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Incorporating trauma-informed care into evidence-based sex offender treatment

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Abstract *As we move forward in the field of sex offender treatment, clinicians should consider incorporating principles of trauma-informed care (TIC) into evidence-based sex offender treatment models. Early adverse experiences are prevalent in the general population and more so in criminal and sex offender populations. Early trauma paves the way for maladaptive coping and interpersonal deficits, which can lead to abusive behaviour. Content-oriented sex offender treatment models emphasising cognitive-behavioural skills should integrate process-oriented components that address the ways in which early trauma shapes adult cognitions and behaviour. Relational approaches to therapy can enhance clients' interpersonal skills and improve general well-being. This type of personal growth would be expected to mitigate future offending as the client adopts and successfully practices healthier, non-destructive strategies for meeting emotional needs.*

Keywords *Sex offender; treatment; trauma-informed care; cognitive behavioural therapy; process*

Looking back… the evolution of sex offender treatment

Over the past 20 years, sex offender treatment has evolved from a specialisation made up of a few hundred isolated clinicians worldwide to an international and inter-disciplinary community of thousands who collaborate daily about the clinical needs of sexually aggressive individuals. Theories have been hypothesised, interventions have been tested and the research literature has grown exponentially. JSA has been instrumental in forwarding our knowledge through its exclusive focus on this important but complex area of research and treatment. As JSA celebrates its 20th anniversary, we have an opportunity to consider Trauma-Informed Care (TIC) as a necessary ingredient in evidence-based models of sex offender treatment.

TIC is a model of service delivery that incorporates evidence about the prevalence and impact of early trauma on behaviour across the lifespan (Bloom & Farragher, 2013; Harris & Fallot, 2001). TIC occurs in a safe and client-centred environment in which service providers view and respond to maladaptive behaviours in the context of traumatic experiences. In the face of childhood maltreatment and poor role models, healthy communication often goes unlearned or is abandoned in favour of interpersonal survival skills. By viewing maladaptive and abusive behaviour through the lens of early trauma, clinicians can help sex offender clients recognise negative interaction patterns, learn and generalise new skills, enhance their interpersonal relationships and improve their general well-being.

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History of sex offender treatment

The problem of sexual violence has emerged as an important social problem requiring a comprehensive, inter-disciplinary response. Dialogue about sexual abuse was virtually absent until the child advocacy and feminist movements of the 1960s and 1970s. With Henry Kempe's pioneering recognition of "Battered Child Syndrome" (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962) came an investment in protecting children and the passage of mandatory child abuse reporting laws. In 1978, Kempe exposed sexual abuse as "another hidden pediatric problem" (Kempe, 1978) and finally, in the 1980s, sexual abuse began to be acknowledged as an important research agenda (Hechler, 1988). Public awareness of child sexual abuse intensified as media coverage increased and victims became willing to step forward to share their stories (Hechler, 1988).

Over the past 30 years, our field has made enormous gains in our conceptualisation of sexual deviance and sexually abusive behaviours. A new understanding of sexual assault and its implications for victims and communities has contributed to the reform of criminal laws, increased social awareness and improved availability of services for both victims and offenders (Crowell & Burgess, 1996). As concerns about sex crimes have grown, so have attempts to reduce repeat perpetration through legislative initiatives and rehabilitation programmes (Levenson & D'Amora, 2007).

At the same time, the effectiveness of sexual offender treatment remains ambiguous and controversial. Practitioners encounter conflicting perspectives on the topic, and contradictory research findings and treatment models are hotly debated. Yet the stakes are high: successful intervention with sexually abusive individuals means fewer future victims, potentially stopping a cycle of violence that leads to high psychological, social and fiscal costs for individuals, families and communities. Researchers continue to evaluate data in an effort to better understand the variables that contribute to reduced recidivism as clinicians strive to implement evidence-based treatment methods that prevent sex offenders from repeating their victimising behaviour.

