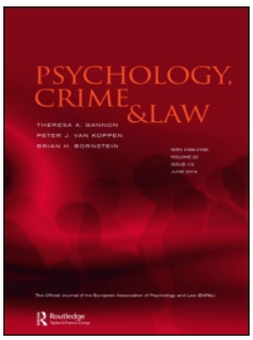

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RESEARCH ARTICLE

A framework for post-conviction traumatic stress: preliminary findings from a focus group of men under community supervision for sex offences

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ABSTRACT

The suite of cognitive-emotional symptoms that one experiences while subject to registration and/or community supervision for a sexual offence has recently been conceptualized as *Post-Conviction Traumatic Stress* (PCTS). In the current study, we present a thematic analysis of transcription data extracted from focus groups with 22 men in treatment for sexual offending. We first describe the main sources of their trauma (e.g. allegation, arrest, court, conviction, jail, prison, parole/probation, and registration). Next, we examine their reported manifestations of symptoms contained in the DSM-5 criteria for Post-Traumatic Stress Disorder (PTSD). All the men described at least one symptom, and many endorsed symptoms in all four criteria categories. Commonly described indicators of PCTS included intrusive memories of the arrest; avoidance of certain people, situations, and environmental cues; negative thoughts about themselves and the future; hyperarousal triggered by reminders of arrest or prison; and fear of being re-arrested for a violation of probation or registration. Finally, implications for trauma-informed practice and future research are discussed.

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Post-conviction traumatic stress; sex offending; registration; SORN; re-entry; trauma-informed care

It is widely accepted that the lived experience of community reintegration following a criminal conviction is generally stressful (LeBel & Richie, 2018; Petersilia, 2003; Pettus-Davis et al., 2019; Western, 2018). We are also now keenly aware that the broad range of additional obstacles and restrictions faced by people required to register as sexual offenders (RSOs) further undermines and obstructs their chances of successful re-entry. A growing body of knowledge has considered practical and systemic barriers regarding the impact of RSO-specific legislation on post-conviction goals such as employment, housing stability, and social support (Levenson et al., 2016; Rydberg, 2018; Sample et al., 2018; Tewksbury & Mustaine, 2009). The psychological stress of RSO reintegration, however, is largely overlooked (Jeglic et al., 2011).

A recent qualitative study introduced the construct of Post-Conviction Traumatic Stress (PCTS) based on themes that emerged from over 70 RSO interviews (Harris & Levenson,

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2020). The men described symptoms of Post-Traumatic Stress Disorder (PTSD) that were directly related to fears, avoidance, negative affect or mood, and hyperarousal associated with returning to and living in the community following a sex crime conviction. The aim of the current study was to more fully describe PCTS symptoms based on focus group discussions with men convicted of sexual offences in Florida.

What is post-conviction traumatic stress?

The phrase Post-Conviction Traumatic Stress (PCTS) was recently devised to capture the specific constellation of cognitive-emotional and physiological symptoms of trauma resulting from contact with the criminal justice (CJ) system (Harris & Levenson, 2020). Trauma typically results from experiencing or observing an event that threatens one's sense of physical or psychological safety and produces feelings of fear and helplessness (American Psychiatric Association, 2013; Bloom, 2013). Many scholars have proposed that involvement in the CJ system and the stress of re-entry should be considered a form of trauma (LeBel & Richie, 2018; Liem & Kunst, 2013; Listwan et al., 2013; Pettus-Davis et al., 2019; Western et al., 2015). An arrest, conviction, and incarceration presumably feel quite threatening and are frequently life-altering. We acknowledge that an arrest or conviction might not strictly meet Criterion A for PTSD in the DSM-5, which requires direct or indirect exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence[1] (American Psychiatric Association, 2013). The symptoms of PCTS, however, are considered to be the same or very similar to those in the symptomatic criteria for PTSD (Harris & Levenson, 2020): intrusive thoughts, avoidance, negative thoughts and moods, and hypervigilance.

An emergent literature illustrates a distinctive cluster of complex PTSD symptoms reported by current and former prisoners, with the latter being described as post-incarceration syndrome (Liem & Kunst, 2013; Pettus-Davis et al., 2019). LeBel and Richie (2018), in their extensive literature review of the psychological effects of contact with the CJ system, described the damaging impacts that can occur at any point along the way from allegations, arrests, charges, court appearances, sentencing, jail, prison, and parole or probation. Even single or brief contacts with police, courts, and jails can produce traumatic stress, resulting in persistent psychosocial and mental health consequences (Fernandes, 2020). The challenges and stressors of CJ involvement can generate mood dysphoria, ruminating thoughts, insomnia, irritability, vigilant observation of the environment, and interference in cognitive processing. Men returning home after long periods of incarceration have been found to display a unique set of enduring features consistent with PTSD: intrusive thoughts and nightmares, hyper-arousal and startle responses, avoidance of crowded places or overwhelming external stimuli, and emotional detachment associated with protection against vulnerability (LeBel & Richie, 2018; Liem & Kunst, 2013).

Institutionalization and paranoia can remain present for long periods after release (Liem & Kunst, 2013). In fact, a recommendation was made for inclusion of a post-incarceration subtype of PTSD in future DSM revisions, with specifiers that conform to observed phenomena such as institutionalized personality traits, spatial-sensory disorientation, and social-temporal alienation (Liem & Kunst, 2013). Probationers and parolees report great fear of revocation for a technical violation, avoidance as a coping strategy,

difficulties adjusting to re-assignments of supervising officers, distress about stigmatization and discrimination, and a sense of powerlessness and impending doom (LeBel & Richie, 2018).

Paradoxically, the persistent fear described by those who are incarcerated or under correctional supervision can have a criminogenic effect on cognitions, coping strategies, and personality styles (LeBel & Richie, 2018). Estrangement from family, unstable housing, and reduced employability, along with ensuing anxiety, social isolation, and material insecurity all produce significant stress during the transition to life after a criminal conviction (Pettus-Davis et al., 2019; Western, 2018; Western et al., 2015). Barriers to successful reintegration such as transience, homelessness, lifestyle instability, civic disengagement, social rejection, and unemployment are simultaneously known to be risk factors for crime (Andrews & Bonta, 2017; Pettus-Davis et al., 2019; Uggen et al., 2004; Western et al., 2015). The collateral consequences and traumatic stress of CJ involvement for defendants, their families, and their communities are well-documented (Pettus-Davis & Epperson, 2015; Western et al., 2015). Mass incarceration and obstacles to reintegration have disproportionately blighted minority communities, leaving in their wake more single-parent households, economic depression, and heightened risk for myriad social problems (Pettus-Davis & Epperson, 2015). Thus, it is in the interest of public safety and recidivism prevention to understand the traumagenic nature of criminal sanctions.

PCTS related to SORN

For RSOs in the USA, registration mandates bring challenges that are especially daunting. Researchers have explored the psychosocial consequences specifically associated with Sex Offender Registration and Notification (SORN) laws and the subsequent stigma and fear experienced by RSOs and their families (Bailey, 2018; Harris et al., 2017; Jeglic et al., 2011; Levenson & Cotter, 2005; Sample et al., 2018; Tewksbury & Levenson, 2009; Tewksbury & Mustaine, 2009; Willis, 2018). For instance, they report employment difficulties, housing insecurity, psychological distress, financial hardships, harassment, invasion of privacy, relationship disruptions, shame, and concerns for their own safety. Again, these conditions may not specifically meet DSM-5 inclusion criterion A, but they represent experiences that are life-altering (and in some cases, life-threatening) and typically create fear and powerlessness, rendering them traumatic (Harris & Levenson, 2020). Hamilton (2020) observed the psychological harms of SORN laws, such as hopelessness, fear, shame, and hypervigilance, but stopped short of using the word *trauma* in her conceptualization.

Harris and Levenson (2020) applied theories related to strain (Ackerman & Sacks, 2012; Agnew, 1992), labelling (Maruna et al., 2004), and human needs (Maslow, 1943) to conceptualize the unique circumstances that contribute to PCTS for RSOs. The effects of chronic fear and stress from housing and employment instability, social rejection, and hopelessness constitute a specific syndrome of ongoing traumatic stress for RSOs. The stigma of being publicly branded as a 'sex offender' creates a tarnished identity and heightened obstacles to goal attainment and even survival. When the amygdala is activated in response to perceptions of threat, emotions and behaviour can become dysregulated (van der Kolk, 2006). Hyperarousal in response to stress can exacerbate dynamic risk via maladaptive coping, impulsivity, and poor decision-making; SORN restrictions preclude

the factors that protect against reoffending (Andrews & Bonta, 2010; de Vries Robbé et al., 2015). Therefore, PCTS symptoms are important to explore in the context of reducing recidivism risk. Our exploration of the trauma symptoms experienced by people who perpetrate sexual crimes is in no way intended to negate or dismiss the suffering of people victimized by sexual harm. We also do not intend to compare one to the other, but simply to acknowledge the traumatic stress related to crime commission and its consequences.

The current study

This paper presents the findings from two guided focus group discussions with 22 RSO participants in a major metropolitan area. The researchers sought input from the focus groups to further develop a theory of PCTS and observe its symptoms. The purpose of the focus groups was to informally ask RSOs to provide examples of DSM-5 symptoms of PTSD resulting from being accused, convicted, and sanctioned for a sex-related crime. The information obtained provided a framework for a subsequent national study about PCTS.

Method

Participants

The 22 men were all residents of Florida and were participating in group treatment for sexual offending (SOTx). Participants were ethnically diverse (45.5% White, 13.6% African American, 40.9% Hispanic). They ranged in age from 31 to 80 years, with a mean age of 47.7 years. All the participants were mandated to attend weekly SOTx sessions, and most were required to register as 'sex offenders'. All the men were involved to some extent in the CJ system except two who were required to attend by professional overseers following a sexual boundary violation complaint. Most of the others had been convicted, but some were pending adjudication following an arrest. Some had been incarcerated in jail and/or prison, but others were under pre-trial supervision or sentenced only to probation. About half of the sample had been convicted of a contact sexual offence against children (31.2%) or adults (18.2%) and more than a quarter (27.3%) had come to the attention of authorities for offences related to Child Sexual Abuse Material (CSAM; previously referred to as child pornography) or other internet-related solicitation of minors for sexual purposes. The study was granted approval from the relevant universities' Institutional Review Boards.

Data collection procedure

A focus group design was the most appropriate approach for data collection. Rather than testing any pre-formed hypotheses (Bachman & Schutt, 2013) we wanted to consider previously understudied processes, and discover what service users themselves experienced as the psychological effects of an accusation, conviction, and/or SORN requirements. Focus groups allow for unstructured group discussion where conversation among participants is encouraged and interactions between participants are observed. As Bachman and

Schutt (2013) explained, focus groups are oriented to the social context of the phenomenon under study and help to illustrate the meaning that participants attach to events and experiences. As is the case in this study, focus groups are particularly fitting when the participants constitute a 'hard-to-study' or 'difficult-to-reach' population and when the topic of interest is thought to be sensitive or 'taboo' (Flick, 2013). A recent systematic literature review revealed that qualitative criminology is quite limited, highlighting the need to give voice to the lived experience of CJ-involved persons (Copes et al., 2020). In their review of the psychological effects of the CJ system, LeBel and Richie (2018) concurred that big data cannot tell the stories that can truly inform our efforts to improve correctional and rehabilitative services. Our specific approach was carefully guided by extant descriptions of focus group methodology, and we refer interested readers to this work (Flick, 2013; Krueger, 2014; Morgan & Nica, 2020).

Voluntary participants were recruited using existing therapy sessions with a trusted mental health professional. This approach capitalized on the men's familiarity with each other and provided a feeling of safety and group cohesion. Having a pre-existing group also enabled us to minimize the time needed for introductions, and reduced participants' inhibitions to discussion (Kitzinger, 1994; Onwuegbuzie et al., 2009a). The research team facilitated two consecutive, single meetings with pre-existing homogenous groups of men participating in SOTx (Flick, 2013; Onwuegbuzie et al., 2009a). Members were invited to participate in one of two 75-minute group sessions with open-ended questions and semi-structured discussion. Informed consent was obtained, and the men were reminded that participation was voluntary and that declining to participate would not bring any negative consequences to their SOTx programme, probation status, or any other court-related matters. Participants were assured that they could refuse, decline, or withdraw participation at any time.

Group size (5-12 people) and session length (90 minutes) was also guided by previous recommendations (Flick, 2013; Patton, 2002). To further ensure voluntariness and self-determination, everyone in the group was invited to affix an orange or green post-it note on their shirt. Orange post-it notes indicated that they wanted to stay and observe the session but did not wish to contribute to the discussion and that we should not call on them to speak. Those who wished to participate placed a green post-it note on which they wrote a chosen name, initials, or alias to indicate that they would like to participate. A total of 22 men agreed to remain in the room for one of two sessions and ultimately, 19 men participated by verbally contributing to the discussion. The first group contained 11 people, and 10 spoke in the meeting. The second group contained 11 individuals and nine men participated. The men who spoke contributed between 1 and 15 separate utterances during their session. With an average of 6 utterances per participant, there was a slight positive skew (four men spoke 8 times, one spoke 11 times, and one spoke 15 times).

In accordance with Krueger's (2014) framework and the descriptions set out by Onwuegbuzie et al. (2009a), the research team consisted of two moderators (the authors). By way of a positionality statement, the first author is an expatriate criminology professor with more than 20 years of research experience (including clinical observation and participant interviews). The second author is a highly seasoned research-practitioner with 30 years of experience delivering individual and group treatment as well as a very active research career as a professor of social work. The second author facilitated the

for the discussion by describing the study, presenting the questions, requesting that overly talkative members yield their time to others, and ensuring that everyone who wanted to participate was able to do so (Flick, 2013). She encouraged interaction between group members, especially around the reinforcement or confirmation of emergent themes. The assistant moderator (first author) was responsible for digitally audio-recording (and later transcribing) the session, noting the initials or pseudonym of each speaker, verifying questions, keeping time, and asking for clarification when necessary. The assistant moderator also observed and noted nonverbal details including the paralinguistic (changes in pitch or volume) and the kinetic (actions or movement) (Onwuegbuzie et al., 2009a) qualities of participants. Obvious nonverbal agreements or dissents (such as head nodding or shaking) were also noted in a matrix like the one proposed by Onwuegbuzie et al. (2009a).

The specific questions asked of the groups were informed by literature about PTSD and its DSM-5 criteria and included the following: (1) please describe the most traumatic event you have experienced related to your sex crime and explain why; and (2) please describe the extent to which you have experienced the following symptoms of PTSD: (a) intrusive thoughts or images, (b) avoidance of people, places or things, (c) negative cognitions and moods, and/or (d) hyperarousal. Participants were provided with a list of the 20 items in the DSM-5 PTSD criteria, so that they could describe examples of each as applicable. Presenting a stimulus to guide and generate discussion is a key feature of the focus group methodology (Bachman & Schutt, 2013; Nili, et al., 2017).

Analytical strategy

The final transcripts were checked against the original recordings to ensure accuracy and both authors reviewed the transcripts multiple times. The transcripts were stored on the first author's password-secured computer and analysed using NVivo software. Qualitative content analysis was performed for each question. We took an intra-member approach (Onwuegbuzie et al., 2009b) in which the *individuals* were the focus of analysis. For example, all responses to the prompt: 'describe the most traumatic event you have experienced' were noted, arranged in order, and collapsed into categories. Next, those responses were reviewed and common themes (defined as occurring three or more times) were identified. As Morgan and Nica (2020) observed, themes 'serve as a major data reduction device in qualitative research, where the complexity of the results are compressed into a small set of reporting units that organize the presentation of the results' (p. 1).

We followed the convention of pioneers in focus group research (Lazarsfeld & Barton, 1955) and begin by presenting quasi-statistics (descriptive statistics extracted from qualitative data). To demonstrate identified themes, illustrative quotations for each theme were noted, and a selection were ultimately included in the results section below. Although the transcripts were initially created verbatim, for readability we have removed excessive verbal fillers such as 'like' or 'y'know' from the excerpts provided below.

Although there is an abundance of guidance about how to prepare for and conduct focus groups, there is comparatively very little material on how best to approach analysis of data (e.g. Kitzinger, 1994; Onwuegbuzie et al., 2009a). While the qualitative content

analysis described above is logical and intuitive, many projects appear to make the mistake of assuming that focus groups can be analysed as if they are a series of individual interviews (Flick, 2013). Importantly, the participants' statements cannot be taken as isolated or spontaneous utterances since they have been made within the context of a discussion. Therefore, the second component of focus group analysis is to consider the interaction between group members, account for conversational turn taking, and how consensus or dissension is reached (Kitzinger, 1994).

Results

The results are presented in two sections. First, we consider the participants' self-reported most traumatic experiences. We describe the strongest themes from the content analysis and provide narrative examples in their own words to illustrate those themes. Participants are identified hereafter by numbers to maintain their anonymity (P1-P22). Second, we describe their illustrations of each of the four symptoms of PTSD. Throughout, we present quasi-statistics and descriptive quotations to support the themes.

Most traumatic event

We first consider the focus group's collective responses when prompted to think about traumatic events in their lives, and to identify the most traumatic. Fifteen participants (79%) (of the 19 who spoke) answered the question and 60% (9 out of 15) said without hesitation that their arrest was the most traumatic experience of their life. Most had never previously been in trouble with the law, and their encounter with the police was described as terrifying, embarrassing, shameful, and life-altering. The men took turns sharing details of their arrests and there was quick consensus among them that three clear themes emerged as to why that event was so traumatic: (1) surprise, (1) uncertainty, and (2) impact on their loved ones.

Almost everyone (89%) recounted how police unexpectedly appeared in full riot gear, often bursting into their home in the middle of the night, with SWAT teams and, in many cases, with automatic weapons pointed at them.

> I was sleeping in a room next to my parents. At five in the morning, they didn't knock, they didn't announce themselves, they just busted the door down. I thought somebody was robbing the place. They were all in black … they threw me to the floor and they told me if I moved they were going to shoot me. I had a [*sic*] automatic weapon pointed to my head, still not knowing why they were there, or that they were cops. (P1)

> Two suburbans, one crashed the back of me, one crashed in front of me and officers with assault rifles got out, drew me out at gunpoint. (P2)

> [They were] pounding on the door of the room. Okay, so I get up, … I have my, my boxers on that I was sleeping in. I open the door and four SWAT team members came in with their guns drawn. (P3)

> It's not easy getting up at four o'clock in the morning with a laser scope in front of your face. (P4)

Uncertainty and the feeling of not knowing what was going on, why they were being arrested, or what would happen, was the second strongest theme and was mentioned by more than half (56%; 5/9) of the men. Another man described a similar uncertainty when recounting an arrest for a violation of probation:

> All they said is that they are executing a warrant and that I would find out when I got in front of the judge. So, I sat in jail for seven days with absolutely no idea why I was there, before they put me in front of my judge. (P5)

Finally, four men expressed that they were most traumatized by the impact of that life-altering moment on their immediate family members (who were, in many cases, present at the time).

