organises us to operate across three domains; a threat-defence domain, a resource gathering domain and a restful and recuperating domain (Figure 1). The interaction between our ancestral (or old) brain and our advanced (or new) brain can generate a number of difficulties and leaves us vulnerable to a range of mental health difficulties and criminogenic challenges; we can now imagine and anticipate threat, be aware of our awareness, ruminate on previous threats and catastrophise about future events.

CFT recognises that human behaviour is directed by an interaction between these domains and features motives, competencies and emotions (Figure 2). Motives are linked to biopsychosocial goals (to detect threat, gather resources and rest) and are therefore constantly in operation. Emotions on the other hand can be recruited by these motives to achieve certain outcomes. If we detect a threat and our optimum way out of it is to fight then we can recruit anger to energise us accordingly. If, on the other hand, fighting seems a poor choice then anxiety may be the optimum emotion that can help us to escape from the threat. Emotions, therefore rise and fall in context. Competencies then enable us to perform in certain ways and outputs are the consequences of that processing. Difficulties in any of

**Figure 1** Three motivational systems that support the satisfaction of key life tasks



**Figure 2** Interacting domains of CFT



these areas can inhibit relationships and interfere with human needs although motives are the overall behavioural navigator. Developing competencies (for example problem solving, empathy or reflective thinking) can offer an individual new skills, but the way that the individual chooses to use these competencies will vary depending on their motivations. The ability to figure out how someone may be feeling, for example, is only a helpful attribute if we are moved by that person's emotions, and motivated to help. If we can recognise that they are feeling distressed but feel indifferent or even gratified by their distress, then this ability alone does not lead to a positive outcome. Many of the CBT interventions for harmful behaviour focus heavily on skills for cognitive competencies and to a lesser extent on emotional regulation, but less explicitly on motives. This is a crucial difference between CBT and CFT; CFT is a motivation focused therapy and sees the motivational states of mind as central to working with people who cause harm to others.

In CFT, compassion is conceptualised as a motivation (not an emotion) based on two psychologies: a sensitivity to suffering (of others and within ourselves), and a commitment to alleviate or prevent it. A therapeutic approach that has a central intention of developing individual motivation and capacity to care for self and others and to act accordingly, has

obvious beneficial implications for forensic practice. These benefits include an understanding of the role of threat in the social environment, the orientation of the therapist or practitioner to their own feelings of compassion, and an understanding of the role of trauma and adversity in the development of criminogenic need and harmful behaviour. The first two of these factors are concerned with a broader therapeutic context, both in terms of the social climate of the intervention setting and the more specific climate of the therapeutic alliance(s) and are not the focus of our attention here (we refer to [Taylor et al., 2020](#) for a more detailed account). Instead, we present a framework that can guide us through the challenges of supporting people with forensic histories to engage in challenging and at times distressing work to address criminogenic need, reduce risk of further harm and improve capacity for a healthy and safe lifestyle.

## Compassion-focused therapy in forensic settings

As mentioned, the recognition that harmfulness sits at the heart of human nature, the significance of sensitised threat processing, and the role of shame and the potential for social rejection, creates a foundation for CFT that offers clear benefits for its application in forensic settings. With this in mind it is perhaps unsurprising that there has been a small, but growing evidence of such an application. An early illustration of the application of *forensic* CFT was provided by [Kolts \(2012\)](#) in his description of work to support men in a medium secure American prison. Kolts presented his application of the key concepts of CFT – the True Strengths approach – and invited men who had cultivated violent methodologies in response to anger to re-evaluate these practices and develop non-harmful responses. Sometime later, [Taylor \(2017\)](#) described CFT as both a model for therapy and an overarching philosophy for forensic practice for men with mild intellectual disability who were convicted of a range of offences. More specific examples of the utility of CFT have since been provided for working with paraphilias ([Walton and Hocken, 2020](#)), working with men who commit sexual offences ([Taylor et al., 2020](#); [Hocken and Taylor, 2021](#); [Taylor, 2021](#)) and violent offending by young people ([da Silva et al., 2020](#)).