Early studies of sexual offender treatment (Furby, Weinrott, & Blackshaw, 1989) led to pessimistic attitudes about the possibility of rehabilitation, though more recent research has suggested more promising outcomes. Researchers have detected reductions in both sexual and general recidivism with treatment based on cognitive-behavioural treatment approaches; sexual recidivism can decline as much as 40% after such interventions (Hanson et al., 2002; Losel & Schmucker, 2005). Therapeutic models incorporating assessment of risk, needs and responsiveness factors have been shown to significantly diminish recidivism for sex offenders (Andrews & Bonta, 2010).

But other studies found no significant differences in recidivism between treated and untreated groups (Hanson, Broom, & Stephenson, 2004; Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005), and Hanson et al. (2002) cautioned that "evaluators are better able to identify high-risk sex offenders than to change them" (p. 187). Most recently, meta-analytic researchers concluded that weaknesses in methodology evaluating sex offender treatment programmes continue to compromise the ability to detect treatment effects and identify successful models (Långström et al., 2013).

A promising and noteworthy finding, however, was that clients who successfully completed the Sex Offender Treatment and Evaluation Project (SOTEP), as opposed to those who simply participated in the treatment programme, did recidivate less often than those who did not seem to "get it" (Marques et al., 2005, p. 97). Levenson and Prescott (2007) highlighted the importance of this SOTEP finding, noting the distinction between demonstrating mastery of treatment objectives versus simply attending a treatment

programme without accomplishing the goals. They emphasised some of the challenges inherent in sex offender outcome studies, such as the expectation of lifelong recidivism avoidance, poorly defined measures that are often dichotomous rather than relative and the difficulties of accounting for client and therapist variability. As well, scholars have questioned the utility of manualised approaches, which, while necessary to standardise service delivery for research purposes, can interfere with the ability of clinicians to respond flexibly to a client's risks, needs and responsivity (RNR) (Levenson & Prescott, 2007; Marshall, 2009).

Historically, sex offender treatment programmes have emphasised relapse prevention strategies modelled after substance abuse interventions. This approach helps clients to identify triggers, high-risk situations and distorted thinking in a cycle of abusive behaviour (Laws, 1989; Laws, Hudson, & Ward, 2000). Increasingly, however, emphasis is being placed on individualised treatment planning that identifies client's RNR (Andrews & Bonta, 2007, 2010). The RNR model adapts an intervention protocol to match the client's criminogenic needs, risk factors and motivation level, while addressing personal characteristics that may interfere with the ability to embrace and engage in treatment. Also gaining currency are Good Lives Models (Ward & Brown, 2004; Ward, Yates, & Willis, 2012; Willis, Ward, & Levenson, 2013; Willis, Yates, Gannon, & Ward, 2013; Yates, Prescott, & Ward, 2010) that strive to help clients attain self-actualisation goals while at the same time improving affective and behavioural self-regulation.

Scholars have questioned the ethics of sex offender treatment, exploring the inherent dilemmas associated with mandated counselling. Some have debated whether sex offender treatment is simply punishment, citing the coercive and paternalistic nature of some programmes that may seemingly contradict ethical codes of mental health treatment (Glaser, 2010; Prescott & Levenson, 2010; Ward, 2010). Others have emphasised the need to balance community safety with client autonomy and responsibility for meaningful change, lest we create a paradoxical double-bind for clients who wish to change but fear the consequences of disclosure (Prescott & Wilson, 2012).

As researchers and clinicians alike endeavour to improve treatment efficacy and service delivery, there is a call for innovative treatment models that take into consideration the unique needs of each individual. In particular, it is important for practitioners to understand the impact of early trauma and maltreatment in the lives of our clients, and the ways trauma might interfere with successful integration and application of new skills. Current models of sex offence therapy have largely ignored the individualised needs of a heterogeneous population and have focused heavily on content areas such as cognitive reframing and relapse prevention strategies. While these skills are important, "one size fits all" approaches fail to consider the role of individual experiences and characteristics in the improvement of self-regulation (Andrews & Bonta, 2010; Willis, Yates et al., 2013; Yates et al., 2010).