> What I recall is just her crying and saying, 'Please don't shoot my son! Please don't! … He's a good person! … What are you guys doing?' … What I re-live is just the experience from my mom. (P6)

> It was my weekend with my kids. And they arrested me in front of my children. Which I think that by itself was hard enough. (P7)

> My mom's 74 years old, my stepfather's currently in a long-term care facility, and then [at the time of the arrest] there's me, protecting them, thinking we were being robbed. (P1)

Three men commented that their arrest was worse than their time spent in combat zones while serving in the military. They described that when going to war, you know that you are in danger and are equipped to protect yourself. 'I was prepared to go to Iraq. I was trained to go to Iraq. I had a weapon to defend myself in Iraq' (P4). Another agreed:

> I was deployed twice, and I honestly went with the mind frame of, this is what I'm expecting, this is what I know could possibly happen, this is what I need to do to avoid that. When you get arrested you don't know. (P8)

Although arrest was cited as the most traumatic experience for most of the participants, others related disconfirmatory evidence. A quarter of the men (27%; 4/15) stated explicitly that their arrest was *not* the most traumatic part of their offence, because they turned themselves in or were called (and thus the element of surprise was removed). They described the most traumatic event as: prison ($n = 2$), loss of professional identity ($n = 1$), and 'everything about this' ($n = 1$). An additional two men identified non-offence related experiences as more traumatic, with both reporting familial death ('both parents [died] close together' and 'two grandchildren drowning') as their most traumatizing experiences. In both focus group sessions, the initial discussion about their most traumatic experience flowed easily to a natural point of saturation.

Four criteria for PTSD

The authors briefly described the four PTSD diagnostic criteria and invited participants to give examples (if applicable) of the 20 specific symptoms. Strikingly, every participant who contributed to the discussion had experienced at least two of the PTSD criteria described in the DSM-5. Six men (32%) described three criteria, and almost half of the sample (nine out of 19) reported symptoms in all four criteria categories of PTSD.

Intrusion

The DSM-5 (APA, 2013) describes intrusion as persistent thoughts, memories, images, or flashbacks of the traumatic event. They can represent recurrent themes and are usually triggered by exposure to internal or environmental cues or reminders of the traumatic context. Some participants described repetitive dreams:

> For the first year or so … I'd wake up and in cold sweats and dreaming about the arrest itself, or the entire situation leading up to it. Like just having a normal dream and then, all of a sudden, just that image of the police officers pulling up on me would wake me up out of a dead sleep. That happened quite frequently. (P5)

> For a couple weeks after I got arrested, I just kept dreaming about it. Every time I was getting arrested somewhere different. It was something different every time. (P9)

Others reported flashbacks and memories of certain upsetting elements, like two members who recounted their shock when a psychologist showed up at the prison to evaluate them for civil commitment. While preparing for release from incarceration at the end of his sentence, one described feeling distraught when 'they changed the rules in the middle of the game' (P11). The other stated:

> Being booked into the civil commitment center … I just see myself going back. And it's just flashbacks that's umm, I get like 3 hours a night sleep because I wake up, I see myself going back to the gates, going back to there. And the humiliation of being booked in there. I mean it just is constant. (P10)

Avoidance

The second cluster of PTSD symptoms involves avoidance of people, places, activities, or situations that evoke distress. For instance, 13 of the men in the focus groups (68%) shared specific examples of people, situations, or places that they actively avoid. Many said they do not watch television shows or movies that depict police or courtroom dramas. Some said they avoided meeting with old friends for fear they will be asked questions that will require an embarrassing disclosure or explanation about their offence. Some described avoidance of places where children congregate, such as going to the grocery store or shopping only during school hours when children are not likely to be present, in order to prevent any possible encounter with youngsters. One man described how avoidance permeates his daily routine, creating an isolative lifestyle:

> I'm afraid of doing anything. This whole experience for me has been very traumatic in the sense it's completely changed the way I do things, pretty much the way I live. For the past 2 years I've pretty much secluded myself. I mean I don't even go visit my family. (P4)

Negative thoughts or feelings

According to the DSM-5, alterations in cognition and mood can include negative or distorted beliefs about self or others, a sense of persistent danger, diminished interest in activities, feelings of detachment or estrangement, and the inability to experience joy. Every single man who contributed to the focus group discussion disclosed experiencing specific and pervasive negative thoughts or feelings, such as constant worries, uneasiness,

and fear, along with depression and a sense of powerlessness. One theme that emerged was related to loss of professional identity:

> *On losing his medical license***:** Seeing that [word] 'inactive' actually put me into a place where I was depressed, I couldn't focus at work, I was experiencing severe anxiety and it just brought me back to a really bad place. (P12)

> *On losing his professional identity as a teacher, and now working in construction:* So going to work everyday is constant reminder of like, oh this is where I am, it's not where I was … it's where I am now. (P13)

Others described a pervasive, intrusive, and ruminating hopelessness for the future due to the reality of lifetime SORN and the impossibility of redemption, saying 'it's endless, there is no stopping it' (P15). One described the ironic juxtaposition of the designation on his driver's license: 'being a registered sex offender, they notate that on your license … [just like] sometimes they put 'safe driver' or 'organ donor' at the bottom' (P13).

> I could be having a good day and any little thing will remind me of my situation, and it'll just suck the life out of that day and it becomes a hopeless, ruminating thought. (P2)

> Every time I even think about my situation, it just becomes a recurring theme and my thoughts, my thought process, I can't get it out of my head. What I'm gonna do in ten years? What happens when my mom passes away? Am I gonna make it through this probation? Y'know, just all that stuff. (P1)

> I just feel like my future's over … have to register and I'm never gonna get a good job. (P9)

> Dealing with individuals that won't rent me an apartment, due to my past crimes. (P16)

There were also many descriptions of repeated disparaging thoughts about oneself, such as: 'mentally beating the hell out of myself for allowing myself to get into the situation to begin with' (P5). Remorse and regret were prominent:

> That was very, very wrong. You feel accused, you feel ashamed, you feel guilty because you done things that you shouldn't be proud of, and I mean just, just makes your wheels turn in a way that umm, it's not really comfortable. You know, you feel ashamed, you feel negative about yourself. (P14)

Two men shared feelings of suicidal ideation, with one reporting a serious suicidal gesture that resulted in police intervention: 'What I meant to do was to shoot myself with the firearm and I … fortunately didn't have the courage to do it' (P12). The other said he frequently thinks about killing himself:

> My mind frame is: the next time I violate, if I have any chance whatsoever, I'm gonna kill myself. I'm not goin' to jail for 15 years. What's the point? What's the point in living after that? … not that I do anything wrong but what if I eat poppy seeds on a bagel or somethin' and I had a positive drug test? I'd go find the nearest bridge or somethin' like that. It would be the first idea that I have. I think about that a lot. [chuckles] Like a lot. (P15)

One man described the anxiety and helplessness of leaving prison after 20 years and finding himself unable to navigate a world that had drastically changed and was unrecognizable to him. He could not figure out how to turn on the water faucets in the bus station restroom, which were now motion-activated with no handles. 'I felt like an alien

at first … like an out-of-body experience. I felt like I didn't fit in … [I was] lookin' for help but I didn't ask nobody' (P16).

Hyperarousal

The fourth DSM-5 PTSD criterion describes hyperarousal such as vigilant scanning of the environment for danger, efforts to keep oneself safe, and the dysregulation that can occur with autonomic nervous system activation. Symptoms include irritability, anger, reckless or self-destructive behaviour, startle responses, problems with concentration, and sleep disturbances. Most of our participants (68%) explicitly illustrated symptoms of hyperarousal. Some members described anxiety every time they have contact with their probation officer. One offered an example of a time police parked in front of his workplace and he found himself in 'full on panic mode, shaking so much I couldn't hold a glass' (P5). Others agreed that seeing law enforcement activated responses such as 'hyperventilating, I couldn't breathe, I was about to have a full-blown heart attack' (P7). One man said he went on medication to curb 'irritability and angry outbursts' (P2). In some cases, symptoms manifested as generalized anxiety, obsessed with breaking a rule without knowing it (especially 'failing to register') while others described an unrelenting focus on adhering to rules or laws, like never speeding, and constantly checking the clock if they are out when the time nears curfew.

Many participants highlighted the types of triggers that instigated hyperarousal symptoms daily, and the resulting psychological distress when exposed to internal or external cues resembling some aspect of the traumatic event(s). For instance, several of them described reactions to unexpected noises like 'a toaster pops up' (P1), arrival of an 'unexpected guest' (P7), 'a noise at night' (P5), 'my cat' (P7) or 'a slamming door' (P6).

> I have a very specific kind of trigger. And I know that it comes from the arrest that morning, and that is hearing any knocking on a door. It makes me uncomfortable and queasy just to do it [*as he demonstrates by knocking on wooden coffee table*]. It could be on a movie, it doesn't matter … And that was five years ago. I still suffer from that today. (P3)

Others described persistent anxiety:

> Everywhere you go, everything you do, you're, you're in this constant state of panic, constant state of paranoia, that you know, and you have a curfew and you have to be home at a certain time. (P7)

> Yeah, whatever you're saying right now, a lot of that is what I feel. Like jumpiness, sleep disturbances, difficulty concentrating, sometimes I lose my mind cause I, I'm not there. (P17)

Many of the men described sleep disturbances, with one saying, 'I don't think I've slept more than an hour to 2, 3 hours maybe at the most, since this happened' (P7) Another, however, described sleep as a refuge from anxiety and rumination: 'I could sleep 17 hours a day' (P3).

Discussion

The present study involved the content analysis of verbatim transcripts of two focus groups held with 22 men in treatment for sexual offending. The sex crime arrest was described as the most traumatic life event for most of them. Other members identified

prominent aspects of post-conviction trauma, such as being incarcerated, loss of professional identity, and being detained for civil commitment. The researchers asked focus group members to specifically describe examples of PTSD symptoms related to their arrest and post-conviction experiences. All the men described symptoms of PTSD, and many endorsed symptoms in all four criteria categories. Commonly described indicators of PTSD included intrusive memories of the arrest, and avoidance of certain people, situations, and environmental cues like police or court-related TV shows. Many described negative thoughts about themselves and hopelessness for the future, along with hyperarousal triggered by reminders of arrest or prison, and fear of being re-arrested for a violation of probation.

Implications for treatment

Researchers have described how involvement in the CJ system and the challenges of re-entry should be considered a form of traumatic stress (Flood, 2018; Liem & Kunst, 2013; Listwan et al., 2013; Pettus-Davis et al., 2019; Western et al., 2015). Criminal sanctions, correctional mandates, and court-ordered conditions produce feelings of fear and helplessness, creating circumstances that feel threatening to one's sense of physical or psychological safety; these conditions are consistent with conceptualizations of trauma (American Psychiatric Association, 2013; Bloom, 2013). A constellation of PTSD symptoms has been observed in current and former prisoners, and in persons subject to SORN (Harris & Levenson, 2020; Higgins & Rolfe, 2017; LeBel & Richie, 2018; Liem & Kunst, 2013; Pettus-Davis et al., 2019). Scholars have noted that persons involved in the CJ system actually use the words 'trauma', 'traumatized', and 'traumatic' to describe their experiences, and that the internalization of stigma manifests in perceptions of self as 'worthless, despicable (p. 153) … flawed, [or] broken (p. 160)' (Flood, 2018). However, the diagnostic features of PTSD listed in the DSM-5 fail to fully capture the complex landscape of trauma specifically related to arrest, incarceration, and re-entry (Flood, 2018; Liem & Kunst, 2013).

PTSD symptoms should be prioritized in SOTx programmes because dysregulation and maladaptive coping can increase dynamic risk factors such as substance abuse, isolation, antisocial thinking, hostility, and impulsivity (Andrews & Bonta, 2010, 2017; Craig & Rettenberger, 2018; Hamilton, 2017; Levenson et al., 2017; Pettus-Davis et al., 2019; Yates et al., 2010). Post-conviction stressors can have criminogenic effects, exacerbating the 'already fragile state of mind' (Flood, 2018, p. 147) of those trying to re-build and pursue productive lives. Ackerman and Sacks (2012) applied criminology's Strain Theory to test the relationship between re-entry stress and recidivism, and found that anger and strain were predictive of general recidivism, with small but non-significant effects on sexual reoffending.

The distress caused by CJ involvement and the devastating physical and psychological effects of incarceration have led to a call for trauma-informed correctional services (Fernandes, 2020; Kubiak et al., 2017; Levenson et al., 2017; Levenson & Willis, 2019; Liem & Kunst, 2013; Pettus-Davis et al., 2019; Sadeh & McNiel, 2015). Trauma-informed practices create safe spaces in which clients can explore their thoughts and behaviours with trusted professionals who collaborate with them to empower a healing journey to a rewarding and prosocial life (Bloom, 2013; Levenson et al., 2017; SAMHSA, 2014). Trauma-informed correctional rehabilitation can help clients to 'reacclimate in an environment where their

journey is understood and not judged … which has been shown to help restore clients' sense of humanity, dignity, self-worth, and contribution' (Flood, 2018, p. 159).

The legacy of adverse life events intersects with the traumatizing nature of CJ involvement (Harris & Levenson, 2020; Pettus-Davis et al., 2019). Mental health professionals working with RSO clients should recognize that the negative behaviours we observe (e.g. substance abuse, anger or aggression, irresponsibility) may exemplify symptoms of traumatic coping in response to early adversity as well as the stress of re-entry (Harris & Levenson, 2020). A positive community adjustment is grounded in stability and support, enabling the cognitive transformation to a prosocial identity and desistance from crime (Lussier & Gress, 2014; Maruna et al., 2004; Western, 2018; Willis, 2018). Reducing risk of reoffending should involve reducing traumatic stress and helping clients manage the emotional and behavioural dysregulation associated with it. With improvements in coping and self-regulation, positive changes can naturally lead to the pursuit of desistance and a good life (Harris et al., 2017; Willis et al., 2013). Attention to the link between (past or present) trauma and dysregulated behaviour represents a novel approach to reducing risk and improving SOTx outcomes (Levenson et al., 2017).

One theme that emerged in our current study was persistent concern about the future due to the unrelenting stress and disgrace of registration. While most traumatic events eventually end (including incarceration and probation), SORN is uniquely permanent, as it is required for life in most cases and carries an unyielding stigma that has no road to redemption in the eyes of public opinion (Harris & Socia, 2016; Higgins & Rolfe, 2017). The 'sex offender' label has been viewed through the lens of *necropolitics* (Higgins & Rolfe, 2017; Mbembe, 2008), a term used to describe the subjugation of various populations by governments and the deprivation of rights to liberty and autonomy. As over-policing and mass incarceration has proliferated in recent decades, the collateral consequences of a criminal conviction can lead to a type of 'civil death' through exclusion of participation in important institutions of our social and political worlds (Chin, 2011). For RSOs, this marginalization is often legislated to a point that even basic human needs like housing are subject to debilitating restrictions (Levenson et al., 2016). RSOs perceive their humanity as irretrievably lost and describe feeling that they are relegated to life as an outcast (Higgins & Rolfe, 2017). Therefore, the psychological harm of shame, depression, hopelessness, fear, hypervigilance, and social losses must be addressed when considering how SOTx can improve client wellbeing, re-entry outcomes, and public safety (Hamilton, 2020).

Limitations

In this paper we have extended a line of inquiry to advance our understanding of PCTS, however, our work is not without limitations. While the focus groups prompted the participants to describe examples of PTSD symptoms, we were unable to conclude how many met DSM-5 diagnostic criteria for PTSD. LeBel and Richie (2018) noted that many studies of CJ involved persons have not used clinical methods to diagnose PTSD in research participants who report symptoms suggestive of the disorder. This limitation reinforces the need for future researchers to collect data using validated measures of PTSD to quantify prevalence of symptoms and devise an evidence-based construct for a post-conviction specifier in future DSM revisions (LeBel & Richie, 2018; Liem & Kunst, 2013).

Focus groups provide an efficient method of qualitative data collection (Flick, 2013) but participants might provide more or less detail than if asked in private. Participants who spoke more times (utterances) articulated more symptoms. It is possible that members were more inclined to speak if they recognized PTSD criteria in themselves, with others failing to report the absence of such symptoms. Conversely, if someone thought their point had been made already, they might not have bothered to share or speak up. Thus, it was impossible to accurately estimate the prevalence of symptoms. For example, only two mentions were made of suicidal ideation (10%), but some clients might have been reluctant to share similar thoughts; higher rates of attempted suicide (18%) and suicidal ideation (15%) by RSOs are reported in the literature (Katsman & Jeglic, 2020). On the other hand, issues of concern might be more likely to be raised in a focus group than would ordinarily be shared without prompting. In general, focus group 'participants tend to provide checks and balances on each other which weeds out false or extreme views' (Patton, 2002, p. 386) and facilitators can quickly observe if a view is shared, as it tends to be endorsed with nods or other affirmations.

The participants were from one state only and may not represent the US population of RSOs. SORN laws and their implementation, as well as arrest policies, prison, probation and parole experiences differ in each state and therefore may lead to different sources of stress, strain, and collateral consequences. The focus groups comprised racial and ethnic diversity but were made up exclusively of men; therefore, the observed themes and reported PCTS symptoms may or may not be relevant for females. The sample was drawn exclusively from the United States and thus will not be generalizable around the globe.

Not all our participants had been convicted for sexual offending. Some were in treatment pre-adjudication, and others had negotiated a plea to a non-sex conviction, avoiding SORN requirements although they were on probation and mandated to attend SOTx. We believe that the RSO status confounds the re-entry experience, and quite possibly exacerbates the manifestation of PCTS symptoms. We recommend future research to specifically explore the traumagenic impact of life as an RSO.

Finally, we continue to ponder the challenges of conceptualizing PTSD for people whose own choices to victimize others have precipitated the traumatizing circumstances in which they find themselves. Furthermore, we acknowledge the delicate dilemma of considering the traumatic consequences to oneself as being a direct result of their causing harm to others. To be clear, we make no excuses for the behaviours of people who committed sex crimes and we believe they should be held to account for their actions. However, their guilt does not preclude their trauma, and these constructs are not mutually exclusive. The trauma of being held at gunpoint with an automatic weapon at point blank range is no less traumatizing because their behaviour was deserving of a legitimate CJ response. Furthermore, by recognizing PCTS and treating trauma symptoms, clinical and criminal justice interventions can help improve self-regulation and therefore reduce an individual's dynamic risk for reoffence. Ultimately, trauma-related dysregulation increases dynamic risk for offending. By ignoring the traumatic impact of criminal justice involvement, we might be neglecting a potentially important treatment target that could improve sexual violence prevention outcomes.