Early data, albeit somewhat anecdotal and pragmatic at times, also offers encouraging support for CFT as a key intervention framework for people who use forensic services. Evidence of reduced violence ([Taylor, 2017](#)), reduced shame, increased experience of guilt and greater risk awareness (Taylor, in press) have emerged from a model for the application of CFT as an intervention to address criminogenic capacities. In a more rigorous evaluation, [da Silva et al. \(2020\)](#) found that CFT was effective at reducing the presence of psychopathic traits (as measured by the Youth Psychopathic Traits Inventory – short: [Van der Baardewijk et al., 2010](#)), when compared to a matched comparison Treatment As Usual (TAU) group. A similarly detailed review of the True Strengths intervention also revealed significant improvements in several indices of anger when compared to a comparison group ([Thomas, 2019](#)). There are encouraging signs, therefore, that CFT offers a promising framework for forensic practice and the remainder of this paper presents a framework for such work.

## Forensic compassion-focused therapy

Forensic CFT (F-CFT) embraces the evolutionary routes of human harmfulness and invites practitioners to acknowledge the core processes that drive our human readiness to harm. F-CFT is the application of CFT to support people to develop a compassionate understanding of their harmfulness and then develop competencies and motives to develop a harm-free pro-social lifestyle. A F-CFT framework therefore addresses risk alongside a sensitivity to trauma and the development of competencies that promote a healthy lifestyle ([Table 1](#)).

F-CFT strikes a balance between content of therapy sessions and attention to the process and relationship dynamics that emerge within the sessions. Although the content of the

**Table 1** Forensic compassion-focused therapy

<i>Phases</i>	<i>Components</i>
Psycho-education	Evolved minds and tricky brains, polyvagal theory. Three motivation circles. Compassion. Multiple selves. Fears, blocks and resistances. Anticipating relapse potential (learning opportunities)
Mindful compassion	Soothing Rhythm Breathing. Attention training. Mindfulness. Visualisation. Self-compassion. Compassionate mind training. Concurrent module that runs across the programme
Formulation	Autobiographical narratives. Formulating a healthy life. Key life events, meanings and learning
Trauma sensitivity	Psychoeducation (how we respond to trauma). Creating a trauma informed understanding. Facing trauma (compassion for our life story, Emotional mirroring, Offence trauma). Noticing missed opportunities (attachments, affection and development of competencies)
Understanding criminogenic need	Origins of criminogenic need. Criminogenic need in current context. Witnessing consequences
Facilitating guilt	Developing a healthy identity and healthy lifestyle. Understanding harm caused. Mentalising the people we harm. Restorative commitments

therapeutic work can be divided into a series of phases to identify key topics, or areas of content, there is an understanding that the process of therapy is equally important to the success of the work. The patterns that emerge in the interactions between client and therapist, the reactions to certain topics, the sensation felt in the body and the feelings towards self and others, are all important sources of information. Therapists are therefore encouraged to identify and explore these processes as they emerge and develop insight into their origins. Key areas of content are outlined below.

### *Psychoeducation*

As with all forms of therapy, psycho-education is intended to socialise individuals to the model, and in F-CFT, we propose that a number of key concepts are discussed early in the therapeutic process, including:

- aims and hopes;
- evolved brain;
- evolved emotions and how they organise us;
- compassion; and
- fears, blocks and resistance to compassion.

As these are widely discussed elsewhere (Gilbert, 2010; Hocken and Taylor, 2021), we will not discuss them in further detail here. However, it is pertinent to note that psycho-education is amplified throughout the work when the process allows and is not simply presented during the initial stages of the work. For example, if a client checks-in and says that he has been worrying about his parole or tribunal hearing, then we may link this to the three circles model of human motives (Figure 1), the tricky brain or even invite the client to explore his anxiety in chair work.