Looking ahead: incorporating trauma-informed models into treatment

As we ponder the development of sex offender treatments thus far, we might acknowledge that little attention has been given to the offender's own developmental history compared to the emphasis on cognitive and behavioural change. It is clear, however, that early adverse experiences can alter neurodevelopment, interfere with relational attachment and contribute to a reliance on maladaptive interpersonal skills (Anda et al., 2006; Creeden, 2009; Felitti, 2002; Finkelhor & Kendall-Tackett, 1997; Weiss & Wagner, 1998). It is, therefore, important to consider the role of childhood adversity in the development of high-risk behaviour.

TIC provides a framework for facilitating change in a sex offender population within a larger model of cognitive-behavioural therapy. TIC draws from an individual's life

experiences to look at the history behind his/her actions; otherwise, treatment focuses on an overly narrow framework and misses opportunities to practice and rehearse healthy interactions within the therapeutic environment. This type of personal growth would be expected to mitigate future potential to re-offend as the client incorporates more successful strategies for relating to others and meeting emotional needs in non-victimising ways.

The prevalence and scope of early adversity

Trauma is defined as any event that is experienced or witnessed which threatens the physical or psychological integrity of oneself or others and to which a person's response includes intense fear or helplessness (American Psychiatric Association, 2000). The Adverse Childhood Experiences (ACE) study, a collaborative research project between the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente, produced staggering evidence of the pervasive and enduring nature of early trauma (Centers for Disease Control and Prevention, 2013b). Begun in 1997, the ACE study was designed to collect etiological data about childhood adversity and its relationship to adult health outcomes. Information was collected from 17,337 participants who sought health services from Kaiser Permanente (Felitti et al., 1998). The sample was 54% female, 75% white, with an average age of 57. Data were collected via a 10-item survey developed from existing scales and literature related to *abuse* (emotional, physical and sexual), *neglect* (emotional and physical) and *household dysfunction* (domestic violence, divorce and the presence of a substance-abusing, mentally ill or incarcerated member of the household). One's ACE score reflects the total number of adverse experiences endorsed by that individual.

The results revealed that early traumatic experiences are frequent and impactful. Over 28% of the participants reported childhood physical abuse, 11% were emotionally abused and 21% had been sexually abused. Women were more likely to report sexual (25%) and emotional (13%) abuse than men (16 and 8%, respectively), and men were slightly more likely to have been physically abused. Nearly one-quarter of the respondents had been physically or emotionally neglected. Household dysfunction was also common; 13% had witnessed domestic violence in the childhood home, 27% experienced parental substance abuse, 19% had a parent who was depressed, mentally ill, or attempted suicide and 23% came from households in which the parents were separated or divorced. Nearly 5% reported that a family member had gone to prison (Centers for Disease Control and Prevention, 2013b).

Over two-thirds of the participants reported experiencing at least one adverse event before they turned 18 and 12% reported four or more (Centers for Disease Control and Prevention, 2013b). Multiple forms of child maltreatment and household dysfunction were interrelated, and the presence of a single ACE factor more than doubled the odds of reporting additional ACEs, suggesting that a disordered social environment increases risk by providing inadequate protection against adverse experiences (Dong, Anda, Dube, Giles, & Felitti, 2003; Dong et al., 2004). Research clearly demonstrates that accumulation of childhood adverse experiences is associated with greater risk for numerous health, mental health and behavioural problems in adulthood (Felitti et al., 1998). As ACE scores increase, so does the likelihood of adulthood alcohol, tobacco and drug abuse, chronic obstructive pulmonary disease, depression, suicide attempts, foetal death, obesity, heart disease, liver disease, intimate partner violence, early initiation of sexual activity, promiscuity, sexually transmitted diseases and unintended pregnancies (Centers for Disease Control and Prevention, 2013a; Felitti et al., 1998). The collective impact of early trauma on behavioural, medical and social

well-being has consistently proven to be robust, with profound and ominous implications for public health (Anda, Butchart, Felitti, & Brown, 2010; Felitti et al., 1998).