Directions for future research

Qualitative methodologies are designed to tell the stories and share the narratives of those typically lacking a voice. Focus groups are a recommended method for exploring under-studied phenomena, developing hypotheses, and formulating future survey questions. This paper informs a broader research agenda to understand the post-conviction traumatic stress of people convicted of sexual crimes as they attempt to reintegrate productively into society. Future research should employ methods to quantify the prevalence and correlates of PCTS symptoms in a larger and more representative sample of RSOs. Understanding more about the internal experience of PCTS might help to direct treatment efforts to improve coping and self-regulation skills, and to enhance prevention of reoffending.

Conclusion

The stress and stigma of probation, parole, or registration can generate anxious symptoms of dysregulation and maladaptive coping. In turn, dynamic risk for reoffence may increase, paradoxically undermining prevention goals. A new concept of 'quaternary prevention' (Gofrit et al., 2000, p. 500) cautions those in the tertiary prevention arena to reflect critically upon their actions with 'emphasis on the need to *do no harm'*(Jamoulle, 2015, p. 1). The adoption of trauma-informed practices can help mitigate the stress caused by re-entry obstacles (such as housing and employment restrictions) that may be designed to improve public safety but possibly hinder that same goal. Western (2018) described how community supervision has moved away from a rehabilitation philosophy to an overly punitive 'culture that emphasizes surveillance over services' (p. 126).

Clinicians, researchers, and policymakers should strive to reduce re-traumatization in the re-entry process and reinforce supportive services. Trauma-informed treatments collaboratively empower clients to recognize cognitive schemas, understand trauma-related hyperarousal and emotional dysregulation, and acquire adaptive coping skills (Levenson et al., 2017). By applying knowledge of traumatic stress and addressing its manifestations, correctional agencies might facilitate better re-entry outcomes and reduced recidivism (Pettus-Davis et al., 2019; Western, 2018; Western et al., 2015). Many of our focus group participants wanted to remind us that they are resilient and doing their best to cope and succeed.

Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data is not available.

The authors confirm that there is no conflict of interest in this study.

Note

1. DSM-5 Criterion A suggests and assumes that the trauma of sexual violence results from being victimized. We note that in this study we did not ask whether *committing* an act of sexual violence was traumatic for our participants, but it certainly could be. Anecdotally, sex-offending treatment clients do report PTSD symptoms related to the commission of a sex offence. This topic should be explored in future research. However, events such as being arrested at gunpoint or encountering dangerous conditions while incarcerated would be consistent with Criterion A.

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References

Ackerman, A. R., & Sacks, M. (2012). Can general strain theory be used to explain recidivism among registered sex offenders? *Journal of Criminal Justice*, *40*(3), 187–193. https://doi.org/10.1016/j.jcrimjus.2011.11.002

Agnew, R. (1992). Foundation for a general strain theory of crime and delinquency*. *Criminology*, *30*(1), 47–88. https://doi.org/10.1111/j.1745-9125.1992.tb01093.x

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed). American Psychiatric Association.

Andrews, D. A., & Bonta, J. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law*, *16*(1), 39–55. https://doi.org/10.1037/a0018362

Andrews, D. A., & Bonta, J. (2017). *The psychology of criminal conduct* (4th ed.). Anderson Publishing.

Bachman, R., & Schutt, R. K. (2013). *The practice of research in criminology and criminal justice*. SAGE Publications.

Bailey, D. J. S. (2018). A life of grief: An exploration of disenfranchised grief in sex offender significant others. *American Journal of Criminal Justice*, *43*(3), 641–667. https://doi.org/10.1007/s12103-017-9416-4.

Bloom, S. L. (2013). *Creating sanctuary: Toward the evolution of sane societies*. Routledge.

Chin, G. J. (2011). The new civil death: Rethinking punishment in the era of mass conviction. *University of Pennsylvania Law Review*, *160*(6), 1789–1833.

Copes, H., Beaton, B., Ayeni, D., Dabney, D., & Tewksbury, R. (2020). A content analysis of qualitative research published in top criminology and criminal justice journals from 2010 to 2019. *American Journal of Criminal Justice*, *45*(6), 1060–1079. https://doi.org/10.1007/s12103-020-09540-6

Craig, L. A., & Rettenberger, M. (2018). An etiological approach to sexual offender assessment: Case formulation incorporating risk assessment (CAFIRA). *Current Psychiatry Reports*, *20*(6), 43. https://doi.org/10.1007/s11920-018-0904-0

de Vries Robbé, M., de Vogel, V., Koster, K., & Bogaerts, S. (2015). Assessing protective factors for sexually violent offending with the SAPROF. *Sexual Abuse*, *27*(1), 51–70. https://doi.org/10.1177/1079063214550168

Fernandes, A. D. (2020). How Far Up the river? Criminal justice contact and health outcomes. *Social Currents*, *7*(1), 29–45. https://doi.org/10.1177/2329496519870216

Flick, U. (2013). *The SAGE handbook of qualitative data analysis*. Sage.

Flood, F. (2018). Reframing trauma: The transformative power of meaning in life, work, and community. *Journal of Psychiatry and Psychiatric Disorders*, *2*(5), 37–54. https://doi.org/10.26502/jppd.2572-519X0052

Gofrit, O. N., Shemer, J., Leibovici, D., Modan, B., & Shapira, S. C. (2000). Quaternary prevention: a new look at an old challenge. *The Israel Medical Association Journal: IMAJ*, *2*(7), 498–500. http://europepmc.org/abstract/MED/10979319

Hamilton, E. (2017). Identity concerns among sexual offenders: The narrative call. *Practice Innovations*, *2*(1), 13–20. https://doi.org/10.1037/pri0000039

Hamilton, E. (2020). Toward a focused conceptualization of collateral consequences among individuals who sexually offend: A systematic review. *Sexual Abuse*, *34*, 3. https://doi.org/10.1177/1079063220981906

Harris, A. J., & Socia, K. M. (2016). What's in a name? Evaluating the effects of the "sex offender" label on public opinions and beliefs. *Sexual Abuse*, *28*(7), 660–678. https://doi.org/10.1177/1079063214564391

Harris, D. A., & Levenson, J. S. (2020). Life on "the list" is a life lived in fear: Post-conviction traumatic stress in Men convicted of sexual offences. *International Journal of Offender Therapy and Comparative Criminology*, *65*(6-7), 763–789. https://doi.org/10.1177/0306624(20952397

Harris, D. A., Pedneault, A., & Willis, G. (2017). The pursuit of primary human goods in men desisting from sexual offending. *Sexual Abuse*, *31*(2), 197–219. https://doi.org/10.1177/1079063217729155

Higgins, E. M., & Rolfe, S. M. (2017). "The sleeping army": Necropolitics and the collateral consequences of being a sex offender. *Deviant Behavior*, *38*(9), 975–990. https://doi.org/10.1080/01639625.2016.1229947

Jamoulle, M. (2015). Quaternary prevention: First, do not harm. *Revista Brasileira de Medicina de Família e Comunidade*, *10*(35), 1–3.

Jeglic, E., Mercado, C. C., & Levenson, J. S. (2011). The prevalence and correlates of depression and hopelessness among sex offenders subject to community notification and residence restriction legislation. *American Journal of Criminal Justice*, *37*(1), 46–59. https://doi.org/10.1007/s12103-010-9096-9

Katsman, K., & Jeglic, E. L. (2020). An analysis of self-reported suicide attempts and ideation in a national sample of incarcerated individuals convicted of sexual crimes. *Journal of Sexual Aggression*, *26*(2), 212–231. https://doi.org/10.1080/13552600.2019.1611959

Kitzinger, J. (1994). The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health and Illness*, *16*(1), 103-121. https://doi.org/10.1111/1467-9566.ep11347023

Krueger, R. A. (2014). *Focus groups: A practical guide for applied research*. Sage publications.

Kubiak, S., Covington, S., & Hillier, C. (2017). Trauma-informed corrections. In D. Springer & A. Roberts (Eds.), *Social work in juvenile and criminal justice system* (4th ed., pp. 92–104). Charles C. Thomas.

Lazarsfeld, P. F., & Barton, A. H. (1955). Some functions of qualitative analysis in social research. *Sociologica*, *1*, 321–361.

LeBel, T. P., & Richie, M. (2018). *The psychological effects of contact with the criminal justice system. In Handbook on the consequences of sentencing and punishment decisions* (pp. 122-142). Routledge.

Levenson, J. S., & Cotter, L. P. (2005). The effect of Megan's Law on sex offender reintegration. *Journal of Contemporary Criminal Justice*, *21*(1), 49–66. https://doi.org/10.1177/1043986204271676

Levenson, J. S., Grady, M. D., & Leibowitz, G. (2016). Grand challenges: Social justice and the need for evidence-based sex offender registry reform. *Journal of Sociology & Social Welfare*, *43*(2), 3–38.

Levenson, J. S., Willis, G., & Prescott, D. (2017). *Trauma-informed care: Transforming treatment for people who sexually abuse*. Safer Society Press.

Levenson, J. S., & Willis, G. M. (2019). Implementing trauma-informed care in correctional treatment and supervision. *Journal of Aggression, Maltreatment & Trauma*, *28*(4), 481–501. https://doi.org/10.1080/10926771.2018.1531959

Liem, M., & Kunst, M. (2013). Is there a recognizable post-incarceration syndrome among released "lifers"? *International Journal of Law and Psychiatry*, *36*(3), 333–337. https://doi.org/10.1016/j.ijlp.2013.04.012

Listwan, S. J., Sullivan, C. J., Agnew, R., Cullen, F. T., & Colvin, M. (2013). The pains of imprisonment revisited: The impact of strain on inmate recidivism. *Justice Quarterly*, *30*(1), 144–168. https://doi.org/10.1080/07418825.2011.597772

Lussier, P., & Gress, C. L. Z. (2014). Community re-entry and the path toward desistance: A quasi-experimental longitudinal study of dynamic factors and community risk management of adult sex offenders. *Journal of Criminal Justice*, *42*(2), 111–122. https://doi.org/10.1016/j.jcrimjus.2013.09.006

Maruna, S., LeBel, T. P., Mitchell, N., & Naples, M. (2004). Pygmalion in the reintegration process: Desistance from crime through the looking glass. *Psychology, Crime & Law*, *10*(3), 271–281. https://doi.org/10.1080/10683160410001662762

Maslow, A. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370-396. https://doi.org/10.1037/h0054346

Mbembe, A. (2008). Necropolitics. In S. M. S. Bygrave (Ed.), *Foucault in an age of terror* (pp. 152–182). Springer.

Morgan, D. L., & Nica, A. (2020). Iterative thematic inquiry: A new method for analyzing qualitative data. *International Journal of Qualitative Methods*, *19*, 1–11. https://doi.org/10.1177/1609406920955118

Nili, A., Tate, M., & Johnstone, D. (2017). A Framework and Approach for Analysis of Focus Group Data in Information Systems Research. *Communications of the Association for Information Systems*, *40*, 1–21. http://dx.doi.org/10.17705/1cais

Onwuegbuzie, A. J., Dickinson, W. B., Leech, N. L., & Zoran, A. G. (2009a). A qualitative framework for collecting and analyzing data in focus group research. *International Journal of Qualitative Methods*, *8*(3), 1–21. https://doi.org/10.1177/160940690900800301

Onwuegbuzie, A. J., Slate, J. R., Leech, N. L., & Collins, K. M. T. (2009b). Mixed data analysis: Innovative integration techniques. *International Journal of Multiple Research Approaches*, *3*(1), 13–33.

Patton, M. Q. (2002). *Qualitative research and evaluation methods*. Sage Publications.

Petersilia, J. (2003). *When prisoners come home: Parole and prisoner reentry*. Oxford University Press.

Pettus-Davis, C., & Epperson, M. W. (2015). *From mass incarceration to smart decarceration*. American Academy of Social Work & Social Welfare. http://aaswsw.org/wp-content/uploads/2015/03/From-Mass-Incarceration-to-Decarceration-3.24.15.pdf

Pettus-Davis, C., Renn, T., Lacasse, J. R., & Motley, R. (2019). Proposing a population-specific intervention approach to treat trauma among men during and after incarceration. *Psychology of Men & Masculinities*, *20*(3), 379–393. https://doi.org/10.1037/men0000171

Rydberg, J. (2018). Employment and housing challenges experienced by Sex offenders during reentry on parole. *Corrections*, *3*(1), 15–37. https://doi.org/10.1080/23774657.2017.1369373

Sadeh, N., & McNiel, D. E. (2015). Posttraumatic stress disorder increases risk of criminal recidivism among justice-involved persons with mental disorders. *Criminal Justice and Behavior*, *42*(6), 573–586. https://doi.org/10.1177/0093854814556880

SAMHSA. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. Substance Abuse and Mental Health Services Administration.

Sample, L. L., Cooley, B. N., & ten Bensel, T. (2018). Beyond circles of support: "fearless" – An open peer-to-peer mutual support group for Sex offence registrants and their family members. *International Journal of Offender Therapy and Comparative Criminology*, *62*(13), 4257–4277. https://doi.org/10.1177/0306624X18758895

Tewksbury, R., & Levenson, J. S. (2009). Stress experiences of family members of registered sex offenders. *Behavioral Sciences & the Law*, *27*(4), 611–626. https://doi.org/10.1002/bsl.878

Tewksbury, R., & Mustaine, E. (2009). Stress and collateral consequences for registered sex offenders. *Journal of Public Management and Social Policy*, *15*(2), 215–239.

Uggen, C., Manza, J., & Behrens, A. (2004). Less than the average citizen: Stigma, role transition, and the civic reintegration of convicted felons. In S. Maruna & R. Immarigeon (Eds.), *After crime and punishment: Pathways to offender reintegration* (pp. 261–293). Willan Publishing.

van der Kolk, B. (2006). Clinical implications of neuroscience research in PTSD. *Annals of the New York Academy of Sciences*, *1071*(1), 277–293. https://doi.org/10.1196/annals.1364.022

Western, B. (2018). *Homeward: Life in the year after prison*. Russell Sage Foundation.

Western, B., Braga, A. A., Davis, J., & Sirois, C. (2015). Stress and hardship after prison. *American Journal of Sociology*, *120*(5), 1512–1547. https://doi.org/10.1086/681301

Willis, G. M. (2018). Why call someone by what we don't want them to be? The ethics of labeling in forensic/correctional psychology. *Psychology, Crime & Law*, *24*(7), 727–743. https://doi.org/10.1080/1068316X.2017.1421640

Willis, G. M., Prescott, D. S., & Yates, P. M. (2013). The good lives model (GLM) in theory and practice. *Sexual Abuse in Australia and New Zealand*, *5*(1), 3–9.

Yates, P. M., Prescott, D., & Ward, T. (2010). *Applying the good lives and self-regulation models to sex offender treatment: A practical guide for clinicians*. Safer Society Press.

Chapter 24
Trauma-Informed Treatment Practices in Criminal Justice Settings

Jill S. Levenson, David S. Prescott, and Gwenda M. Willis

Abstract Many people convicted of criminal offenses have a complex history of trauma that is overshadowed by the harm caused by their crimes. Although these truths do not excuse their criminal behaviors, it is important to understand and respond to trauma as one of the numerous and complex factors that contribute to criminality. Efforts to reduce crime and prevent future offending can be strengthened through trauma-informed policies and interventions. This chapter provides insight on the importance of trauma-informed care (TIC) in the criminal justice system by (1) discussing risk factors for criminality within the context of childhood adversity and adult trauma; cultural, historical, intergenerational, and systemic racism; and the trauma of poverty; (2) conceptualizing the impact of trauma on development of behavioral problems and mental health disorders; and (3) defining and describing trauma-informed care for practitioners in the criminal justice system. TIC uses principles of safety, trust, empowerment, choice, and collaboration to enhance engagement, build self-regulation and resilience skills, and avoid retraumatization of criminal justice clients. This chapter concludes with useful questions that professionals and organizations should consider when implementing trauma-informed care in their practice.

Keywords Trauma-informed · Risk · Self-regulation · Recidivism · Rehabilitation · Corrections · Treatment · Offender

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When professionals and laypeople read media accounts about high-profile crimes, it is easy to experience a kind of "flashbulb moment" in which we develop a single image in our mind of the worst image of the event. We may think: "what kind of horrible person does that?" or "lock that guy up and throw away the key!" all the while forgetting the complexities of the human beings involved in these situations.

Likewise, whether in policy or programming, it is easy to approach crime from only a punitive angle when so many people are profoundly harmed by personal violence. Narratives of life-altering trauma and the immeasurable effects of criminal behavior inspire compassion and empathy for those who have been victimized, along with demands for harsh penalties and greater attention to public safety. We tend to forget that behind every headline are other stories. The stories of those who commit crimes elicit little sympathy. We conveniently overlook the fact that many of the people we condemn today were often the abused and deprived children of yesterday.

The stories behind the headlines are overflowing with trauma: childhood maltreatment, community violence, lives of poverty, and generations of systemic injustice. Although these truths do not excuse criminal behavior, it is important to understand the numerous and complex factors that ultimately manifest in criminal behavior. The more we know, the better we can tailor and improve the policies and interventions that seek to reduce crime and prevent future offending. When we understand these factors, we start to build trauma-informed rehabilitation programs that hold promise for prevention of future recidivism.

We already know of many issues surrounding systemic racism, marginalized communities, and the desperate need for reform in law enforcement, sentencing, and bail inequities. Beyond that, we face challenges in assessing risk and reducing barriers to successful reentry to life on the outside. Parole and probation can resemble landmines rather than support systems. All of these factors influence clients in the criminal justice system and their efforts to build better futures. Innovation aimed at systemic policy reform can improve conditions and outcomes from arrest to incarceration to reentry programs, case management, and community supervision. In this book, authors consider various models of strengths-based treatments intended to rehabilitate justice-involved clients. In this chapter, we offer a paradigm shift—through the lens of trauma—to understanding and treating the complexities of behavioral health symptoms, disordered personality styles, and addiction.

Trauma and Crime

A myriad of theories ponder the causes behind criminal behavior. Especially relevant to trauma, *strain theory* suggests that social and psychological stress can lead people to commit crimes (Agnew, 1992). The source of these strains can range from apparently unfair treatment by others, to real or perceived obstacles that prevent a person from reaching their goals, to the inability to escape from painful life circumstances or social injustice (e.g., systemic racism, oppression, discrimination, and the

trauma of poverty). Seemingly intractable gaps between one's goals and achievements can create anger, disempowerment, and learned helplessness. Frustration and inequity can prompt desperate and even criminal attempts to meet human needs, seek vengeance against unfairness, or re-empower the individual (Agnew, 1992). Bandura described the crucial role of *self-efficacy*, the belief in one's own capacity to achieve goals, accomplish tasks, and respond competently to challenges (Bandura, 1977). When personal or societal obstacles stand in the way of an individual's forward motion, they may compensate in maladaptive ways: through violence, self-medication, or crime to meet basic human needs.