Furthermore, we suggest that clients should be encouraged to identify their own goals for therapy rather than being “mandated” into therapy by parole/tribunal directions. This is not to suggest that parole directives are not addressed – we are suggesting that F-CFT can address risk after all. We are emphasising, however, that personal objectives and aspirations are also important.

### ***Compassionate mind training***

Mind and body awareness, alongside physiological regulation, are important elements of CFT and enable people to be more attentive to what is going on in their own minds and bodies as they arise. F-CFT uses the various methods of CMT to encourage clients to practice and develop their mind and body awareness. In forensic services, this can be challenging when hypermasculine or anti-social cultures may undermine the rehearsal of such practices, and these context based Fears, Blocks and Resistances (FBRs) are validated and explored early in the work. CFT also teaches a specific breathing exercise (called soothing rhythm breathing) that is designed to stimulate the body's rest and digest system (the parasympathetic nervous system) which in turn improves frontal cortex functioning and capacities for reflective thinking (Lin *et al.*, 2014). The development of mindful abilities and reflective capacities supports people to engage with compassionate mind training that is fundamental to the stimulation of compassion, self-compassion and guilt.

CMT is introduced at the beginning of the work and is rehearsed in all sessions. Rehearsals encourage a series of competencies including attention monitoring and training, mindful attention, body awareness, imagery, etc.

### ***Autobiographical narratives: formulation***

Formulation is a process of co-production that aims to capture an autobiographical narrative. The narrative provides a unique insight into the personal experiences that have punctuated the client's life, the meanings that have been applied to events, and the repercussions that may linger from the learning that came from these experiences. Giving authorship to the client is a key aspect of the formulation process. The formulation is explicitly based on certain key assumptions – including that we all have an evolved brain, that the way the person presents to us has been shaped by lifetime experiences, and that this presentation therefore represents a functional and survival based response to this lifetime. These responses, because of their survival value, are also understood to be resilient to change (rather than intervention resistant). We strive to develop a formulation that is based on a phenomenological rather than categorical understanding and can be held in the mind of the author (to be accessible for their use in the moment). Helping individuals to understand the unintended and often unhelpful consequences of their safety or acquisition strategies is important and will become a focus of work later in the intervention. At this stage, however, we focus attention on the tragedy of life events and both the inevitability and necessity of survival strategies.

The focus at this stage of the work is therefore to build compassionate understanding. As therapists our aim is to model and hold the first psychology of compassion – turning towards, validating and tolerating distress. Key life events and the meanings that are applied to these events are signposted for further exploration, both in relation to more trauma focused work as well as the identification of criminogenic capacities.

The autobiographical narrative is also laid alongside a future orientated healthy life formulation that we have found supports men to understand the competencies that can support their aspirations and allows us to see the potential gains when we develop abilities to contain harmfulness.

### ***Trauma sensitivity***

Despite the evidence that trauma and adversity are recurring experiences in the lives of our service users, the traditional approach to reducing risk has been two-fold; to enhance skills associated with resilience while reducing or managing those factors that increase the probability of harm. Drawing on our understanding of compassion, we would suggest that

this approach is somewhat restrictive and a broader consideration of the role of life experiences in the genesis of offending behaviour will offer a more holistic understanding and approach to working with people involved with forensic services. Trauma-focused interventions recognise some common human responses to trauma and adversity, including dissociation (Sinason, 2020), anxiety (Fernandes and Osório, 2015), depression (Heim *et al.*, 2008) and shame (Gilbert, 2018). In her classic text, Judith Herman (1997) describes the way that trauma disempowers and disconnects people and she advocates the need for empowerment and connection to be at the core of interventions. Trauma sensitive (risk) interventions need to have this sensitivity in both process and content. Process takes account of the interaction between clients and therapists, ensuring that actions are not inadvertently reinforcing of previous trauma experiences and are open to exploration. Therapists can use the relational process to model healthy attachment and coach skills for healthy relationships. The content of the intervention should then help individuals to understand their responses to trauma as contextually adaptive and recognise the impact of these responses across the lifespan and within domains of psychological functioning.