A history of child abuse is common among criminal offenders. Though prevalence rates can vary depending on how variables are defined or measured, about one-third to over half of male US prisoners reported being physically abused in childhood and 10–30% reported unwanted sexual contact (Courtney & Maschi, 2013; Maschi, Gibson, Zgoba, & Morgen, 2011; Weeks & Widom, 1998). Household dysfunction was also common among inmates and co-occurred with other childhood adversities. For instance, prisoners frequently reported witnessing violence in childhood and many experienced the death of a family member, parental separation or abandonment, foster care placement or parental substance abuse (Courtney & Maschi, 2013; Haugebrook, Zgoba, Maschi, Morgen, & Brown, 2010; Maschi et al., 2011; Messina, Grella, Burdon, & Prendergast, 2007).

Childhood adversity is clearly associated with adult criminality, particularly interpersonal violence, and greater exposure to adverse events significantly increases the likelihood of mental health problems and serious involvement in drugs and crime (Harlow, 1999; Messina et al., 2007). Abused prisoners are more likely that non-abused inmates to be incarcerated for a murder, violent offence or sexual crime (Harlow, 1999). As well, Harlow found that adult illegal drug use and heavy drinking were more common among abused state prisoners than non-abused prisoners.

In a study administering the ACE questionnaire to child abusers, domestic violence offenders, sex offenders and stalkers (n = 151), significantly higher rates of adverse childhood experiences were found compared to males in the general population (Reavis, Looman, Franco, & Rojas, 2013). Only 9.3% of the sample reported no adverse events in childhood, compared to 38% of males in the Centers for Disease Control (CDC) (Reavis et al., 2013). As well, 48% of the offenders reported four or more adverse experience, compared to 9% of the males in the ACE study (Reavis et al., 2013). Sex offenders in particular had significantly higher ACE scores than the general population (Reavis et al., 2013). Weeks and Widom (1998) also found higher rates of child maltreatments for sex offenders, with 26% reporting sexual abuse in childhood, 18% reporting neglect and two-thirds revealing childhood physical abuse. In a study of 679 American sex offenders, 42% reported child physical abuse, 38% reported sexual abuse and 38% said they were emotionally neglected; sex offenders were more likely than males in the general population to have experienced any of the ACE items (Levenson, Willis, & Prescott, under review).

A meta-analysis of 1717 offenders found that about 28.2% of sex offenders reported a history of childhood sexual abuse (Hanson & Slater, 1988), a figure which exceeds the estimated 16–17% rate of sexual victimisation for males in the general population (Centers for Disease Control and Prevention, 2013b; Hunter, 1990). A more recent meta-analysis involving 1037 sex offenders and 1762 non-sex offenders also revealed that sex offenders were more than three times more likely to have been sexually abused than non-sex offenders (Jespersen, Lalumière, & Seto, 2009). Sex offenders against children were more likely to have been sexually abused, but those who assaulted adults were more likely to have experienced physical abuse in childhood (Jespersen et al., 2009). Reavis et al. (2013) opined that due to the prevalence of early adversity in the histories of sex offenders, it is perhaps predictable that offence-specific models of sex offender treatment have produced mixed results in terms of effectiveness and suggested that treatment programmes should more strongly emphasise the role of early trauma in self-regulation and attachment deficits.

Laying the groundwork: understanding the role of early trauma in the development of high-risk behaviour

The cumulative stress of childhood adversity leads to alarming increases in the likelihood of a range of diseases and social problems (Anda et al., 2010; Felitti, 2002; Felitti et al., 1998). A somewhat simplistic construction of an enormously complex bio-psycho-social process is as follows: environmental stressors stimulate the overproduction of stress-related hormones associated with fight-or-flight responses, inhibiting the growth and connection of neurons and contributing to lasting effects such as affective dysregulation, deficits in social attachment and cognitive problems (Anda et al., 2006, 2010; Creeden, 2009). These social, emotional and cognitive impairments result in adoption of high-risk behaviours as coping strategies, culminating, for many people, in the development of illnesses, disabilities, psychosocial troubles and premature mortality at rates higher than in the general population (Felitti et al., 1998).