Not surprisingly, suspicion has historically prevailed over understanding adverse life experiences of people who commit crimes. Bestsellers, such as *The Abuse Excuse: And other cop outs, sob stories, and evasions of responsibility* (Dershowitz, 1995), emphasized that defense based on victimization status contradicted the values of democracy. In an influential 2001 study, researchers polygraphed people who committed sex crimes to investigate their claims of childhood molestation and concluded that many of them embellished abuse histories to gain sympathy or deflect responsibility (Hindman & Peters, 2001). After John Hinckley Jr., a mentally ill man with erotic delusions about actress Jodie Foster, attempted to assassinate then-President Reagan in 1981, Congress rewrote laws about the insanity defense.

The role of the criminal justice system includes punishment (retribution for crimes), deterrence (preventing others from committing crimes), incapacitation (detention to remove any opportunity to commit crimes), and rehabilitation (improving the well-being and coping skills of people who offended in order to reduce their risk to re-offend). Treatment programs based on risks, needs, and responsivity are part of the therapeutic ideal in criminal justice (Andrews & Bonta, 2010). Rehabilitation works best when practitioners identify unique risks, strengths, and needs for individuals, thereby enhancing clients' ability to respond to relevant interventions delivered in a strengths-based, empowering, and respectful manner (Andrews & Bonta, 2010, 2017; Hanson et al., 2009; Jung, 2017; Olver et al., 2018). Amid this process, the concept of *responsivity* might be most important: the best hope for treatment success comes from culturally relevant, gender-specific, and individualized interventions delivered in flexible ways so that clients are best able to respond to them (Jung, 2017; SAMHSA, 2014a). Understanding how trauma can hinder an individual's ability to engage in treatment is therefore an important responsivity factor. For this reason, incorporating knowledge about trauma into correctional programming is crucial.

Trauma: What is It, and Why Does It Hurt?

The American Psychiatric Association describes *trauma* as an experienced or observed event that threatens one's sense of physical or psychological safety, produces feelings of anxiety and helplessness, and overwhelms a person's typical capacity to cope effectively (American Psychiatric Association, 2013; Bloom, 2013;

SAMHSA, 2014a). The experience of trauma can involve a single event and its aftermath, but many people live in chronic traumagenic environments that create cumulative toxic stress. Such conditions can disrupt the integration of emotions and experiences, leading to dysregulated feelings and behavior (Bloom, 2013). Efforts to adapt to the demands of an environment that feels unsafe can alter personal growth, leaving individuals with unhealthy ways of thinking about themselves, others, and the world. They might learn to cope in maladaptive ways, which can, in turn, lead to addiction and criminal behavior (Bloom, 2013; Najavits et al., 2009). Although clinical presentation of trauma and stress-related disorders varies among individuals, symptoms usually involve reexperiencing the trauma, avoiding triggers, negative thoughts, hypervigilant behaviors, and emotional reactivity (American Psychiatric Association, 2013).

Traumatizing experiences exist on a continuum. Some traumas may be overt and easily identified, and others subtle and harder to define, but chronic adversity can create a persistent sense of the world as an unsafe place. The impact of trauma is also determined by what happens in its aftermath and by the strength and availability of positive support systems that contribute to resilience (Shonkoff et al., 2012). Trauma is best understood not as a discrete event, but as a web of experiences through which one's understanding of self, others, and the world is organized (Bloom, 2013).

The Traumatic Childhood

In the mid-1990s, research in the US revealed the staggering frequency of developmental traumas called *adverse childhood experiences* (ACEs) (Centers for Disease Control and Prevention, 2013a; Felitti et al., 1998). Nearly two-thirds of American adults in the sample ($n > 17{,}000$) had experienced at least one form of child maltreatment (physical or emotional abuse or neglect, or sexual abuse) or family dysfunction in the childhood home (domestic violence, an absent parent, substance abuse, mental illness, or criminality). Nearly 13% had experienced four or more ACEs (Centers for Disease Control and Prevention, 2013b; Felitti, 2002). The accumulation of ACEs is associated with poorer physical and mental health, as well as negative psychosocial outcomes of different sorts, such as chemical dependency, suicidality, depression, cigarette smoking, physical diseases, obesity, alcoholism, intimate partner violence, and unintended pregnancies (Anda et al., 2010).

People who have committed crimes typically experience higher rates of ACEs than the general population, and higher ACE scores correspond to increased risk for criminal behavior and incarceration (Baglivio et al., 2014; Harlow, 1999; Jäggi et al., 2016; Levenson & Grady, 2016; Maschi et al., 2011; Pettus-Davis et al., 2019; Roos et al., 2016). Among adults who have engaged in criminal behavior, greater exposure to early trauma was often followed by mental health disorders, drug abuse, and serious crime (Henry, 2020). Some people exhibit resilience following adversity, but traumagenic childhood environments may be the most destructive for those

with negative personality traits and limited intellectual or social resources; impoverished socioeconomic conditions can further exacerbate problems (Masten & Cicchetti, 2010; Patterson et al., 1990).

Prolonged exposure to traumagenic conditions results in *toxic stress*, which produces an abundance of hormones designed to prepare the body to scan for danger and respond quickly to threats (fight-flight-freeze response) (Bloom, 2013; van der Kolk, 2006). When the nervous system is constantly over-activated with stress, these physiological responses can alter the brain's architecture, hindering the integration of thoughts, feelings, and experiences, which ultimately leads to emotional or behavioral dysregulation (Bloom, 2013; van der Kolk, 2006). Early adversity sets up the individual for disrupted attachment, distorted cognitive schemas, and poor interpersonal skills (Bloom, 2013; Carlson & Sroufe, 1995; Grady et al., 2016; Harris & Fallot, 2001). Children exposed to an abusive, neglectful, or tumultuous home life tend to cultivate needed survival skills, but development in certain areas of the brain may suffer, particularly executive functioning (cognitive processing, decision-making, and self-regulation). Ongoing trauma can cause people to develop unhealthy ways of thinking about themselves and the world around them, sometimes prompting maladaptive coping strategies in response to the demands of an environment that feels threatening (Bloom, 2013; Van der Kolk, 2017). These effects also occur when people live in impoverished or high-crime communities, when they are exposed to interpersonal violence in adulthood, or when they experience other life-altering events like an accident, natural disaster, or war.

These neurocognitive deficits in adaptive functioning seem to underlie what are known as dynamic risk factors and the central eight criminogenic needs (Cheng et al., 2019; Wojciechowski, 2020). Most abused children do not grow up to engage in crime, but the risk for offending later in life increases due to biological, social, and psychological consequences of early trauma (Baglivio & Epps, 2016; Jäggi et al., 2016; Topitzes et al., 2011; Wallace et al., 2011). Mistreated youngsters may develop impulsive or risk-taking behavior. They are more likely to socialize with delinquent peers, to self-medicate with drugs or alcohol, and to provoke interpersonal conflict with others. Early relational traumas can foster a tendency to seek out or exploit others who are more vulnerable and less threatening (Ardino, 2012; Grady et al., 2016). Ultimately, antisocial or criminal behaviors such as violence, substance abuse, and impulsive acts are often really trauma symptoms in disguise.

Cultural, Historical & Intergenerational Trauma, Systemic Racism, and the Trauma of Poverty

All too often, minority groups are marginalized, stigmatized, and discriminated against. These experiences are traumagenic, increasing risk for mental health problems and decreasing the likelihood of seeking help (Bryant-Davis, 2019; Pattyn et al., 2014). Cultural and historical trauma continues to exist in the legacy of

slavery, displacement of indigenous peoples, and experiences of immigrants and refugees (Bryant-Davis, 2019; St. Vil et al., 2019). Systemic injustice exists in overt and subtle ways, and the causes and effects are often reciprocal: minority groups are disproportionately represented in the criminal justice system, and mass incarceration has subsequently changed the economic, social, and familial landscapes of impacted communities (Pettus-Davis & Epperson, 2015). These conditions raise the risk of crime, creating an intergenerational cycle that repeats itself. The trauma and insecurity of poverty contribute to a stigmatized identity compounded by the social construction of inadequacy (Hudson, 2016). The intergenerational and historical traumas of poverty, systemic racism, oppression, and discrimination must therefore be understood and seriously considered as we develop treatment models for criminal rehabilitation (Jäggi et al., 2016; Sotero, 2006; St. Vil et al., 2019).

Diagnostic Considerations

We know that behavioral health disorders can lead people to get caught up in the criminal justice system, and that jails serve as the largest mental health facilities in the US raising risk for criminal recidivism (Messina et al., 2007; Sadeh & McNiel, 2015). A history of trauma increases risk for arrest, and reciprocally, arrest and incarceration exacerbate the symptoms of PTSD. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) clinical workgroup refined the definition of traumatic experience in Criterion A of PTSD to life-threatening events, serious injury, or sexual violence (Friedman, 2013). While childhood adversity experiences and developmental trauma do not explicitly meet the criteria for PTSD Criterion A, they do lead to post-traumatic stress symptoms that are perceived as persistent and distressing (Van der Kolk, 2017).

Furthermore, though they may not specifically meet diagnostic criteria for PTSD, a crime accusation, arrest, court hearings, incarceration, probation/parole, or sex-offender registration can all constitute experiences that are life-altering. They create fear and powerlessness, rendering them traumatic and leading to what Liem and Kunst (2013) called "post-incarceration syndrome" and Harris and Levenson (2020) called "post-conviction traumatic stress" (Harris & Levenson, 2020; Liem & Kunst, 2013; Pettus-Davis et al., 2019). The history of the criminal justice system and broader western cultural values have often combined to lead professionals to have uninformed views of the role of trauma and adversity in the lives of our clients. At the front line of correctional services are practitioners who have not always recognized the effects of trauma and adversity in shaping the lives of criminal justice clients (Levenson et al., 2017). The complex intersection of past and current trauma requires practitioners in criminal justice settings to consider the need for trauma-informed care (TIC).

What Exactly is Trauma-Informed Care?

There are numerous definitions for Trauma-Informed Care (TIC). At its heart, TIC (also referred to as trauma-informed practice) addresses the link between past experiences and presenting problems by conceptualizing and responding to clients through the lens of trauma (Levenson et al., 2017). More formally, the trauma-informed approach has been defined as "a program, organization, or system that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization" (SAMHSA, 2014a). Trauma-informed practice differs from trauma-specific interventions that aim to reduce PTSD symptoms and improve skills to cope with distress (though many people in the criminal justice system may benefit from trauma-resolution methods such as EMDR or Cognitive Processing Therapy). TIC is a strengths-based and empowering framework for delivering interventions in a way that promotes resilience and internal locus of control (Bloom, 2013).

TIC begins with an understanding of the *three Es* of trauma: Events, Experience, and Effects (SAMHSA, 2014a). Traumatic *events* can be acute or ongoing circumstances and can cause various degrees of fear. It is the individual's unique *experience* of the trauma that determines its longer term impact and psychological harm. In other words, people attach meaning to the things that happen to them. For more resilient people, a terrible trauma can mean that hard things happen, but you learn you can get through it, you can count on others to support you, and you still perceive the world as a generally safe place. Another person might interpret the traumatizing experience as something they deserved because they believe they are bad, or because the world is fundamentally unfair. These differing interpretations reflect an intersecting web of thoughts, feelings, and experiences that lead to differential *effects* of trauma that vary uniquely in duration and severity for each individual. Shapiro (2018) described Big Ts and Little Ts, recognizing that while easily identifiable traumas exist, we all experience many small but distressing experiences in life that can have surprisingly profound and lasting effects. For instance, a rape or near-fatal auto accident might be universally understood to be a Big Trauma, but we might discount a childhood humiliation (Little Trauma) that continues to haunt a person through a shame reaction whenever a similar situation triggers the memory (Shapiro, 2018).

Essentially, TIC helps clinicians respond to client problems by understanding how traumatic life experiences shape behavior, thoughts, feelings, and relationship patterns, instead of a pathology-driven assessment of what is "wrong" with someone (SAMHSA, 2014b). SAMHSA's *Concept of Trauma and Guidance for a Trauma-Informed Approach* describes the six key guiding principles of TIC (SAMHSA, 2014a, pp. 11–12): safety, trust and transparency, peer support, collaboration, empowerment, and awareness of cultural, historical, and gender-based trauma. These fundamental features can counteract the damaging impacts of trauma

by creating physical, interpersonal, and moral safety within a social environment that ensures trust, collaboration, choice, and empowerment in the delivery of services (Bloom, 2013).

TIC emphasizes client-centeredness, authenticity, and positive regard (Rogers, 1961), which allow us to humanize our clients and remember that they are more than just the worst thing they have done. Trauma-informed practice relies on building a partnership with clients that promotes psychological safety, trust, choice, and collaboration while avoiding disempowering dynamics in the therapeutic encounter (Bloom, 2013). It utilizes strengths-based principles consistent with the RNR and Good Lives Model (GLM) to help clients build skills, self-efficacy, and meaningful relationships (Andrews & Bonta, 2010; Marshall et al., 2011; Willis et al., 2013; Yates et al., 2010). TIC relies on relational and experiential methods for modeling healthy boundaries and shared power, which were often absent or inadequate in the early environments of people in the CJ system. In addition to correctional program *content*, TIC relies on the therapeutic *process* to facilitate better self-regulation and healthy intimacy skills. In a trauma-informed environment, the process of service delivery should be respectful, empowering, nonconfrontational, and non-shaming (Levenson et al., 2017).

Some trauma-informed targeted interventions have been found to be effective when tested in quasi-experimental designs like the *Trauma Recovery and Empowerment Model* (Fallot et al., 2011), *Seeking Safety* (Najavits, 2009), and other addiction recovery programs (Covington et al., 2008). However, because experimental research requires rigid and replicable conditions, it does not lend itself readily to TIC, which responds to the needs of each client in flexible ways as they come up in the treatment setting. Instead, TIC is a framework of practice principles based on evidence from neurobiological, psychological, and social research into the etiology and impact of trauma. Interdisciplinary literature provides a base of theoretical and empirical support for the use of TIC, including the disproportionate prevalence of adversity in samples of people involved in the criminal justice system (Baglivio et al., 2014; Harlow, 1999; Jäggi et al., 2016; Levenson & Grady, 2016; Maschi et al., 2011; Pettus-Davis et al., 2019; Roos et al., 2016); developmental psychopathology and the neuroscience of trauma (Cicchetti & Banny, 2014; Shonkoff et al., 2012; Van der Kolk, 2017); and the principles of effective psychotherapy (Prescott et al., 2017; Wampold, 2015). The real challenge in this process is fitting TIC principles into functional outcomes and measures of effectiveness (Berliner & Kolko, 2016).

Under any circumstance, evidence-based practice (EBP) begins with a consolidation of interdisciplinary and cross-theoretical knowledge to build a foundation for effective treatment protocols. EBP then integrates research evidence with clinical expertise and client characteristics (APA Presidential Task Force on Evidence-Based Practice, 2006). The practitioner must account for the client's trauma history as they consider the assessment of client needs, risks, and strengths, along with knowledge of the research most applicable to the client's problems, and incorporate all of it into a delivery style that is relevant for the individual (Andrews & Bonta, 2010; Grady et al., 2017).

Trauma-Informed Care and Criminal Justice

In the US, the Substance and Mental Health Administration (SAMHSA, 2014a) outlines four foundational principles—Recognize, Realize, Respond, and avoid Re-traumatizing—known as the "4 Rs of TIC." In a correctional context, these can be integrated into treatment as follows: (1) *Recognize* the high prevalence of trauma and adversity among clients in the criminal justice system (Jäggi et al., 2016; Martin et al., 2015; Pettus-Davis et al., 2019); (2) *Realize* the endless ways that trauma can stimulate criminogenic risk through its effect on self-regulation, neurocognitive functioning, and relational patterns (Ardino, 2012; Cheng et al., 2019; Holley et al., 2017; van der Kolk, 2006; Wojciechowski, 2020); (3) *Respond* to client needs by understanding trauma and providing trauma-responsive interventions (Pettus-Davis et al., 2019); and (4) Avoid *re-traumatizing* clients with harsh confrontational and punitive approaches that fail to support client well-being and model empathy and respect (Blagden et al., 2016; Sachs & Miller, 2018; Stinson & Clark, 2017; Sturgess et al., 2016).

While TIC programming appears in women's corrections and juvenile facilities, its application to adult males is relatively new. Traditionally in the US, men's correctional treatment services have been highly confrontational and focused on risk, all but ignoring the principles of effective correctional rehabilitation and trauma-informed care (Kubiak et al., 2017; Levenson et al., 2017; Miller & Najavits, 2012). Engaging clients who are or have been in correctional settings presents special challenges to apply a trauma-informed approach that builds a supportive relationship and fosters positive change (Donisch et al., 2016). Miller and Najavits (2012) described *institutional trauma* by which "inmates begin to re-enact the dynamics of their chaotic and abusive families. The more the system responds with authoritative measures, the more deeply the dynamics are repeated and reinforced" (p. 3). These challenges in implementing TIC in prison settings can become self-perpetuating. When security and program staff encounter aggressive or hostile clients, it provokes fear for their safety in the workplace, and they (understandably) react with punitive practices that prevent opportunities for role-modeling healthy interpersonal boundaries and interactions.

The whole mindset changes when we begin to recognize aggressive behaviors as symptoms of trauma. By understanding client problems as survival and coping skills that developed in response to traumagenic experiences, our questions evolve from "what's wrong with you?" to "what happened to you?" (Bloom, 2013; SAMHSA, 2014a). By rethinking our approach, we begin to recognize behaviors that helped them survive in an unsafe world. The task at hand is to understand the context and see client behaviors as a set of skills that may have helped in a threatening environment but ultimately undermine the client's ability to find appropriate paths to reach their personal goals and establish intimate connections with others.

SAMHSA's trauma-informed approach builds on these core principles rather than following a prescribed set of practices, interventions, or procedures. These principles apply to diverse service delivery settings, allowing adaptations in

terminology and application to suit the specific problem or population. SAMHSA emphasizes the importance of human relationships in promoting recovery and resilience and the need to prioritize and enhance consumer engagement, empowerment, and collaboration. Many criminal justice clients have encountered disdain, contempt, or judgment from others in their lives, and even from helping professionals. TIC creates a corrective experience to build resilience and post-traumatic growth.

The Anatomy of Trauma-Informed Care

Safety Instilling a sense of physical and psychological safety is vital to trauma-informed practice. This is especially challenging in the correctional culture because prisons are built for perpetrators, not those who have been victimized (Kubiak et al., 2017; Miller & Najavits, 2012). Prisons are designed to be disempowering places with rigid and unilateral rules enforced by authority figures with little regard for the effect of confinement on inmates (Kubiak et al., 2017; Levenson et al., 2017). The environment consists of few choices, loud noises, power disparities, locked spaces that create trapped feelings, and exploitation of power by both staff and inmates. Ironically, individuals who end up in the correctional system bring their troubled and traumatized histories with them, and confinement can trigger PTSD reactions and increase risk for aggression and impulsivity (Kubiak et al., 2017). Unfortunately, habituated trauma responses from abusive homes or violent communities combined with the need to survive a threatening prison environment can fortify criminogenic thinking and manipulative behavior. The interaction between inmates and staff in these circumstances can generate a reciprocal process of threat and hostility (Bloom, 2010; Kubiak et al., 2017).