If we conceptualise the acquisition of hurtful behaviour in a developmental sequence it seems logical to address the foundation of harmful behaviour before we turn our attention to the scaffolding that maintains and structures such behaviour. As we have seen, the first psychology of compassion invites us to turn towards distress and recognise the distress that can be experienced (by self and by others). With this in mind, and in line with a developmental approach to understanding the way we are shaped, we move from formulation into an exploration of distressing and traumatising experiences. This is not to say that we present a “trauma module” but rather that the work on formulation flows naturally into a desire to understand how early life experiences influence us, the focus being on the nature and then subsequently on the repercussions of adverse early life experiences.

While much of this work will focus on the impact of childhood adversity, it is important to recognise that adversity does not end at adulthood. When we are exploring traumatic events and ongoing adversity we are open to experiences across the lifespan and in different contexts. Adult experiences – unemployment, homelessness, discrimination, imprisonment and hospitalisation – can all layer further traumatising experiences over previous ones and would all be considered legitimate areas for therapeutic exploration. For both adult and childhood adversity, it can be helpful to consider the Dimensional Model of Adversity (McLaughlin and Sheridan, 2016) to capture adversity that includes both threat and deprivation.

As we move into this phase of the work we draw on the skills that have been developed in phase two (self-compassion and mindful awareness) and bringing our own attention to the process of the session alongside the content that may emerge. As therapists, we aim to model our willingness to notice distress and then, only having validated the nature of this distress, work to alleviate further suffering. A challenge here for therapists is to tolerate the distress that we witness to develop our understanding sufficiently. The temptation to rush to alleviate before we have sufficient understanding can close down further expression of distress.

This stage of the work draws heavily on CFT for trauma (Lee and James, 2012) merged with our understanding of risk to offer a three-stage approach (Table 2) that turns towards

**Table 2** Sources of trauma

<i>Threat</i>	<i>Deprivation</i>
Physical abuse	Neglect
Sexual abuse	Poverty
Exposure to violence (home, community, prison/hospital)	Homelessness
Prejudice (racism, sexism, etc.)	Unemployment

distress, strives to validate and alleviate distress and encourages a responsible awareness of the origins of criminogenic need (thus forming a bridge to the next phase of the work).

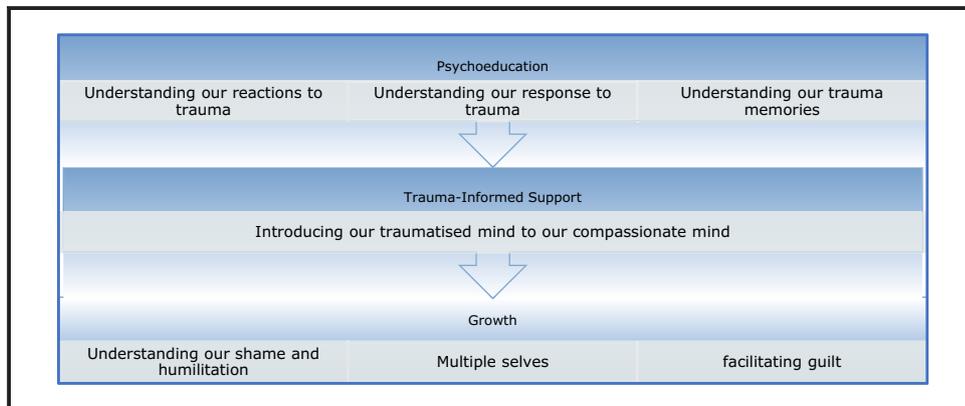
As with other components of this work, the content is flexible and can accommodate and respond to the processes that emerge in the group. Nevertheless, we start with psychoeducation and support people to develop their understanding of how human beings respond to trauma. The learning within this phase enables us to build a trauma informed understanding and prepare to turn towards distress. The final phase, growth, involves exposure to trauma material and supports the group to *re-write* the scripts that have been held in their minds. These practices have been described in some detail elsewhere (Lee and James, 2012) and therefore are not repeated here. However, we stress that this work should be offered before we consider offence focused work (Figure 3).