These problems are exacerbated when the trauma experience is denied or invalidated by the victim, family or helping professionals (but mitigated when victims are supported in a way that allows their traumatic stress to be expressed and processed) (Whitfield, 1998). The dynamics that characterise abusive relationships include betrayal at the hands of a trusted person (often a caregiver), violation of hierarchical boundaries, keeping of secrets and distortion of reality in a way that reinforces the values, beliefs and behaviours of the abuser (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Harris & Fallot, 2001; Teyber & McClure, 2011). In abusive environments, the victim's voice in unheard, denied or invalidated, and the victim feels powerless to alter or leave the relationship (Harris & Fallot, 2001). These experiences shape an individual's expectations of him/herself, others, and the world around them.

Early maltreatment is commonly believed to create a cycle of abuse in which individuals grow up to repeat behaviour witnessed and learned in childhood. The breeding ground for sexual offending begins with an adverse family environment, characterised by various forms of abuse and neglect. A lack of nurturance and guidance leads to problems in social functioning, such as mistrust, hostility and insecure attachment, which then contribute to social rejection, loneliness, negative peer associations and delinquent behaviour (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).

Exposure to chronic harsh conditions as a child produces anxiety, anger and depression along with an intense sense of helplessness (Felitti, 2002; Felitti et al., 1998; Whitfield, 1998). High-risk behaviours, including aggression, might be viewed as coping mechanisms with immediate benefits for relief of emotional pain. For example, sexual or aggressive activities can stimulate dopamine production, providing an antidote to depression and resulting in the reinforcement of high-risk behaviours (Anda et al., 2006; Creeden, 2009; Felitti et al., 1998; Whitfield, 1998). Such behaviours are often mechanisms put into play to cope with stressors in the environment, and these strategies may seem to work well. Their risks to oneself and others are overlooked in the need for instant relief from environmentally induced distress and an inability to meet emotional needs in more healthy and less harmful ways.

High-risk behaviours are, therefore, more accurately understood not as "crazy" or "antisocial" but as maladaptive strategies designed to cope with previous trauma or to attempt to protect oneself from perceived threats in the environment (Whitfield, 1998). Hyperarousal

becomes a necessary tool in the arsenal to defend against unexpected and unpredictable events. Chronic trauma lays the groundwork for a range of interpersonal problems and maladaptive coping skills stemming from relational deficits and distorted cognitive schema about oneself and others (Elliott et al., 2005; Harris & Fallot, 2001; Teyber & McClure, 2011). These behaviours are long-standing and well-rehearsed. When a child's world seems like a dangerous place with few protective or nurturing caregivers, the ability to trust becomes impaired and expectations of others are fraught with wariness and scepticism. At the same time, individuals who never learned to trust their own instincts are prone to detrimental choices and associations with delinquent peers or abusive partners. The role of traumatic events in the development of high-risk behaviour should be recognised by sex offender clinicians.

Incorporating trauma-informed principles with sex offenders

Perpetrators of interpersonal violence are perhaps among those most in need of trauma-informed services. Punishment and criminal justice responses are, of course, important components of accountability and protection of society. When in the therapeutic setting, however, clinicians should model respectful and collaborative communication lest they reproduce and reinforce the very types of disempowering relational patterns they seek to correct. Clinicians who create a trauma-informed therapy environment recognise the impact of violence and victimisation on psychosocial development and coping skills (Elliott et al., 2005; Harris & Fallot, 2001). TIC seeks to create a safe, trustworthy treatment setting in which choice, collaboration and empowerment are emphasised (Elliott et al., 2005; Harris & Fallot, 2001). TIC highlights strengths over pathology and skills-building over symptom reduction. Above all, it ensures that the dynamics of abusive relationships are not unwittingly replicated in the helping relationship (Elliott et al., 2005; Harris & Fallot, 2001).