In some cases, aggressive behavior can put the safety and security of correctional clients and staff at risk. Even so, the use of restraints and seclusion should be a last resort, as these methods can re-traumatize people who were abused or neglected, quite easily leading to worsened behavior (Frueh et al., 2005). De-escalation strategies validate feelings, do not invade personal space, and can give people a chance to make behavioral choices that reinforce self-regulation and self-correction skills while ensuring the safety of others (Frueh et al., 2005). Likewise, validating feelings need not be the same as endorsing or colluding with someone's behaviors; they help people feel listened to, and that helps them calm down. Therapeutic prison models, sometimes called psychologically informed planned environments (PIPEs), can benefit from a growing body of research that puts a focus on emphasizing rehabilitation and interpersonal skills. Ideally, such facilities will create a climate of safety, purpose, and positive relationships that are consistent, predictable, and non-shaming as they support readiness to change and hope for the future (Bainbridge, 2016; Blagden et al., 2016).

Trust and Honesty Often, clients in prison or in mandated community treatment have a history of relationships where they could not depend on others to be loyal,

supportive, or responsible. Therefore, lack of trust is adaptive when skepticism protects the individual from betrayal, which they may have come to expect through past experience. In any relationship, trust must be earned and develops over time through demonstrated credibility, honesty, caring, and concern.

Mandated services can be oppressive and disempowering. At the same time, traumatized clients may approach services with a mistrust of authority figures and a wariness of professional helpers. Instead of interpreting this kind of guarded behavior as hostility, lack of motivation, or resistance to services, practitioners in criminal justice programs might recognize these as normal protective reactions displayed when people feel vulnerable. The burden is on therapists to facilitate trust, which requires a compassionate and respectful approach to engaging with clients. A therapist's style of interaction should be genuine and authentic. Clients should not be pressured in initial sessions to disclose information before they are ready to share. The atmosphere of trust develops when professionals recognize clients' needs for safety, respect, and acceptance (Elliott et al., 2005). Over time, clients and service professionals can earn and demonstrate each others' trust. Without ambiguity and vagueness surrounding them, clients can anticipate what is expected of them and what they can expect from their service providers (Harris & Fallot, 2001).

For any rehabilitation program to succeed, clients must be able to see that their therapists have their well-being in mind and want to help them. Trust begins with respectful language and interactions that humanize people who have offended. In this case, language matters. Calling people by the very label we do not want them to be (e.g., "offender," "inmate," or "addict") reinforces self-narratives that preclude the sort of cognitive transformation associated with reduced recidivism risk (Maruna et al., 2004; Willis, 2017). It is important to convey messages of hope, belief in people, and desire to help them be their best selves. Clients routinely face barriers against their attempts to reenter communities, causing despair, and challenging coping skills that are already compromised. Practitioners can promote support systems and help clients navigate the complicated landscape of reentry.

Peer Support: We Get by with a Little Help from our Friends Mutual self-help and peer support are key opportunities to establish hope that healing and change are possible. When individuals who share similar life experiences come together, they can become support systems in their own collective recovery. There is almost nothing more reassuring than sitting with others who seem to get it. This commonality and personal connection are vital to decreasing shame and isolation. Listening to the narratives and lived experiences of clients also helps workers understand what they need to promote recovery and healing. Also, keep in mind that correctional staff and officers can suffer vicarious trauma from hearing about crimes committed and clients' early adversity (Lee, 2017). Therefore, these TIC peer support principles apply to professional helpers as well!

Programs that offer group therapy use peer support as a modality. Therapists can foster a group climate where members establish norms regarding mutual support, model compassionate interactions, challenge one another supportively, and practice

effective communication skills (Macgowan, 2003; Marshall, 2005; Marshall et al., 2013, 2003). A TIC model encourages respectful and accepting encounters in the group room, maintaining a nonjudgmental atmosphere and avoiding negative labels. Lack of trust and lack of modeling of healthy interpersonal skills often results in clients having relatively few emotionally intimate relationships. Pioneering existential psychotherapist Irvin Yalom contended that discovering that others have problems similar to one's own and the recognition that one is not alone in their circumstance is important in group therapy. Sharing one's inner world and receiving acceptance from others is a healing force. Group therapy also provides opportunities to develop and practice new social skills and constructive conflict resolution techniques (Jennings & Sawyer, 2003).

The internet also provides opportunities for peer support. Countless informational resources can offer informal support systems for people who have offended and their families, including websites, blogs, chat forums, and social media sites that provide educational resources along with discussion platforms. Online groups can also coordinate advocacy activities such as legislative testimony or lobbying efforts for criminal justice reform. Online support forums can offer powerful antidotes to the stressors and secondary stigma faced by people with criminal records.

Collaboration It is important to partner with clients and neutralize power imbalances. Shared power and decision-making in relationships promote healing. Supporting and guiding clients to explore their options and identify their best choices facilitates self-determination and autonomy. Nowhere more than in correctional settings or mandated treatments, the inherent power disparities in the worker–client relationship require constant attention. Because so many childhood trauma survivors were betrayed by those who were supposed to protect and care for them, relationships that should be helpful may instead be fraught with the potential for re-traumatization. Clients may be habituated to please others, to conform to authority, and to seek acceptance and attention. They may be inclined toward instinctive compliance and may need to be reminded that they have the right to ask questions, refuse treatment, or make requests. On the other hand, they may be resentful and rebellious toward authority or those with privilege. A truly collaborative therapeutic relationship is one in which client and professional discuss and agree on treatment goals based on the professional's expertise along with the client's knowledge about their own life history and behavioral patterns.

Voices and Choices Power differentials are inherent in correctional systems. Historically, clients in these conditions have been denied voice and choice, often finding themselves on the wrong end of coercive or oppressive treatment. Truly effective treatment involves collaborative decision-making and models goal-setting to help clients develop appropriate boundaries and healthy self-advocacy skills. Therapists should recognize and build on strengths, fostering belief in resilience and the ability of individuals to heal and thrive. They should facilitate recovery instead of demanding compliance with paternalistic or moralistic case planning. The foundation of trauma-informed care depends on maximizing clients' choices and control

over their own treatment goals whenever possible, helping them to transform their self-narrative, encouraging them to make their life decisions, and essentially allowing them to own the associated outcomes and feel more in control of their destiny (Elliott et al., 2005). True empowerment comes from a strength-based approach that reframes criminality as adaptation and highlights resilience over pathology. Above all, professionals in helping relationships who remain true to the principles of trauma-informed care can avoid dynamics that disempower their clients and prevent harm to them from otherwise well-intended interventions.

Correctional programming should include opportunities for developing self-regulation skills. Delayed gratification, communication skills, and conflict resolution are all important in preventing future offending, but the most effective way to impart those strategies is through experiential learning in the rehabilitative setting. Guiding clients through problem-solving with one another can reduce tension and decrease threats to staff and other clients. De-escalation tactics can help clients manage distress, calm themselves down, and correct themselves during interactions with others. Innovative methods can help clients recognize disinhibition, reduce impulsivity, and teach negotiation and compromise, which are important power-sharing skills. In the Cook County (Chicago) jail, for example, inmates can join a chess club, which builds critical thinking, planning, and problem-solving skills. The chessboard becomes a metaphorical life lesson about cause-and-effect, cost-benefit analyses, strategic decision-making, and patience (Koeske, 2016).

Cultural Considerations Services must feel that services are gender-relevant (Covington & Bloom, 2007) and culturally responsive with regard to race, ethnicity, and sexual minority issues (Bryant-Davis, 2019). Men and women who have offended have different motivational factors for committing crimes as well as different priorities to consider in their recovery and rehabilitation. Practitioners should avoid cultural stereotypes and be aware of implicit biases that may involve race, ethnicity, sexual orientation, age, religion, gender identity, socioeconomic status, or other factors. Agency values should include policies and practices that recognize the diverse racial, ethnic, and cultural needs of client populations. Some minority groups have long legacies of historical trauma due to slavery, denial of civil rights, and social policies that have created enormous and unjust obstacles for them. We know that historical trauma can be passed down intergenerationally, epigenetically, and through family dynamics. Early adversity often correlates with social problems, and prevention of crime also requires communities to invest in human capital in the interest of the public good (Larkin et al., 2014).

What It All Means for Practitioners

Mental health practitioners working in criminal justice must be sensitive to myriad challenges and consequences. A significant portion of the prison population suffers from various forms of mental illness, including PTSD. Unfortunately, the many

criminal justice practitioners who engage in harsh or confrontational methods are not only using an ineffective approach (Marshall, 2005) but may actually be replicating the very types of abusive environments in which their clients grew up. Compounding this challenge, some clients who have been abusive or violent may seem to invite therapists to adopt a confrontational style. Finally, when professionals' treatment approaches mimic the punitive and shaming nature of the justice system, it paradoxically reinforces clients' maladaptive responses to the environmental dynamics they experienced growing up.

Implementing trauma-informed practice at the individual and institutional level requires a long-term commitment. The medical world's early effort to implement handwashing as disease prevention demonstrates clearly that implementing any evidence-based practice or protocol seldom goes quickly or according to plan. Authentic trauma-informed practice requires self-compassion and diligence at both individual and institutional levels.

In any criminal justice setting, treatment professionals and administrators have very natural concerns regarding the risk that their clients pose to the community. This can lead to approaches that focus exclusively on short-term risks at the expense of addressing longer term needs and responsivity. It bears repeating that considering past trauma in treatment design and practice does not mean absolving people of responsibility for their behaviors. Neither does it mean that treatment does not challenge distorted thinking and inappropriate behavior. Instead, becoming more trauma-informed offers insight for professionals and allows treatment programs in secure facilities to develop a deeper understanding and ability to engage these individuals.

Useful Questions for Professionals and Organizations Interested in Implementing TIC

- Is your program and the practitioners within it ready to think about your clientele differently? Are you ready to adopt a different stance toward the people you treat? One in which a spirit of partnership, acceptance, and compassion, exist to empower clients to lead better lives? Can your program develop policies that embody these and other TIC principles? Do the words in your mission statement and policies reflect TIC language?
- In moving toward a more trauma-informed approach, does your program openly accept that adverse experiences have affected many (or most) of the people in its care and that these experiences likely contributed to their harmful behaviors? While the general public tends to see a divide between victims and victimizers, those who victimize have often been victimized themselves. If we maintain the value of supporting those who have been harmed by trauma and adversity, does this not include individuals whose behavior has landed them in correctional rehabilitation? Does hurting others after having been traumatized negate our concern for the welfare of all people who have been hurt? Is your program ready to

acknowledge and respect the widespread prevalence of trauma within its clientele?

- When considering potential treatment approaches, has the program examined how recognizing and working with the impact of past trauma can improve overall outcomes beyond the scope of the therapeutic services offered? After all, becoming trauma-informed means transforming the treatment and the culture in which that treatment exists.
- In considering the signs and symptoms of trauma in clients, to what extent do professionals in secure programs recognize the many ways that trauma manifests in current behavior patterns? This might include many of the items in risk assessment scales, such as relationship instability, emotional dysregulation, and other markers. It might also be that impact of trauma and adversity culminated in various diagnoses, such as antisocial and borderline personality disorders or substance abuse disorders, among others.
- Are signs and symptoms of trauma in staff recognized and responded to in a trauma-informed way? Generalizing TIC beyond client–therapist relationships to an entire organization—including co-worker and supervisory relationships—may be one of the most difficult tasks in any effort to implement a trauma-informed program. Far-sighted agencies include assistance programs for staff who may be concerned about how the work they do affects them or opens up old wounds. In some instances, this means bringing in licensed therapists for the staff to see at no cost. Although a number of research studies have looked at vicarious or secondary traumatization, personal trauma histories of staff members have received insufficient research attention and need consideration for an agency to consider itself truly trauma-informed.
- Finally, what processes are in place to actively prevent re-traumatization in secure settings? Unlike inflicting trauma, re-traumatization refers to reexperiencing elements of past traumatic events in one's current environment. This has been known to spark memories of adverse incidents or produce responses beyond the subject's awareness. These reactions occur both with clients and staff, so trauma-informed organizations attend to reducing potentially triggering conditions.

In the authors' experiences, becoming trauma-informed is a process rather than an event. It requires leadership within agencies to ensure that the values underlying TIC become enshrined in policies, practices, and procedures. As much as implementing TIC involves developing new skills and perspectives in accordance with the extant research, the hardest work may involve terminating old habits including brusque interactions with clients. Hurt people hurt people, and when we model empathy and healthy relationships, we help troubled clients experience what they missed out on. In turn, shared humanity and connections may prove to enhance the prevention of future criminal behavior. When we help people learn to self-regulate rather than simply employ punitive measures, we allow a sense of self-control that can reduce risk for recidivism.

TIC is a way of understanding and responding to problematic behavior through the lens of trauma. It does not replace the evidence-based cognitive-behavioral interventions we are familiar with, but rather it provides a strengths-based

framework for delivering those interventions in a way that maximizes client self-determination, locus of control, and personal ownership of change. Frontline workers in the justice system have an opportunity to engage with correctional clients using trauma-informed practices that reduce barriers, encourage accountability, and support reintegration and rehabilitation (Sachs & Miller, 2018). Such practices can enhance the likelihood of reduced recidivism by building adaptive skills for resilience and post-traumatic growth. Recidivism prevention is not just about *avoidance* of risky situations, but about skills that *move toward* meeting emotional needs in healthy ways so that tendencies to act out are diminished. Ultimately, improved self-efficacy, stability, and social support can help minimize risk so that clients are less prone to meet needs through victimizing, self-destructive, or aggressive means.

References

Agnew, R. (1992). Foundation for a general strain theory of crime and delinquency. *Criminology, 30*(1), 47–88. https://doi.org/10.1111/j.1745-9125.1992.tb01093.x

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Author.

Anda, R. F., Butchart, A., Felitti, V. J., & Brown, D. W. (2010). Building a framework for global surveillance of the public health implications of adverse childhood experiences. *American Journal of Preventive Medicine, 39*(1), 93–98. https://doi.org/10.1016/j.amepre.2010.03.015

Andrews, D. A., & Bonta, J. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law, 16*(1), 39–55. https://doi.org/10.1037/a0018362

Andrews, D. A., & Bonta, J. (2017). *The psychology of criminal conduct* (4th ed.). Anderson Publishing.

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *The American Psychologist, 61*(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Ardino, V. (2012). Offending behaviour: The role of trauma and PTSD. *European Journal of Psychotraumatology, 3*(1), 18968. https://doi.org/10.3402/ejpt.v3i0.18968

Baglivio, M. T., & Epps, N. (2016). The interrelatedness of adverse childhood experiences among high-risk juvenile offenders. *Youth Violence and Juvenile Justice, 14*(3), 179–198. https://doi.org/10.1177/1541204014566286

Baglivio, M. T., Epps, N., Swartz, K., Huq, M. S., Sheer, A., & Hardt, N. S. (2014). The prevalence of Adverse Childhood Experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice, 3*(2), 1–23. Retrieved from https://www.ojp.gov/pdffiles/246951.pdf

Bainbridge, C. L. (2016). Restoring ordinariness for women offenders: Why every wing matters. *The Journal of Forensic Psychiatry & Psychology, 28*(2), 172–187. https://doi.org/10.1080/14789949.2016.1204466

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*(2), 191–215. https://doi.org/10.1037/0033-295X.84.2.191

Berliner, L., & Kolko, D. J. (2016). Trauma informed care. *Child Maltreatment, 21*(2), 168–172. https://doi.org/10.1177/1077559516643785

Blagden, N. J., Winder, B., & Hames, C. (2016). "They treat us like human beings"—Experiencing a therapeutic sex offenders prison: Impact on prisoners and staff and implications for treatment. *International Journal of Offender Therapy and Comparative Criminology, 60*(4), 371–396. https://doi.org/10.1177/0306624x14553227

Bloom, S. L. (2010). Trauma-organized systems and parallel process. In N. Tehrani (Ed.), *Managing trauma in the workplace—Supporting workers and the organisation* (pp. 139–153). Routledge.

Bloom, S. L. (2013). *Creating sanctuary: Toward the evolution of sane societies*. Routledge.
Bryant-Davis, T. (2019). The cultural context of trauma recovery: Considering the posttraumatic stress disorder practice guideline and intersectionality. *Psychotherapy, 56*(3), 400–408. https://doi.org/10.1037/pst0000241
Carlson, E. A., & Sroufe, L. A. (1995). Contribution of attachment theory to developmental psychopathology. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology, Vol. 1: Theory and methods* (pp. 581–617). Wiley.
Centers for Disease Control and Prevention. (2013a). *Adverse Childhood Experience study: Major findings*. Retrieved from https://www.cdc.gov/violenceprevention/aces/about.html
Centers for Disease Control and Prevention. (2013b). *Adverse Childhood Experiences Study: Prevalence of individual adverse childhood experiences*. Retrieved from https://www.cdc.gov/violenceprevention/aces/resources.html
Cheng, J., O'Connell, M. E., & Wormith, J. S. (2019). Bridging neuropsychology and forensic psychology: Executive function overlaps with the Central Eight risk and need factors. *International Journal of Offender Therapy and Comparative Criminology, 63*(4), 558–573. https://doi.org/10.1177/0306624x18803818
Cicchetti, D., & Banny, A. (2014). A developmental psychopathology perspective on child maltreatment. In M. Lewis & K. Rudolph (Eds.), *Handbook of developmental psychopathology* (pp. 723–741). Springer.
Covington, S., & Bloom, B. (2007). Gender responsive treatment and services in correctional settings. *Women & Therapy, 29*(3–4), 9–33. https://doi.org/10.1300/J015v29n03_02
Covington, S. S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs, 40*(Suppl. 5), 387–398. https://doi.org/10.1080/02791072.2008.10400666
Dershowitz, A. M. (1995). *The abuse excuse: And other cop-outs, sob stories, and evasions of responsibility*. Back Bay Books.
Donisch, K., Bray, C., & Gewirtz, A. (2016). Child welfare, juvenile justice, mental health, and education providers' conceptualizations of trauma-informed practice. *Child Maltreatment, 21*(2), 125–134. https://doi.org/10.1177/1077559516633304
Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of traumainformed services for women. *Journal of Community Psychology, 33*(4), 461–477.
Fallot, R. D., McHugo, G. J., Harris, M., & Xie, H. (2011). The trauma recovery and empowerment model: A quasi-experimental effectiveness study. *Journal of Dual Diagnosis, 7*(1–2), 74–89. https://doi.org/10.1080/15504263.2011.566056
Felitti, V. J. (2002). The relation between adverse childhood experiences and adult health: Turning gold into lead. *The Permanente Journal, 6*(1), 44–47.
Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8
Friedman, M. J. (2013). Finalizing PTSD in DSM-5: Getting here from there and where to go next. *Journal of Traumatic Stress, 26*(5), 548–556. https://doi.org/10.1002/jts.21840
Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., Yim, E., Robins, C. S., Monnier, J., & Hiers, T. G. (2005). Special section on seclusion and restraint: Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services, 56*(9), 1123–1133. https://doi.org/10.1176/appi.ps.56.9.1123
Grady, M. D., Levenson, J. S., & Bolder, T. (2016). Linking Adverse Childhood Effects and attachment: A theory of etiology for sexual offending. *Trauma, Violence, & Abuse, 18*(4), 433–444. https://doi.org/10.1177/1524838015627147
Grady, M. D., Levenson, J. S., & Prescott, D. (2017). Empirically informed forensic social work practice. In T. Maschi & G. S. Leibowitz (Eds.), *Forensic practice: Psychosocial and legal issues across diverse populations and settings*. Springer. https://doi.org/10.1891/9780826120670.0020

Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and Behavior, 36*(9), 865–891. https://doi.org/10.1177/0093854809338545

Harlow, C. W. (1999). *Prior abuse reported by inmates and probationers*. Bureau of Justice Statistics. Retrieved from https://www.bjs.gov/index.cfm?ty=pbdetail&iid=637

Harris, D. A., & Levenson, J. S. (2020). Life on "the list" is a life lived in fear: Post-conviction traumatic stress in men convicted of sexual offenses. *International Journal of Offender Therapy and Comparative Criminology, 65*(6–7), 763–789. https://doi.org/10.1177/0306624x20952397

Harris, M. E., & Fallot, R. D. (2001). *Using trauma theory to design service systems*. Jossey-Bass.