### *Criminogenic need*

This phase of the work is concerned with developing a deep understanding of early life events (including trauma, adversity and neglect) and the impact of these experiences on the developing child. The phase builds the notion that our experiences texture us and that there will be unintended consequences that arise from our attempts to generate feelings of safety in adverse circumstances. The compassionate approach to this work therefore starts with the emotional memories and historical influences that were identified in the formulation. Given the upsetting nature of this work, the concurrent exercises in phase two will be important practices and our clients may want to try some soothing breathing/mindful compassion at the opening and the ending of each session (Table 3).

Fundamental to this work is the aspiration to continue to hold a context that supports clients to grieve for their own distress before they are asked to experience sadness and remorse for their own harmful behaviour. A key focus of this work is to support group members to understand the effect that their early experiences had on their mind. The role of the threat system and the functioning of the threat system (i.e. to operate from a 'better safe than sorry' position and to organise us to manage threat in the most effective way open to us at that time) are also important aspects of the work. Ultimately, we are also looking to bring compassion to the younger version of the self, develop understanding of the strategies used to seek out safety, while also understanding the unintended consequences of these strategies. We recognise that unintended consequences may include ways of thinking or responding that can cause harm directly (for example, children who learn that violence is effective). Alternatively, unintended consequences can include missed opportunities, the opportunity to develop mentalisation skills, problem-solving skills or consequential thinking,

**Figure 3** Interconnecting processes for trauma sensitivity



**Table 3** Traumatic origins of criminogenic factors

<i>Criminogenic need (unintended consequence)</i>	<i>Traumatic origins</i>
Harm minimisation, rationalisation	No one was held responsible for what I went through
Emotional dysregulation	Mum was too high to take any notice of me
Hostile attributions	I never knew if Dad was ready to hit me or not
Empathy inhibitors/callousness	When I cried I got hit (or worse)
Intervention attendance	My needs don't matter
Intervention engagement	I don't trust these people
Addictions	Reliance on external regulation (for containment or excitement)
Sexual preferences	Sexually focused developmental period or genetic bias
Emotional congruence with children	I learned that adults were a source of harm
Resistance to rules	Don't trust authority
Sympathy seeking	Group rejection/shame/disgust

which may signal a need to develop competencies. Using this approach we can begin to understand criminogenic need through the eyes of the child who was seeking safety. From this, we can develop a compassionate understanding of both the need for safety and the unintended consequences of safety seeking strategies. It is important at this stage to hold in mind that we are looking to understand the reaction to external sources of threat. Internal threats (e.g. self-criticism) are understood as possible side-effects that have arisen from the external facing safety seeking strategies – if I put myself down first, then it does not hurt as much when other people do.

In relation to sexual offending there are perhaps some particular considerations. There is a considerable body of research that points to the central roles of sexual preference and sexual preoccupation in the lives of men who commit sexual offences ([Hanson and Morton-Bourgon, 2019](#)). Indeed, a combination of harmful sexual interests and a preoccupation with sexual activity are reported to be the strongest predictors of future harmful sexual behaviour ([Seto, 2019](#)). Historically, interventions for these two areas of need have tended to draw on pharmacological ([Winder et al., 2017](#)) and/or behavioural strategies ([Marshall et al., 2009](#) for a review). In the former, the objective has been to tone down sexual preoccupation, while in the latter a fundamental change in sexual interests is thought to result from classical conditional practices where harmful interests are paired with some kind of noxious or painful stimuli and healthy sexual fantasy is reinforced through masturbation. The intention of both, of course, is to reduce future harm. From a CFT perspective, despite these intentions, both have the potential to resonate with trauma. Aversive practices can lead to harm in two ways. First, the nature of the therapeutic alliance is clearly compromised when the therapist (i.e. the person in power) advocates the application of a painful act. Indeed, when a person in power invites a person without power to experience pain, there may be a striking resemblance to earlier experiences. Second, the implicit message that is carried in the use of aversive practices, that there is an aspect of the self that needs to be changed or punished, may promote a shame focused self-perspective. Shame, as we have seen already, encourages a focus on self and simultaneously compromises engagement with harm caused, a focus that is ultimately inhibiting of the more direct criminogenic work.