Sex offender treatment programmes have historically utilised confrontational strategies. Ironically, however, such approaches may serve to recreate traumatic experiences in the clinical setting and reinforce dysfunctional coping strategies once used to adapt to a traumatogenic environment. Conversely, the therapy session could provide, for some sex offenders, their first encounter with healthy boundaries and respectful interaction patterns (Levenson & Macgowan, 2004; Marshall, Burton, & Marshall, 2013). This provides a ripe opportunity for a corrective emotional experience and a rehearsal of new and improved relational skills. Though content is a significant element in sex offender therapy, the process of engagement is equally important (Prescott & Wilson, 2012; Walji, Simpson, & Weatherhead, 2013).

A trauma-informed approach differs from a traditional approach to therapy in several ways. Rather than focusing on specific symptoms as "presenting problems," a TIC approach views a history of trauma not as a discrete event but as a defining and organising set of experiences that deeply influence the core of an individual's identity (Creeden, 2009; Harris & Fallot, 2001). Understanding how traumatic events impacted the client's fundamental assumptions about the world, the clinician sees as a salient component of therapy the construction of new ways to organise and understand coping skills, behaviours and relationships. By understanding the meaning attached to traumatic events and early relationships, the clinician can conceptualise how interpersonal behaviors were once adaptive in the abusive childhood environment but now prove to be unhealthy or harmful across various domains of adult functioning. TIC emphasises a holistic understanding of the individual in the context of his/her collective experiences; maladaptive (irrational, aggressive, self-destructive or abusive) attempts to cope are reframed as survival skills that were once necessary but now interfere

with the ability to establish healthy interpersonal relationships and boundaries. By using a strengths-based approach to growth and mastery, we can help clients prevent problematic behaviours, choose healthier relationships, deal with crises more effectively and parent and protect their own children in a more nurturing and responsive fashion. Through this corrective experience, we can help interrupt the often intergenerational cycle of trauma and victimisation (Harris & Fallot, 2001).

Motivational interviewing has gained popularity with various resistant or health-risk populations (including sex offenders) by combining cognitive-behavioural techniques with humanistic principles and a more client-centred approach (Miller & Rollnick, 2002; Prescott, 2009). People who engage in harmful or victimising behaviours may be dismissed as disturbed or unstable when clinicians overlook the history of trauma and attribute their behaviour to an erroneous or unrelated cause. When clinicians perceive their clients as defective in some way, we further exacerbate the very problems that need to be addressed through TIC. A TIC model attempts to employ a more respectful and accepting view of clients, maintaining a non-judgemental atmosphere and avoidance of negative labels. One study noted that social acceptance can be successful at helping sex offenders out of the downward spiral of criminal behaviour (Elisha, Idisis, & Ronel, 2013).

A sex offender's core schema of defensiveness and entitlement may understandably elicit negative, confrontational or "boundary-setting" responses from a therapist. On the other hand, if we begin to consider a client's world view in the context of trauma, we might speculate that enduring feelings of helplessness and inadequacy have overwhelmed a client who then compensates with denials of vulnerability, externalised attributions of responsibility and a rigid, intimidating or bullying demeanour (Bloom & Farragher, 2013). Abuse survivors are susceptible to an impaired ability to trust and have difficulties forming intimate attachments. A need for control might exist, which further exacerbates superficiality and a lack of intimacy. Insecure attachment to a primary caregiver can hinder empathy development (Adams, 2003). Though low victim empathy has not been linked to sexual recidivism, modelling empathy for the sex offender's own abuse may help reduce distorted cognitions about the harmfulness of one's behaviour to others.