Henry, B. F. (2020). Typologies of adversity in childhood & adulthood as determinants of mental health & substance use disorders of adults incarcerated in US prisons. *Child Abuse & Neglect, 99*, 104251. https://doi.org/10.1016/j.chiabu.2019.104251

Hindman, J., & Peters, J. M. (2001). Polygraph testing leads to better understanding adult and juvenile sex offenders. *Federal Probation, 65*(3), 8–15. Retrieved from https://www.uscourts.gov/sites/default/files/65_3_2_0.pdf

Holley, S. R., Ewing, S. T., Stiver, J. T., & Bloch, L. (2017). The relationship between emotion regulation, executive functioning, and aggressive behaviors. *Journal of Interpersonal Violence, 32*(11), 1692–1707. https://doi.org/10.1177/0886260515592619

Hudson, N. (2016). The trauma of poverty as social identity. *Journal of Loss and Trauma, 21*(2), 111–123. https://doi.org/10.1080/15325024.2014.965979

Jäggi, L. J., Mezuk, B., Watkins, D. C., & Jackson, J. S. (2016). The relationship between trauma, arrest, and incarceration history among Black Americans: Findings from the National Survey of American Life. *Society and Mental Health, 6*(3), 187–206. https://doi.org/10.1177/2156869316641730

Jennings, J. L., & Sawyer, S. (2003). Principles and techniques for maximizing the effectiveness of group therapy with sex offenders. *Sexual Abuse: A Journal of Research & Treatment, 15*(4), 251–267. https://doi.org/10.1177/107906320301500403

Jung, S. (2017). *RNR principles in practice in the management and treatment of sexual abusers*. Safer Society Press.

Koeske, Z. (2016, April 27). *Cook County jail chess program teaches inmates self-empowerment*. Chicago Tribune. Retrieved from http://www.chicagotribune.com/suburbs/daily-southtown/news/ct-sta-jail-chess-st%2D%2D0427-20160426-story.html

Kubiak, S., Covington, S., & Hillier, C. (2017). Trauma-informed corrections. In D. Springer & A. Roberts (Eds.), *Social work in juvenile and criminal justice system* (4th ed., pp. 92–104). Charles C. Thomas.

Larkin, H., Felitti, V. J., & Anda, R. F. (2014). Social work and adverse childhood experiences research: Implications for practice and health policy. *Social Work in Public Health, 29*(1), 1–16. https://doi.org/10.1080/19371918.2011.619433

Lee, R. (2017). The impact of engaging with clients' trauma stories. *Probation Journal, 64*(4), 372–387. https://doi.org/10.1177/0264550517728783

Levenson, J. S., & Grady, M. D. (2016). Childhood adversity, substance abuse, and violence: Implications for trauma-informed social work practice. *Journal of Social Work Practice in the Addictions, 16*(1–2), 24–45. https://doi.org/10.1080/1533256X.2016.1150853

Levenson, J. S., Willis, G., & Prescott, D. (2017). *Trauma-informed care: Transforming treatment for people who sexually abuse*. Safer Society Press.

Liem, M., & Kunst, M. (2013). Is there a recognizable post-incarceration syndrome among released "lifers"? *International Journal of Law and Psychiatry, 36*(3–4), 333–337. https://doi.org/10.1016/j.ijlp.2013.04.012

Macgowan, M. J. (2003). Increasing engagement in groups: A measurement based approach. *Social Work with Groups, 26*(1), 5–28. https://doi.org/10.1300/J009v26n01_02

Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research & Treatment, 17*(2), 109–116. https://doi.org/10.1177/107906320501700202

Marshall, W. L., Burton, D. L., & Marshall, L. E. (2013). Features of treatment delivery and group processes that maximize the effects of offender programs. In J. L. Wood & T. A. Gannon (Eds.), *Crime and crime reduction: The importance of group processes* (pp. 159–174). Routledge.

Marshall, W. L., Fernandez, Y. M., Serran, G. A., Mulloy, R., Thornton, D., Mann, R. E., & Anderson, D. (2003). Process variables in the treatment of sexual offenders: A review of the relevant literature. *Aggression and Violent Behavior, 8*(2), 205–234. https://doi.org/10.1016/S1359-1789(01)00065-9

Marshall, W. L., Marshall, L. E., Serran, G. A., & O'Brien, M. D. (2011). *Rehabilitating sexual offenders: A strength-based approach*. American Psychological Association.

Martin, M. S., Eljdupovic, G., McKenzie, K., & Colman, I. (2015). Risk of violence by inmates with childhood trauma and mental health needs. *Law and Human Behavior, 39*(6), 614–623. https://doi.org/10.1037/lhb0000149

Maruna, S., LeBel, T. P., Mitchell, N., & Naples, M. (2004). Pygmalion in the reintegration process: Desistance from crime through the looking glass. *Psychology, Crime & Law, 10*(3), 271–281. https://doi.org/10.1080/10683160410001662762

Maschi, T., Gibson, S., Zgoba, K. M., & Morgen, K. (2011). Trauma and life event stressors among young and older adult prisoners. *Journal of Correctional Health Care, 17*(2), 160–172. https://doi.org/10.1177/1078345810396682

Masten, A. S., & Cicchetti, D. (2010). Developmental cascades [Editorial]. *Development and Psychopathology, 22*(3), 491–495. https://doi.org/10.1017/S0954579410000222

Messina, N., Grella, C., Burdon, W., & Prendergast, M. (2007). Childhood adverse events and current traumatic distress: A comparison of men and women drug-dependent prisoners. *Criminal Justice and Behavior, 34*(11), 1385–1401. https://doi.org/10.1177/0093854807305150

Miller, N. A., & Najavits, L. M. (2012). Creating trauma-informed correctional care: A balance of goals and environment. *European Journal of Psychotraumatology, 3*(1), 17246. https://doi.org/10.3402/ejpt.v3i0.17246

Najavits, L. (2009). Seeking Safety: An implementation guide. In A. Rubin & D. Springer (Eds.), *The clinician's guide to evidence-based practice* (pp. 311–347). Wiley.

Najavits, L. M., Schmitz, M., Johnson, K. M., Smith, C., North, T., Hamilton, N., Walser, R., Reeder, K., Norman, S., & Wilkins, K. (2009). Seeking Safety therapy for men: Clinical and research experiences. In *Men and addictions* (pp. 37–58). Nova Science Publishers.

Olver, M. E., Marshall, L. E., Marshall, W. L., & Nicholaichuk, T. P. (2018). A long-term outcome assessment of the effects on subsequent reoffense rates of a prison-based CBT/RNR sex offender treatment program with strength-based elements. *Sexual Abuse, 32*(2), 127–153. https://doi.org/10.1177/1079063218807486

Patterson, G. R., DeBaryshe, B. D., & Ramsey, E. (1990). A developmental perspective on antisocial behavior. *American Psychologist, 44*(2), 329–335. https://doi.org/10.1037/0003-066X.44.2.329

Pattyn, E., Verhaeghe, M., Sercu, C., & Bracke, P. (2014). Public stigma and self-stigma: Differential association with attitudes toward formal and informal help seeking. *Psychiatric Services, 65*(2), 232–238. https://doi.org/10.1176/appi.ps.201200561

Pettus-Davis, C., & Epperson, M. W. (2015). *From mass incarceration to smart decarceration*. American Academy of Social Work & Social Welfare. Retrieved from http://aaswsw.org/wp-content/uploads/2015/03/From-Mass-Incarceration-to-Decarceration-3.24.15.pdf

Pettus-Davis, C., Renn, T., Lacasse, J. R., & Motley, R. (2019). Proposing a population-specific intervention approach to treat trauma among men during and after incarceration. *Psychology of Men & Masculinities, 20*(3), 379–393. https://doi.org/10.1037/men0000171

Prescott, D., Maeschalck, C. L., & Miller, S. D. (2017). *Feedback-informed treatment in clinical practice: Reaching for excellence*. American Psychological Association.

Rogers, C. (1961). *A therapist's view of psychotherapy: On becoming a person*. Houghton Mifflin.

Roos, L. E., Afifi, T. O., Martin, C. G., Pietrzak, R. H., Tsai, J., & Sareen, J. (2016). Linking typologies of childhood adversity to adult incarceration: Findings from a nationally representative sample. *American Journal of Orthopsychiatry, 86*(5), 584–593. https://doi.org/10.1037/ort0000144

Sachs, N. M., & Miller, J. (2018). Beyond responsivity: Client service engagement in a reentry demonstration program. *International Journal of Offender Therapy and Comparative Criminology, 62*(13), 4295–4313. https://doi.org/10.1177/0306624X18763762

Sadeh, N., & McNiel, D. E. (2015). Posttraumatic stress disorder increases risk of criminal recidivism among justice-involved persons with mental disorders. *Criminal Justice and Behavior, 42*(6), 573–586. https://doi.org/10.1177/0093854814556880

SAMHSA. (2014a). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* Retrieved from https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

SAMHSA. (2014b). *TIP 57: Trauma-informed care in behavioral health services*. Retrieved from https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Shapiro, F. (2018). *Eye movement desensitization and reprocessing (EMDR) therapy*. Guilford Press.

Shonkoff, J. P., Richter, L., van der Gaag, J., & Bhutta, Z. A. (2012). An integrated scientific framework for child survival and early childhood development. *Pediatrics, 129*(2), 460–472. https://doi.org/10.1542/peds.2011-0366

Sotero, M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. *Journal of Health Disparities Research and Practice, 1*(1), 93–108.

St. Vil, N. M., St. Vil, C., & Fairfax, C. N. (2019). Posttraumatic slave syndrome, the patriarchal nuclear family structure, and African American male–female relationships. *Social Work, 64*(2), 139–146. https://doi.org/10.1093/sw/swz002

Stinson, J. D., & Clark, M. D. (2017). *Motivational interviewing with offenders: Engagement, rehabilitation, and reentry*. Guilford Publications.

Sturgess, D., Woodhams, J., & Tonkin, M. (2016). Treatment engagement from the perspective of the offender: Reasons for noncompletion and completion of treatment—A systematic review. *International Journal of Offender Therapy and Comparative Criminology, 60*(16), 1873–1896. https://doi.org/10.1177/0306624X15586038

Topitzes, J., Mersky, J. P., & Reynolds, A. J. (2011). Child maltreatment and offending behavior: Gender-specific effects and pathways. *Criminal Justice and Behavior, 38*(5), 492–510. https://doi.org/10.1177/0093854811398578

Van der Kolk, B. (2006). Clinical implications of neuroscience research in PTSD. *Annals of the New York Academy of Sciences, 1071*(1), 277–293. https://doi.org/10.1196/annals.1364.022

Van der Kolk, B. A. (2017). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401–408.

Wallace, B., Conner, L., & Dass-Brailsford, P. (2011). Integrated trauma treatment in correctional health care and community-based treatment upon reentry. *Journal of Correctional Health Care, 17*(4), 329–343. https://doi.org/10.1177/1078345811413091

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270–277. https://doi.org/10.1002/wps.20238

Willis, G. M. (2017). Why call someone by what we don't want them to be? The ethics of labeling in forensic/correctional psychology. *Psychology, Crime & Law, 24*(7), 727–743. https://doi.org/10.1080/1068316X.2017.1421640

Willis, G. M., Yates, P. M., Gannon, T. A., & Ward, T. (2013). How to integrate the Good Lives Model into treatment programs for sexual offending: An introduction and overview. *Sexual Abuse: A Journal of Research and Treatment, 25*(2), 123–142. https://doi.org/10.1177/1079063212452618

Wojciechowski, T. W. (2020). PTSD as a risk factor for the development of violence among juvenile offenders: A group-based trajectory modeling approach. *Journal of Interpersonal Violence, 35*(13–14), 2511–2535. https://doi.org/10.1177/0886260517704231

Yates, P. M., Prescott, D., & Ward, T. (2010). *Applying the good lives and self-regulation models to sex offender treatment: A practical guide for clinicians*. Safer Society Press.

Original Research Article

Learning From Consumers of Mandated Sex-Offending Programs: "It's Not Treatment, I Wish It Was."

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Abstract

The purpose of this qualitative study was to explore clients' perceptions of sex-offending treatment. The sample included 291 people required to register as sex offenders in the U.S. who answered an open-ended question in an online survey asking them to describe their positive and negative experiences in mandated treatment. Using qualitative analysis, three overarching themes (with several subthemes) were identified: (1) positive and (2) negative treatment experiences and (3) the affiliation between the criminal justice system and clinical services. Experiences in sex offending treatment were viewed as positive when clients had opportunities to learn about themselves, experience group cohesion, build a positive alliance with a caring therapist, learn tools and skills for emotional health, explore the roots of offense behavior, and create healthy life plans to reduce risk for re-offending. Negative themes emerged when treatments were viewed as coercive, confrontational, or demeaning; when therapists seemed inexperienced or unqualified; and when seemingly outdated or unscientific methods were emphasized without explanation or dialogue. The entanglement between court-mandated treatment providers and the criminal justice system led to concerns about confidentiality, conflicts of interest, and role ambiguity. Drawing upon literature related to therapeutic alliance, trauma-informed care, and Risk-Need-

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Responsivity models, we offer suggestions for integrating client feedback to improve treatment responsivity and prevent re-offending.

Keywords
Sexual offender treatment, qualitative, consumer perceptions, treatment effectiveness, risk, need, Responsivity

Introduction

There are few crimes that inspire as much public fear and anger as sexual offenses. Prevention of recidivism is an important public safety goal. Often neglected in policy debates is the role of therapeutic rehabilitation, due in part to widespread but erroneous beliefs that recidivism rates are alarmingly high, that people who perpetrate these crimes are destined to reoffend, and that they cannot be helped (Ellman & Ellman, 2015). Despite these assumptions, sex-offending treatment programs are almost always mandated in all 50 U.S. states for people convicted of sexual crimes, and a body of literature has amassed to guide clinical practice in this area (Association for the Treatment & Prevention of Sexual Abuse, 2022). Quantitative treatment outcome studies have been useful in determining recidivism rates and trends, conducting group comparisons, exploring associations between risk factors and reoffending, and using predictive modeling to devise actuarial tools and evaluate their utility. Big data, however, are less helpful in understanding how to improve therapeutic interventions to prevent future victimization.

Qualitative research captures the narratives of those who perpetrate harm so we can improve our understanding of why they offend and gain insights into which treatment strategies are perceived as relevant and helpful (Grady & Brodersen, 2008; Waldram, 2007). Yet, only about 11% of articles published in criminology journals between 2010 and 2019 used qualitative methods (Copes et al., 2020). Neglecting the voices and stories of service users overlooks the complexities of criminal behavior and over-simplifies the psychological and social interventions used to address it (Waldram, 2007). The current study offers a qualitative analysis of the treatment experiences of consumers of mandatory sex-offending treatment services after a conviction for a sexual crime in the U.S.

Treatment Effectiveness

Answers to questions about which treatment strategies work best for whom (and why) remain obscure (Levenson & Prescott, 2014). Empirical studies have demonstrated mixed results and small effect sizes (Gannon et al., 2019; Grady et al., 2015; Hanson et al., 2002, 2009; Långström et al., 2013; Marques et al., 2005; Schmucker & Lösel, 2015). Risk-Need-Responsivity (RNR) models aim to improve treatment delivery by

focusing on individualized assessment of risk level, dynamic variables, treatment needs, and protective factors (Bonta & Andrews, 2017; de Vries Robbé et al., 2015; Hanson et al., 2009; Jung, 2017; Stinson & Clark, 2017). The primary objective of treatment is, of course, to prevent future victimization. Recidivism rates are typically used as the primary (or only) measure of successful outcomes in criminal rehabilitation, while other indicators of client improvement and well-being have been ignored (Levenson et al., 2020; National Academies of Sciences & Medicine, 2022). Empirically-supported interventions are often narrowly defined as conforming to the "gold standard" of randomized controlled trials, but such studies may offer little insight and nuance about what contributes to positive results and desistance from offending (Harris, 2017; Levenson & Prescott, 2014).

Evidence-based practice requires empirical evidence, theoretical knowledge, clinical expertise, and consideration of client characteristics (APA Presidential Task Force on Evidence-Based Practice, 2006; Drisko & Grady, 2019). Person-centered interventions require us to assess client needs, risks, and strengths, apply research knowledge, and incorporate all of it into a delivery style that is relevant for each individual (Grady et al., 2017). Skillful clinicians minimize engagement barriers by utilizing positive, strengths-based, collaborative, and motivational approaches that integrate the wishes, perspectives, and goals of their clients (Drisko & Grady, 2019; Prescott & Wilson, 2013; Seligman & Csikszentmihalyi, 2000; Seligman et al., 2006; Ward & Brown, 2004).

The benefits of quantitative methods in criminology and psychology include scientific rigor, efficiency, statistical power, and their appeal to grant funders (Copes et al., 2020). Quantitative data, however, do not tell the stories of human complexity. Empirical inquiry can be bolstered by the powerful narratives of real people who share the substance and meaning of their real-life experiences (Ahmed et al., 2021; Reid et al., 2005; Van Manen, 2016). Qualitative methods (e.g. interviews, focus groups, and immersive fieldwork) are increasingly recognized as valuable to the application of theories and the refinement of interventions in criminal justice (Copes et al., 2020). Personal narratives get beyond stigma and stereotypes to elucidate pathways for meaningful clinical change and successful re-entry in correctional programs (Copes et al., 2020; Grady & Brodersen, 2008; LeBel & Richie, 2018; Waldram, 2007; Western et al., 2015).