Rather than approaching these key areas of difficulty as problematic aspects of the person, CFT would encourage a compassionate understanding. Sexual preferences would be understood as a source of arousal that are not chosen by the individual but simply unfold through our developmental processes. Currently, there are limited services available for those who discover that their arousal may be tuned into harmful activities so there is little optimism or support for anyone who finds, for example, that they are sexually attracted to children or rape ([Lievesley et al., 2018](#)). Using self-compassion to support acceptance of a quirk of evolutionary design may help to reduce shame and stigma and thus allow people to face the guilt that would ensue if they were to act on their preferences. This positions CFT as not only a promising approach for

those who have offended to prevent further offending but also for interventions to prevent first time sexual offending, as outlined by Hocken (2018). Indeed, Marshall *et al.* (2005) suggest that the goals of intervention should be the attainment of good lives, which is achieved by enhancing hope, increasing self-esteem and developing approach goals. Criminogenic need is therefore understood as a human capacity. In F-CFT, we see that these harmful capacities arise from three primary sources; our intrinsic drive to satisfy evolutionary tasks (e.g. for survival), as a consequence of human trauma responses, or as a result of our need for social acceptance and inclusion. Recognising the innate readiness for us to cause harm is not, however, seen in a deterministic manner and F-CFT invites clients to develop responsibility for a harm-free lifestyle (Figure 4).

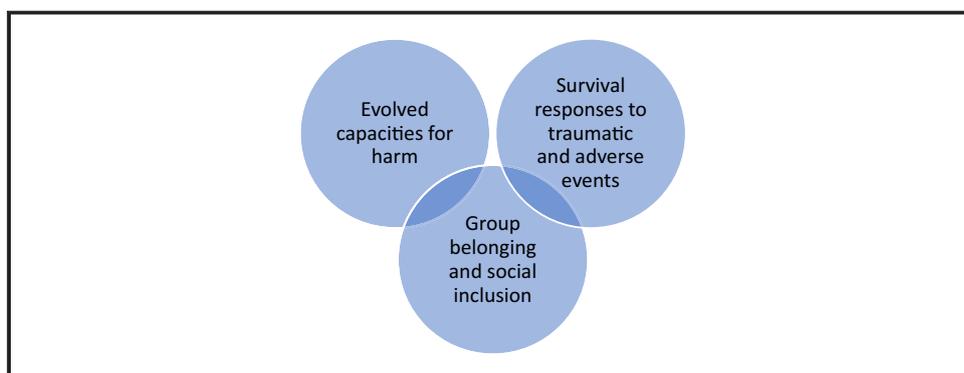
### *Facilitating guilt, restorative commitments and healthy lifestyles*

A significant area of debate within the risk reducing intervention community has been around the significance of empathy as a mediating factor in the commission of an act of abuse. Prior to the turn of the millennium almost all CBT-based interventions incorporated direct work to address limitations in empathy and would typically address these limitations by exposing men to the impact of their behaviour via victim accounts (Daniels, 2011; McGrath *et al.*, 2010). Any *cognitive distortions* associated with the process of victimisation would be challenged with the aim of individuals providing an account of their behaviour that showed concern for their victim. The role of personal victimisation in the development of denial of harm was rarely accounted for.