When clinicians fail to respond effectively to hostile, resistant or critical encounters with clients, a negative process can occur, inhibiting the client's engagement and creating a therapeutic failure (Binder & Strupp, 1997; Teyber & McClure, 2000). Therapists of every theoretical orientation respond at times to client's resistance with anger, judgment, emotional withdrawal or subtle rejection (Binder & Strupp, 1997). Therapists who treat sexual abusers may be especially vulnerable to this negative process, since most clients are non-voluntary and often enter treatment programmes with some resistance and denial (Jenkins-Hall, 1994; Jennings & Sawyer, 2003; Marshall, Thornton, Marshall, Fernandez, & Mann, 2001; Serran, Fernandez, Marshall, & Mann, 2003; Winn, 1996). Binder and Strupp (1997) noted that negative process has rarely been addressed by researchers but may account for a majority of treatment failures in all therapeutic modalities and client populations. Sex offender therapists are encouraged to explore the ways in which their own beliefs, values, attitudes and experiences might impact their engagement skills and inadvertently recreate a disempowering dynamic in the treatment relationship.

Most sex offender treatment programmes utilise group therapy modalities, and negative process can affect group dynamics as well. Conversely, the group setting can be a powerful and positive modelling opportunity. Respectful peer confrontation can foster reframing of distorted thinking and lead to increased engagement. On the other hand, persistent, harsh or adversarial confrontation by group members or therapists can inhibit clients from being forthcoming in treatment. Therapists should foster a group climate in which members establish acceptable norms regarding peer support and confrontation, model compassionate interactions and

practice effective communication skills (Clark & Erooga, 1994; Macgowan, 2002; Marshall et al., 2003, 2013; Prescott & Wilson, 2012; Walji et al., 2013). When members see honesty and disclosure being rewarded with support and encouragement, anxiety and threat will be reduced, thereby decreasing the need for defensive posturing.

Clinical practice with sex offenders should focus equally on process and content, implementing relationally informed treatment along with cognitive-behavioural skills (Singer, 2013). Sex offender treatment has historically emphasised aspects of relapse prevention, such as "triggers" and "cues" of a "cycle," which may be the exception rather than the rule for many clients. Instead, most offending patterns may be better viewed as behavioural and emotional deficiencies in the capacity to regulate affect and employ healthy interactions with others. These deficits may point to an underlying inability to utilise a flexible and varied repertoire of coping strategies aimed at ameliorating distress or communicating with others (Singer, 2013).

Poor affect regulation is a salient problem for many sex offender clients. Disempowering dynamics in early relationships can thwart the development of an internal locus of control later in life. Traumatic re-enactment occurs when failed attempts to gain control over the environment lead to self-fulfilling prophecies of failure, resulting in anger, depression and inflexible coping. When patterns of behaviour develop in the context of coping with frightening experiences, they can become deeply embedded (Bloom & Farragher, 2013). In the case of sex offenders, sexualised coping may be a way of soothing distress and/or satisfying unmet needs for intimacy, affection, attention and control.

Sex offender clients often present for therapy with a range of interpersonal problems that stem from long-standing relational deficits and distorted thinking about themselves and others (Morin & Levenson, 2008). Inadequate skills can cause and reinforce a vicious cycle in which problematic distress-relieving coping strategies contribute to dysfunctional patterns of relating to others. Such interactions between client and therapist allow opportunities for immediacy interventions in which the therapist responds to relational patterns as they present themselves in the therapeutic encounter (Teyber & McClure, 2011) and in the group therapy setting (Jennings & Sawyer, 2003; Levenson, Macgowan, Morin, & Cotter, 2009).

The style and characteristics of the therapist, therapeutic alliance and group climate are all essential to creating a safe setting in which clients can learn and practice new skills (Marshall et al., 2013; Wampold, 2001). Relationship skills can be modelled, experienced and rehearsed—rather than simply taught— within a therapeutic environment that offers an opportunity for true intimacy, trust and emotional safety with the therapist and other clients. This is accomplished by exploring relational themes and maladaptive coping patterns that developed in response to significant events and relationships throughout the client's life (Bloom & Farragher, 2013; Teyber & McClure, 2011). By gaining awareness of these recurring relational patterns, clients can recognise them as they occur in the therapeutic setting, rehearse new skills, and ultimately generalise these skills to others in their lives. As clients enhance both their interpersonal experiences and general well-being, they adopt and successfully practice healthier, non-destructive strategies for meeting emotional needs, which might be expected to diminish future risk to offend.