Perceptions of Consumers of Sex Offending Treatment Programs

People who commit sex crimes are a diverse group, and they yearn to have their voices heard (Waldram, 2007). It can be helpful to view them not simply through the lens of the worst thing they have ever done (Stevenson, 2014), but as "everyman" who is, in many ways, more similar than different from other citizens (Douglass et al., 2022; Marshall, 1996). As contemporary society evolves, interpretive science can shed light on social problems and cultural phenomena; the voices of marginalized populations can enhance social justice and public safety (Ahmed et al., 2021; Copes et al., 2020).

The consumer-driven services movement began in the 1990s in response to disempowering programs for people with physical disabilities and psychiatric illnesses (Charlton, 1998; Segal & Hayes, 2016; Substance Abuse and Mental Health Services Administration, 2011). The phrase "nothing about us without us" became a defining principle of service design, implementation, delivery, and evaluation, emphasizing the importance of self-determination, self-advocacy, personal agency, and mutual peer support (Segal & Hayes, 2016; Substance Abuse and Mental Health Services Administration, 2011). Including consumers in decisions about their own care empowers them as experts who can help guide social services to be more useful and relevant. When ownership and responsibility are shared between organizations and their clients, along with mutual respect and consensus about what is helpful, service users become active partners in shaping the outcomes of interventions (Segal & Hayes, 2016). Consumers of services within the criminal-legal system in the U.S. are rarely included in this type of dialogue, and if they are, research usually focuses on evaluating the treatment protocol itself rather than the client's experience of the legal system or service delivery process (McCartan et al., 2021).

Client-centered programs focus on each person's unique strengths, needs, and goals (Rogers, 1961) and seek feedback from consumers (Prescott et al., 2017). The "common factors" of psychotherapy are well-established in the psychology literature and explain most of the variance in client outcomes (Duncan et al., 2010; Wampold, 2010). These factors include warmth, positive regard, collaborative problem-solving, empathic engagement, and authentic interest in understanding the client's experiences without judgment (Rogers, 1961; Wampold, 2019).

Sex-offending treatment research has revealed that warm, empathic, encouraging, directive but non-confrontational therapist characteristics were associated with client improvement and helped to reduce defensive denial and cognitive distortions (Marshall, 2005; Marshall et al., 2002, 2003). Consumer surveys revealed that client-centered qualities were perceived as crucial to their engagement and progress in counseling (Levenson et al., 2009, 2010; Levenson & Prescott, 2009). Because these clients in the U.S. typically enter treatment under post-conviction mandates, therapists may be predisposed to expect resistance, denial, and lack of motivation, and therefore respond to clients in negative or confrontational ways (Jenkins-Hall, 1994; Jennings & Sawyer, 2003; Marshall et al., 2001; Serran et al., 2003; Wakeling et al., 2005; Winn, 1996). Therapeutic ruptures in psychotherapy can contribute to treatment failures in every clinical population (Binder & Strupp, 1997; Ward et al., 2012). Beech and Hamilton-Giachritsis (2005) found that therapists tended to overestimate their effectiveness, holding more positive evaluations of group therapy than the members themselves.

Links between therapeutic alliance and treatment outcomes are difficult to ascertain with quantitative measures alone (Blasko & Jeglic, 2016). Qualitative exploration has therefore been recommended to help improve program efficacy (Wakeling et al., 2005). Using qualitative interviewing methods, researchers have identified common themes related to treatment content and process, engagement, therapeutic alliance, and peer

support (much of the qualitative research about sex offending treatment appears to be conducted outside of the U.S.). Beneficial content areas include self-development, risk-awareness, accountability, changes in thinking, victim empathy, and coping skills (Grady & Brodersen, 2008; Levenson et al., 2010; Wakeling et al., 2005). Positive group process included sharing with and learning from groupmates, relating to others, and receiving support (Grady & Brodersen, 2008; Levenson et al., 2010; McCartan et al., 2021; Wakeling et al., 2005). Clients in different countries perceived therapeutic alliance and group atmosphere to be among the most important contributors to the effectiveness of sex-offending treatment (Blagden et al., 2016; Grady & Brodersen, 2008; Levenson et al., 2010; McCartan et al., 2021; Wakeling et al., 2005; Willemsen et al., 2016). Obstructions to change include professionals' negative assumptions and expectations (Blagden & Wilson, 2020; McCartan et al., 2021; Wakeling et al., 2005). Societal messages act as a mirror by which we see ourselves; the cognitive transformation to a non-criminal identity and desistance can be impeded when professional helpers reinforce stigmatizing and negative beliefs (Cooley, 1902; Maruna et al., 2004)

Purpose of This Study

The purpose of this study was to explore clients' perceptions of treatment for sex offense behavior. We provided an open-ended narrative prompt asking participants to describe their positive and negative experiences. Engaging services users when evaluating health and mental health care is desirable, but it rarely happens within the U.S. criminal legal system (McCartan et al., 2021). Qualitative research can inform our understanding of therapist qualities and program content that help consumers to prevent re-offending and enhance their well-being. The voices of clients can help us improve responsivity to service delivery, the often-neglected third principle within the RNR framework (Jung, 2017).

Method

This study was part of a larger project aimed at exploring the post-conviction experiences of individuals listed on sex offender registries. The full study used a mixed methodology to collect quantitative and qualitative data about post-traumatic stress symptoms following a sex crime conviction. We asked only one question about treatment at the end of the survey, and purposely left it very vague and open-ended. Data were collected through an online survey launched on the Survey Monkey platform in March 2021. People required to register as sex offenders and their family members were recruited with assistance from several registry reform advocacy groups in the U.S. These organizations agreed to send our recruitment email with the survey link to their distribution lists, social media, and networking partners, which also led to snowball sampling. Any registrant or family member who was eligible (over 18, living in the U.S., and required to register) was invited to participate. The anonymous, confidential survey asked questions about the impact of experiences related to the sex crime arrest,

Table 1. Descriptive Stats and Demographics (N = 292).

Demographics		RSO
Age	(Mean)	52.9
Gender	Male	94%
	Female	6%
	Trans/Non-Binary	1.4%
How would you describe your race?	White	88%
	Black	5%
	Other	7%
Are you Hispanic, latino, or of Spanish origin?	yes	8%
Which of the following best describes your current relationship status?	Married	37%
	Widowed	1.4%
	Divorced	24%
	Separated	1.2%
	Partnered	13.4%
	Single never married	22.6%
Which of the following categories best describes your employment status?	Employed full-time	41%
	Employed part-time	14%
What is the highest level of education you completed?	HS grad	7.5%
	College grad	36%
	Graduate degree	23%
Which of the following categories best describes your current income?	<$20,000	34%
	$20,000-$49,999	38%
	$50,000-$79,999	14%
	$80,000+	13%

court proceedings, incarceration, probation/parole, and registration. Of the 379 registrant participants who began the survey, 292 completed the entire survey. The current sample was derived of the registrant participants who answered one open-ended question about their mandated treatment experiences (n = 291).

Participants were given a narrative prompt to describe their experiences in sex-offending treatment programs, which is the topic of analysis for this study. The participants were asked: "If you are registered, please describe your experience in any treatment, counseling, or therapy that you received related to the sex offense (positive and/or negative)." Participants were permitted to write as much as they wished. The Institutional Review Boards at both lead authors' universities approved the project.

The demographics of the sample can be seen in Table 1 and included respondents from 37 states with the highest counts in Florida and California. Offenses included sexual contact with minors (54%) or adults (6%), Internet-related offenses such as downloading or sharing child sexual abuse material (CSAM), and solicitation or traveling to meet a minor (48%). The totals may exceed 100% because respondents were asked to check all that apply, and some people were charged with more than one

type of sex offense. About 59% served a prison sentence (average length 5.25 years), and 94% said they were on probation or parole after conviction, with 31% on community supervision at the time of the survey. They were all required to register as sexual offenders and reported that they had been on the registry for an average of 12.5 years; 71% said they are required to register for life. The participants said they had been in treatment for an average of 4.6 years, with 82% saying five years or less, 12% reporting 6–10 years of treatment, and 6% saying treatment lasted 10 years or more.

Qualitative Data Analysis

A thematic analysis process (Braun & Clarke, 2006; Vaismoradi et al., 2013) was used and followed the constant comparative method (Glaser, 1965; Kolb, 2012; Olson et al., 2016). Thematic analysis involves the creation of codes based on constructs that emerge from the narrative answers; it differs from content analysis by emphasizing the knowledge and meaning that can be discovered through the themes rather than focusing simply on classification (Vaismoradi et al., 2013). Using the constant comparative method, codes are clustered and organized into larger categories that represent the major patterns and ideas from the data (Glaser, 1965; Kolb, 2012; Olson et al., 2016).

In this study, two coders (doctoral students) conducted the analytic process and met regularly with the supervising researcher to discuss data analyses and findings as they emerged to ensure inter-coder reliability (Burla et al., 2008). Using Olson's et al. (2016) 10-step analytic methodology, each researcher: (1) performed open-coding of data within MAXQDA 2020 (Kuckartz & Rädiker, 2019); (2) collaborated to unify codes; (3) recoded the data and incorporated them into MAXQDA 2020; (4) used MAXQDA 2020 to calculate the Kappa; (5) collaborated to discuss each code and identify areas lacking agreement; (6) repeated the above process for each segment of the data, producing a unified codebook applicable to all data subsets; (7) recoded all data using intercoder agreement in MAXQDA 2020, producing themes; (8) selected themes for further analysis; (9) conducted co-occurrence analysis; and (10) constructed an exploratory model to identify thematic findings of the study.

The units of analyses were the sentences within the transcripts, which were used to construct the codes and then develop conceptual or implicit meanings for the ideas shared by the participants (Braun & Clarke, 2006; Burla et al., 2008). The first round of coding yielded 58 codes. After resolving technical errors, three additional rounds of conferencing and coding took place until coder differences produced resolution, and the Kappa score was 1.0 for all codes. The codes were then clustered into primary groups based on the research team's discussions and consensus, and three overarching themes were identified with multiple subthemes (see Table 2): (1) positive and (2) negative treatment experiences and (3) the affiliation between the criminal justice system and clinical services.

Table 2. Themes and Sub-Themes.

Theme	Sub-themes
Positive experiences N = 60	Learning about self
	Being part of a group
	Positive experiences with therapist
	Learning new tools and skills
	Learning the "whys" of offending
Negative experiences N = 125	Coercive treatment
	Abusive and demeaning therapists
	Inadequate qualifications of providers
	Unscientific interventions and structural program barriers
Interconnections between criminal justice System and mandated treatment N = 64	Lack of client confidentiality
	Perceived conflicts of interest and role ambiguity

Results

We will first focus on two sets of themes describing positive and negative treatment experiences. We will then describe the third theme: the inextricable interconnection between mandated treatment and the criminal legal system. The word "positive" (n = 57) was specifically used by participants more frequently than the word "negative" (n = 21)[1]. However, these word counts were somewhat misleading. A vast variety of words were used to capture both positive and negative experiences, but the participants tended to use a much more expansive vocabulary of descriptive language and shared more details when explaining their negative experiences. Within each theme, we will summarize sub-themes and provide salient quotes that capture the sentiments of the participants.

Positive Treatment Experiences

The following subthemes emerged as most salient for individuals who felt that their treatment experiences were positive or helpful. Clients appreciated opportunities to make sense of their behavior and contextualize it into their broader self-conception. Treatment felt most positive when it was holistic, individualized, and delivered by a therapist who was warm and non-judgmental. Participants enjoyed being part of a group that allowed for sharing, cohesion, and mutual aid.

Learning about self. Programs were described as positive when participants were able to gain insight about themselves. For example, one person noted "of course at first you think you don't belong there, but after a while you see the benefits." Another stated that treatment was "very revealing and gave me tools if I ever encountered myself feeling that way again…the counseling gave me strength." Therapy was perceived as offering

strategies to deal with life's challenges and "become a better person," as well as "resources which enabled me to really figure out who I was and get an identity for my life for the first time." Others described an "in-depth look into self and exploring causes for acting out," learning to deal with stress, avoiding patterns that led to offending, dealing with childhood trauma, and accountability: "I know I have no one to blame but myself." Another summed up treatment success in this way: "I learned to stop lying to myself, keeping secrets from my wife, and using sexual fantasy like a drug to make myself feel better." One noted: "I learned so much about myself and have been offense free for 30 years."

Being part of a group. Connecting with group members was a salient theme, with many saying that it was helpful to hear from others who "were experiencing the same fears, doubts, and circumstances that I was." Several found camaraderie and support in group sessions, noting that it was useful to "hear their stories, to know I was not alone." For others, who also "felt less alone" in group, it was safe to open up and be more honest. Several appreciated the opportunity to decrease isolation, share information, and discuss experiences: "The biggest advantage of the group therapy for me now is dealing with the ongoing effects of being on probation, and on the registry, and the stigma involved with sexual offenses."

The ability to take on a leadership or mentorship role in group sessions was viewed as a chance to build self-efficacy. One participant described this notion: "I enjoyed the therapy because I liked helping others deal with their issues even though I had difficulty with my own." Another shared that he feels valuable "to other sex offenders in group meetings because I'm a positive role model for them."

Positive experiences with the therapist. Many attributed their positive experiences in treatment directly to the therapeutic alliance with counselors whom they viewed as "wonderful," "introspective, credible, and helpful," "amazing," "remarkable," "useful and insightful," "phenomenal, a great advocate," "understanding," and "invaluable." Participants noted gratitude for professionals who seemed to genuinely care about clients, with one describing his counselor as "supportive" as well as informative. Some participants spoke favorably of therapists who had clear expectations and "assigned a curriculum [and] gave honest professional reports to the court."

Many respondents found it beneficial when a therapist allowed them to express feelings of shame and stigma that were paired with a sexual offense conviction. "Thankfully…his primary approach is based on acceptance and commitment therapy. He understands how counter-productive shaming and the registry are. I am grateful for him." Participants described learning to separate their behavior from their self-perception, with one saying he learned that "I messed up, I am NOT a mess up." Another reported that his therapist "helped me realize that I was not as bad as I felt I was… One cannot change their attraction - only what they do with it."

Learning new tools and skills. Respondents described the importance of learning new life skills and coping strategies for preventing future offenses, improving self-regulation, and dealing the with stress of registration and probation. In their narratives they used expressions such as "learning to be mindful," "self-actualization," and "self-accountability" when describing increased capacities to "discover my triggers, [and] methods to counter them and prevent relapse." Several commented on the importance of learning about risk factors, prevention, coping, and "measures to detect and avert precursor dangerous behaviors." Understanding their "addictive" behavior was seen as useful but they also valued "delving into deeper issues" that contributed to problems in their lives. One summarized how his learning "expanded my knowledge and gave me skills and knowledge I did not have before. It made me grow as a person and helped me deal with my new reality, while providing skills I can apply to live a better life."

Learning the "why" of the offenses. In addition to learning about their own offense patterns and ways to manage them, they also learned about the influences that contributed to the development of abusive or problematic behaviors. For some, this meant exploring their life history, experiences of trauma, and how they coped (perhaps maladaptively) with adversity. For example, one reported that therapy "was very illuminating. I was a victim when I was very young, and I carried that around inside of me for years … I tried to suppress those feelings with drugs and alcohol." Another shared that:

> Therapy has helped a lot. I had many deaths in my family that led me to deal with the depression and guilt of not being able to be there for them in unhealthy ways. I sought an escape through porn. Now, due to therapy, I have learned how to deal with loss and guilt and feel much more healthy mentally.

Many respondents referred to their own early abuse and explained how treatment offered new opportunities for "dealing with childhood trauma [of] being molested and moving step by step through it all." Others described themselves as "broken" and as a "victim." One wrote that therapy "brought to light previous sexual abuses that I'd ignored for years." Several noted that their therapy helped them to confront past histories of victimization and make direct links between early abuse and offending. For example, one said therapy helped him understand how his early abuse normalized inappropriate boundaries and "allowed me to lower barriers to my offending." Another "received EMDR to help eliminate some of the childhood trauma I suffered." One respondent summed it up this way: "life changing. I was finally able to deal with all my past hurts, current hurts, see myself for who I really was, and start having healthy relationships."

Others described new insights into distorted thinking that enabled offense behavior: "brought me to a realization of the abuse in child pornography, [but] before I only saw an image. Now I know there was a person in that image, one who deserved my protection not sexualization." Another shared how he has used treatment "to get real

and deal with some prior traumas instead of medicating over them." One person summarized the overarching process by sharing how overwhelming treatment can feel as they strive to heal themselves and prevent future harm: "Sometimes I feel that I am fighting an endless battle though. It's tough understanding all of the ways that I have been broken, but at least I am working on fixing those broken parts now."

Negative Treatment Experiences

When describing negative experiences, participants used strong language to portray programs they perceived as inappropriate, ineffective, deleterious, and even "traumatic" and "abusive." To illustrate unhelpful experiences in therapy, various participants used terms such as "demeaning, false-science, hurtful, embarrassing," "laughable," "indoctrinating and brainwashing," "shame-based and barbaric," "bullying and destructive," "humiliating and degrading," and "geared towards judgment and self-hatred." Many people used the words "a joke," "waste of time," and "pointless." A participant described his experience as "atrocious." One stated, "I hated every minute of it" and another said treatment "just adds to the misery of being a sex offender."

Coercive treatment. Feeling a sense of coercion was described in ways that seemed to go beyond the basic premise of being court-mandated. For instance, many respondents reported being required to remain in treatment until the end of parole or probation with no path to graduation or successful completion. Coercive practices were described as overly focused on pushing for "confessions" and admissions of wrongdoing as an end in itself, seemingly with no goal other than "to be reminded weekly of my own failure." One individual shared that "I've never had a positive experience with 'treatment,' they just want you to admit you're a pedophile." Several described therapy as "designed to force us to confess to other sexual offenses even if we had to make them up," with another stating treatment was "traumatizing. Forced to say things that are not true. Degraded." Some respondents maintained that they were wrongly convicted, saying the treatment mandate was based on false allegations and that they felt coerced "to confess to crimes you did or did not do," or "having words put in my mouth that I never said." Another participant wrote about how he managed such an experience:

> They didn't believe me and threatened to return me to custody if I didn't come clean. I returned the following week and told a completely made-up story to which the response was, "I don't know why you waited so long to admit this. Don't you feel better?"

Many expressed significant fear of being perceived by providers as lying or withholding information: "Any resistance is met with punitive actions such as dismissal from group and probation violations under the category of refusing to cooperate." At the same time, ironically, they feared that sharing openly and honestly would be used against them, creating a double bind. For example: "I once admitted my wife and I had

video sex over Skype. She [the therapist] promptly wrote me up as being involved in online porn!"