More recently, research has questioned the association between empathy and recidivism (Mann *et al.*, 2010), and there has been lively debate about the inclusion of such work in intervention programmes with various arguments being proposed both for and against. The central aspect of the debate has been concerned with the criminogenic status of empathy; whether empathy, or lack of it, contributes to offending (Mann and Barnett, 2013).

However, CFT would propose a somewhat different approach; empathy is a human competency that can be used to satisfy differing motives and the motive determines the manner in which empathy is used. While the competencies of empathy; the ability to adopt another person's perspective and the ability to understand how they may feel; may be important, the motivation to use these skills would be considered central. As Gilbert (2018, p. 231) notes, understanding of someone's feelings does not dictate compassion; "a non-empathic torturer puts the gun to your head, an empathic one to the heads of your children". In this sense, the debate over the inclusion of empathy as an intervention target may be somewhat mis-judged and the *motivation* to behave in a compassionate manner may be a more appropriate target,

**Figure 4** Reconceptualising criminogenic need to understand origins; functional responding from evolved minds



which includes understanding the role of shame and the growth of guilt. Empathy would thus become an important competency to develop, to serve a compassionately motivated behaviour.

In F-CFT, we approach this through a series of stages (see Guilt and Restoration), though as with other aspects of the intervention, there is a willingness on the part of the therapist to respond to the needs of the client and re-focus content as necessary. Facilitating guilt, as we refer to it, builds on the individual's ability to draw on compassionate motives and turn towards distress with an intention to alleviate or prevent that distress. This ability to notice distress with compassion is based on an individual's ability to experience sadness and guilt that in turn flows from the trauma work. Indeed, we do not approach this work until the opportunity to process traumatic experiences has been provided. As this aspect of the work invites clients to understand the impact of their harmfulness, we also take a number of precautions prior to beginning the work. These include the development of a healthy life formulation (how I hope to live in the future), restorative opportunities (how I can make amends in a concrete manner) and a consideration of support systems.

Facilitating guilt:

- formulating a future/healthy life;
- identifying restorative commitments;
- establishing support (compassionate others, compassionate self);
- practicing guilt: developing awareness;
- Practicing guilt: developing tolerance;
- Practicing guilt: developing remorse; and
- Sustaining compassion: restorative actions.

We similarly emphasise support systems for therapists; comprehensive training and regular clinical supervision as a minimum.

With these in place we can work through the stages identified above, supporting clients to experience increasing levels of guilt (compassion for the distress that we cause). Although we recommend a gradual exposure to increasingly intense feelings of guilt we have also found that some people may want to start with more challenging exposures so we will explore which approach fits best with each person.

As we work through this stage there are a number of cautions to hold in mind. First, as we have mentioned, the work is challenging and it is important to offer support outside of sessions when necessary. Second, guilt can be difficult to tolerate (it does not feel nice in the body) and this can flip back into a more shame-based response if competencies associated with tolerance are not sufficiently matured. Third, as an evolved emotion, guilt includes a behavioural component that allows for restoration. For many people who cause harm there is no opportunity to offer restoration to their victim which can create a barrier to guilt. The restorative commitments that we develop (which can be written into licence conditions) can support people to navigate this difficulty, while the life formulation can also support people to hold a future perspective.

## Conclusions

This paper has argued for revising the approach to working with people who have caused harm to others. Drawing on a compassion-focused therapy, we propose an understanding of the evolved human capacity for harm and of the processes that inhibit compassionate motivation as central to forensic work. The personal experience of trauma and adversity, whether caused directly by abuse, indirectly by negligence, or as a chronic experience of a lifestyle, can over sensitise our threat systems and undermine the experience of safety and affiliation. The safety seeking strategies used to manage these adversities can cultivate our

innate harmfulness (as a defence) and stimulate the development of a broad range of criminogenic capacities. Working with these criminogenic capacities will need an understanding of their origins, their functions and their intentions, and these will need attention just as readily as the harmfulness that emerged across time.

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