Summary and conclusions

JSA has provided us a unique opportunity to use our hindsight to identify clinical interventions showing promise with sex offenders. As well, we have an opportunity to think innovatively about how to draw from other literatures to inform our understanding of our clients and how to help them change. Trauma-informed practice can be incorporated into existing models of evidence-based sex offender treatment and can assist in mitigating future

potential to reoffend. Therapists face unique challenges when treating non-voluntary sex offenders who may be resistant to change, but the inclusion of process-oriented approaches in treatment has been neglected despite the influence of relational factors on therapeutic progress (Beck & Lewis, 2000; Bergin & Lambert, 1978; Binder & Strupp, 1997; Greenberg & Pinsof, 1986; Kivlighan & Tarrant, 2001; Marshall 2005; Prescott, 2009; Wampold, 2001; Willis & Ward, 2013). When treating sex offenders, engagement of clients is a crucial component in facilitating change and promoting accountability, no matter how empirically sound the intervention. Identifying and mitigating engagement difficulties early in treatment by recognising and addressing the impact of early trauma may enhance treatment effects.

TIC can be integrated into common programme models or theories of practice, including relapse prevention, cognitive behavioural therapy, the Good Lives Model and Risk/Needs/Responsivity models. TIC simply delivers clinical services in a way that recognises the prevalence and impact of early trauma on behaviour across the lifespan. In this way, therapists can establish a non-threatening treatment environment that facilitates trust, emotional safety, empowerment and intimacy and responds to maladaptive behaviour in the context of traumatic experiences. Although cumulative early negative experiences can result in irreversible neurodevelopmental deficits, the enduring neuroplasticity of the brain allows for reorganisation and accommodation of new experiences (Anda et al., 2006; Creeden, 2009; Weiss & Wagner, 1998). When clinicians respond to traumatised clients with compassion, validation and respect, corrective emotional experiences allow new skills to be learned, enhanced, practiced and reinforced. These new positive experiences allow not only for the healing of the soul but might assist the brain to discover neural pathways to new behaviours.

A history of trauma can set the stage for poorly executed interpersonal skills and the deviant secrets of sex offenders have further limited their opportunities for emotionally intimate relationships and acceptance from others (Seidman, Marshall, Hudson, & Robertson, 1994). The stigma caused by sex offender registration can further exacerbate barriers to reintegration and social support (Levenson, 2012). Intimacy deficits have been correlated with sex offence recidivism (Hanson & Harris, 2001; Hanson & Morton-Bourgon, 2005), and trauma-informed programming can model safe and healthy intimacy while mitigating the loneliness and alienation often felt by sex offenders.

Research indicates that a directive but compassionate therapeutic style can result in a reduction of pro-offending attitudes (Beech & Hamilton-Giachritsis, 2005; Marshall 2005; Marshall et al., 2002). In fact, it is clear in the general psychotherapy research literature that the therapeutic alliance and a client's experience of the counselling relationship account for significantly more variance in outcomes than theoretical framework or specific counselling techniques (Ahn & Wampold, 2001; Duncan, Miller, Wampold, & Hubble, 2010; Wampold, 2001). In sex offender treatment, a positive perception of therapists and group members increases engagement in treatment and investment in the goals of intervention (Levenson & Macgowan, 2004; Levenson et al., 2009; Levenson, Prescott, & D'Amora, 2010). For some sex offenders, counselling is the most intimate relationship they have ever had. When offenders engage in the therapeutic process and experience an honest connection with others who validate their experience, opportunities exist for developing and practicing intimacy skills relevant to reducing recidivism risk.

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