As a related sentiment, dissatisfaction with services was sometimes compounded by having to pay for treatments they did not view as helpful. Many participants noted that self-pay treatment mandates created significant financial strain because they were "required to participate in weekly group sex offender therapy program at [their] own cost." Some described substantial expenses that added stress to already onerous financial burdens: "taking money out of my pocket, and often times, my family's pocket." One said that he was "forced to attend three sessions per week with an out-of-pocket expense of $180 per week for 5 years [and] there was nothing positive to say about the experience." Some participants revealed threats of arrest or revocation for inability to pay, "even though they knew I was jobless; told me that they were to be my number one budgetary priority, even above housing, food, and even God."

Abusive and demeaning therapists. Negative experiences in therapy were often attributed to the characteristics or styles of therapists who treated clients with disrespect, disdain, or contempt. Some of the language used to refer to therapists included: "liar," "accusatory and domineering," and "lacking compassion." One said he was told he was "dirt and worthless" and another said he was "ridiculed in group therapy." Similarly, another participant observed that group "was horrible, shame based" because the leader was "a vengeance minded person." A few respondents referred to treatment as "traumatic." One respondent simply described their experience as "demeaning and horrific." Another described anxiety triggered by a demanding "overall tone of questioning" in the group and said, "talking about what happened only gave ammunition to shoot at me instead of help me."

Many participants felt that their therapists posed little curiosity or acknowledgement of individualized risks, needs, and strengths, and assumed that all clients had paraphilic disorders, compulsively repetitive patterns, and substantial risk to reoffend. Several participants felt that therapists projected messages of an unavoidable negative future. In the words of one participant: "the facilitator treated us like we would all eventually reoffend at some point. He was very negative and never gave any of us praise for doing well." Another shared a similar sentiment: "they said many times that they were there to reduce the likelihood of recidivism but that it was going to eventually happen again." One described the sense of hopelessness conveyed by a therapist who would "drill the same thing into your head day after day … you are a sick and depraved person and there is no hope. Only through lifetime supervision and close monitoring you could ever live any kind of life."

The inability to form a meaningful therapeutic relationship with a caring professional who prioritized client well-being was woven throughout many narratives. One was especially poignant:

> I was so crushed mentally that … I could only think of suicide for months. It was so heavy, I can't even put it into words right now. And when I finally, for the first time, ADMITTED I

> FELT SUICIDAL, the therapist didn't even care. She didn't comment or tell me where I could reach out for help or anything. So I didn't talk about it anymore.

The process of therapy was viewed by some as re-traumatizing because it "involved hearing child abusers talk of their cases, when I myself was a child abuse VICTIM (so caused me to re-live that trauma), the whole experience was horrible." Another shared that "group triggered me," and therapists seemed unaware of the potential impact of abuse descriptions on clients. The perception of re-traumatization was conveyed again with this anecdote:

> I am a survivor of military-related sexual assault. The [program] will not acknowledge this and therefore it is never taken into consideration in my "care." On one occasion I was having a panic attack as someone in the group was describing sexual harm that they had caused. To try and protect myself, I put my head down and discretely plugged my ears. The next week I was scolded by my probation officer and therapist at the same time and told that I was in danger of being kicked out of group. Why? Because plugging my ears was disruptive. At that moment I broke down. I was told to apologize to the group for being inconsiderate. When I did, no one in the group knew what I was talking about. None of them had even noticed. That whole ordeal eliminated what little trust I had left in the [program] and their therapists.

In fact, several participants said that treatment was so traumatizing that "I thought I was going to need therapy afterwards for the treatment I got." Another shared a similar sentiment and said that the "state should pay for my mental therapy to try to get over my traumas related to treatment."

Qualifications of the providers. Many participants reflected on encountering unqualified therapists, and some related issues that emerged were high turnover rates, disruptions in continuity of care, and lack of experience or training. "There was a tread mill of replacement therapists," said one respondent, and another described that his "program went through several providers over time." Changes in therapists were sometimes related to the seasonal attrition of student internship training, which intersected with concerns about counselor inexperience. "Unfortunately, the sitting therapists were all temporary students/interns with virtually no experience working with SOs." One participant expressed dismay, saying that "the SOTP "therapist" has a master's in Anthropology! She had zero ethics, had no idea what she was doing." Another simply declared "They need more training."

Gender responsiveness was mentioned only three times, but it seems important to note these observations. One male participant mentioned that he "dislike[d] having to talk about masturbation to female therapists." Another questioned "the rationale of predominately hiring [young] female therapists to work with mostly male prison inmate SOs." He further observed that many of the men in his group seemed to "suppress their true telling of the offense or issues objectifying women… some were flustered to the

point of not being able to speak… about their dark shame and guilt about the female gender." A female participant shared that she "had to have counseling with a group of 15 men because I could not attend the women's group" and indicated that she found this arrangement to be unhelpful.

Unscientific interventions and structural program barriers. Many participants encountered what they perceived as "unscientific" or "outdated" treatment methods, along with rigidly structured programming without individualization or a clear path to completion. For example, one respondent referred to what he called "false science," and another shared in detail his experience of a program that he believed "held on to several archaic and untrue positions very stubbornly… they insisted the re-offense rate was nearly 99%." He said that he brought in a Hanson et al. meta-analysis that showed a low recidivism rate and "met with their disfavor… they were constantly telling me that all sex offenders were liars, were incapable of showing or feeling empathy, etc." Others also commented that when they challenged providers, they were ignored or experienced negative consequences as a result. "You basically had to go by her thought agenda, or you would get shut down; sometimes hard."

Many respondents expressed distress at what they perceived to be intrusive questioning or "invasive" practices: "they force, under threat of revocation, one to undergo unscientific and torturous procedures" (referring to penile plethysmograph (PPG) and polygraph exams). One described his assessment:

> A negative experience was being forced to pull my pants down, have a device attached to my penis and to watch two hours worth of nude and semi nudes of children and adults to determine what my sex orientation was -- very shameful experience.

Another described a similar incident: "I will never forget having to take the computer test and look at pictures of children and rate their attractiveness. I cried for hours. My daughter was two at the time." Said one more: "I felt like I was living in the movie *Clockwork Orange*." Polygraph exams also ignited much angst. Many expressed a fear of "failing" even if they were being truthful. One narrative said, "everything described or discussed in group would be handed to probation/parole and verified by a biased polygraph then used in revocation." While a few comments described the positive experience of a polygraph being used for confirmation of low risk or treatment progress, many questioned its utility, and one said his "therapist refused to believe my responses in session even though polygraph supported [it] all."

A common complaint was a "generic" or "one size fits all" approach, pointing out that without individualized and explicit goals, the treatment was not a good fit or appropriate for their needs. Some observed a perceived lack of oversight over an "ineffective curriculum" or "no curriculum" by courts or state regulators. Programs were described as "rudderless…facilitator did not have clearly defined goals for session" and that there was "no 'path' for completion of treatment." One person reported that it soon became clear that "no one was graduating or completing the

curriculum (no workbook, only weekly handouts to move from 'Weekly' to 'Monthly Individual' status)." Another explained: "there is no set timeline. That's what's been so maddening and has produced such feelings of helplessness. There are no progress markers."

Interconnections between community corrections and mandated treatment (n = 28)

The third prominent theme was the undeniable interconnection between treatment programs and probation/parole requirements. The entanglement between clinical providers and correctional staff was described as problematic primarily because it felt difficult to establish a safe and trusting therapeutic alliance as noted throughout the subthemes below.

Lack of confidentiality. Concerns about confidentiality were described by many as excessive sharing of information between treatment and probation, to a point that in "each session I never knew if the leader was going to give a negative report to my probation officer and what that could mean." Though signing a waiver to release information is conventional in court-ordered services, an all-inclusive, non-discretionary lack of confidentiality seemed to preclude any semblance of clinical sanctity. "Everything is reported to parole, so I tell them what they want to hear. It's not treatment, I wish it was." Another shared a similar sentiment and explained that "it isn't real treatment because you waive confidentiality. It's more just monitoring and supervision. You learn what to say and do to get through it, even if you don't really believe in it." One narrative remarked "there is no anonymity…that should not be allowed." Some participants indicated that probation or parole officers sat in the treatment groups with clinicians, and that this practice was extremely uncomfortable.

Perceived conflicts of interest and role ambiguity. The inseparable relationship between the criminal justice system and treatment providers became interwoven with perceptions of financial conflicts of interest as well as a lack of role clarity. Participants opined that there is a "cottage industry" that is "all about the money," and that the system does "everything they can to keep you there so they can continue that steady supply of income." While seemingly cynical, one respondent described this experience: "Anything I said in treatment was open to being reported to my agent who could (and did) act on it. The provider even said the only way he could keep his contract was to keep the [probation officers] happy." Another individual asserted that "treatment professionals saw us as a bank. We were just a commodity. They gained in power because they were able to have power over us."

Some suggested that programs were incentivized to prioritize relationships with referral sources and that therapists seemed to have little concern about their clients. Whether these opinions were factually true or not, perceptions of structural and role

ambiguity seemed to create daunting obstacles to building positive and meaningful helping relationships with clinical staff:

> The therapist was fed sex offenders by the probation office, and I don't think rehabilitation was the goal. The therapist charged us a weekly fee (which I couldn't afford). If you couldn't pay the weekly fee, then arrest was threatened. I felt that I wasn't in a safe place and couldn't openly talk about the issues I was dealing with or had without thinking that they are trying to find something to lock me back up. I think the therapist …[was] in cahoots with the probation department. How can rehabilitation happen under those feelings? 10–12 people in "class" with the therapist at $40 a week. Nice pay day. That's all we were. We all agreed on this point. I wonder what kickback the probation department received.

Discussion

Experiences in treatment for offending were viewed as positive when clients had safe opportunities to learn about themselves, experience group cohesion, build a positive alliance with a caring therapist, learn tools and skills for emotional health, explore the roots of their offense behavior, and create healthy life plans to reduce risk for re-offending. Negative themes emerged when treatments were viewed as coercive, confrontational, abusive, or demeaning; when therapists were inexperienced or unqualified to help; and when seemingly dubious, outdated, or unscientific methods were emphasized without explanation or dialogue. The inextricable entanglement between court-mandated treatment providers and the criminal legal system led to concerns about confidentiality, conflicts of interest, and role ambiguity.

If the themes could be encapsulated in a few words, they might be trust, emotional safety, client-centeredness, and support. When these conditions were present, clients found their professional counselors and groupmates helpful in promoting personal agency, well-being, and desistance from offending. When the conditions were absent, clients felt disempowered, cynical, or even traumatized by the intervention that was supposed to help them. At the same time, it is possible that some therapists might be perceived positively by some clients and not by others; it is true that every therapist is not a good fit with all clients. As well, some narratives may represent inner ambivalence about treatment; clients might want to change but find it difficult or threatening to share their shameful inner thoughts. These mixed feelings can challenge therapeutic engagement.

Of course, treatment providers and community supervision agents might be inclined to dismiss client voices as disgruntled, unmotivated, manipulative, or pathological. In some cases, there might be truth to these assertions. But many of the participants made efforts to qualify their criticisms with descriptions of what they had hoped therapy would offer – the same factors known to empirically explain the most variance in therapy outcomes – warmth, positive regard, mutual respect, and collaboration between

expert and patient (Duncan et al., 2010; Prescott et al., 2017; Rogers, 1961; Wampold, 2015).

Perhaps therapists can be more effective when keeping in mind that despite their crimes, our clients are more similar to other therapy clients than they are different. They arrive in our offices only after perpetrating sexual harm, but like "regular" clients, they seek support, acceptance, guidance, and knowledge to help navigate what is probably the most challenging period of their lives. Treatment is not something we do *to* clients. It should be a collaborative process that honors self-determination while exploring the meaning that clients attach to their experiences. These concepts are difficult to measure quantitatively, which is why qualitative research is useful to capture the inner experiences of those we seek to help. Drawing upon literature related to therapeutic alliance, trauma-informed care, RNR, and dynamic risk, we offer some ideas for integrating the feedback offered by participants in this study.

Implications for Practice

Therapeutic alliance. Treatment that induces fear is not therapeutic. Let's put the therapy back into treatment and utilize the theories and skills known to enhance engagement and self-actualization for all clients who seek social and psychological services. Although it is appropriate for therapists to address entitlement, victim-blaming, and denial, confrontational styles were perceived by participants as dismissive, demeaning, shaming, and bullying. As noted widely in the psychotherapeutic literature over many decades (but surprisingly often overlooked in our own field), clients need safe spaces for self-reflection, healthy modeling, and the mutual aid of groupwork to help them harness positive change (Beech & Fordham, 1997; Blagden et al., 2016; Rogers, 1961; Wampold, 2010; Willemsen et al., 2016; Yalom, 1995). Potentially harmful therapies can lead to client deterioration or drop-out, and professional helpers tend to attribute treatment failures to client variables when therapist factors are more likely responsible (Binder & Strupp, 1997; Lilienfeld, 2007). Clinicians should remember that attending to the quality of the relationship is the most important factor in predicting treatment outcomes (Baldwin et al., 2007; Wampold, 2019).

We might sometimes doubt that a client is being honest with us, which can feel frustrating. Because we feel responsible for preventing future victimization, we might be eager to defend against perceived manipulation. We might be better able to create conditions that encourage honesty, however, if we reframe resistance as ambivalence (a simultaneous struggle between a genuine desire for change and the need to maintain what is familiar) or self-protection (concern about disclosing unlawful behavior or paraphilic interests due to fear of judgment and consequences). It is difficult for most people to share shameful secrets or to give up maladaptive coping strategies. Therapists should *expect* resistance and prepare to provide an accepting (of the person and their feelings, not of victimizing behavior) and safe environment to reflect upon past actions and explore the hopes and fears of future change (Miller & Rollnick, 2012; Teyber & Teyber, 2017; Willemsen et al., 2016).

Seeking help for any psychosocial problem can produce feelings of vulnerability (Pattyn et al., 2014) and being mandated to treatment undoubtedly exacerbates these anxieties. According to the participants in our study, treatment for sexual offending often feels punitive, shaming, coercive, and financially burdensome. Our clients wish to be viewed as individuals, understood by professional helpers, approached with respect, curiosity, and compassion, and helped to build strengths (Blagden et al., 2016; McCartan et al., 2021; Scott & Jenney, 2022). For therapists, the responsibility of preventing future victimization can feel daunting, being exposed to details of sexual crime can create negative countertransference, and organizational or community pressures can create stressful work environments (Hardeberg Bach & Demuth, 2018).

Professional associations provide guidance for providing non-voluntary services in their codes of ethics (American Psychological Association, 2017; National Association of Social Workers, 2018). We must respect clients' right to autonomy and self-determination, ensuring that informed consent is given freely and without undue influence, coercion, or duress. Clients' choice and right to refuse services should be discussed. Limits of confidentiality should be explained in clear and understandable language, and clinicians should recognize that a release of information allows but does not necessarily compel sharing of all clinical material without reason and discretion. One size does not fit all, and our ethical codes require us to collaborate with clients to determine a clear path to successful completion of individualized goals (which is consistent with RNR). The ultimate goal of any therapy is to enhance psychological well-being, which is also likely to contribute to desistance from crime.

There are a few other considerations to highlight in response to these survey participants. First, given evidence of DNA exonerations in sexual assault cases (Saber et al., 2022), it is possible that a small number of our clients were indeed falsely accused or wrongly convicted. This creates an inherent dilemma for both the mandated client and the treatment provider, but denials should be explored in treatment and not unilaterally dismissed as untrue. Second, we should be willing to hear the discomfort of clients who underwent PPG and computerized sexual interest assessments. We should be sensitive to the intrusive and embarrassing nature of these procedures and recognize that they might be re-traumatizing for survivors of past sexual or physical abuse (Raja et al., 2015). Physical touch by professionals can trigger reminders and hyperarousal about past violations including abuse, medical trauma, or mistreatment perpetrated by an authority figure in an institution of trust (Raja et al., 2015). Finally, we should be aware of the potential vicarious trauma and/or reminders of one's own victimization when clients hear other group members share details of their abusive behavior.

Incorporating trauma-informed practices. Negative childhood experiences are not uncommon for people who sexually offend, and early adversity can cause loneliness, boundary confusion, and lack of social skills (Grady, Levenson, Glover, & Kavanagh, 2022; Kåven et al., 2019; Levenson et al., 2018). Complex trauma can precipitate deficiencies in executive functioning (such as attention, inhibition, problem-solving, flexibility, and planning) (Ansbro, 2008; Grady et al., 2016; Masten & Cicchetti, 2010;

van der Kolk, 2006). These characteristics can contribute to the dysfunctional antisocial lifestyle described within the central eight criminogenic risk factors (Bonta & Andrews, 2017; Cheng et al., 2019; Vaske, 2017). Case conceptualization that integrates the neuroscience of trauma provides a nexus between the etiology of problematic sexual behavior, assessment of risk factors, and strengthening of protective factors for prevention (Craig & Rettenberger, 2018; de Vries Robbé et al., 2015; Swaby et al., 2020).

Trauma should therefore be viewed as a salient aspect of treatment rather than viewed as an excuse for offending and avoided (Grady, Levenson, Glover, & Kavanagh, 2022). Clients report that psycho-education about dysregulation and hyperarousal helps them understand how past traumas might influence subsequent offense behavior and dynamic risk factors (Grady et al., 2022; Scott & Jenney, 2022). It is also clear (though often ignored) that involvement in the criminal legal system creates real and ongoing traumatic stress, which can contribute to maladaptive coping and dynamic risk (Glantz et al., 2017; Harris & Levenson, 2021; LeBel & Richie, 2018; Pettus-Davis et al., 2019; Western et al., 2015).

Treatment programs serving clients who perpetrated sexual harm should apply trauma-awareness, create emotional safety for help-seeking, foster opportunities for connection, and facilitate skill-building so clients can meet their needs in healthy ways that are neither victimizing nor self-destructive (Levenson et al., 2017; Scott & Jenney, 2022; Swaby et al., 2020). In treatment, clients may appear to be either agitated or detached, which can be misinterpreted by therapists as resistance or lack of motivation. Overly confrontational or invalidating responses can re-activate past trauma and exacerbate hyperarousal and dysregulation. In order to avoid and/or repair therapeutic ruptures that disrupt treatment progress, therapists must be attuned to the maladaptive relational patterns that clients re-enact (Teyber & Teyber, 2017; Watson et al., 2015). Scott and Jenney (2022) emphasized that coercive or confrontational interventions with people who perpetrate violence will paradoxically reinforce distorted beliefs that relationships involve imposing power over others. When we reduce the sense of emotional threat, we offer a corrective experience that better enables clients to explore and change distorted thinking, dysphoric emotions, and dysregulated behavior.

Translating risk-need-responsivity concepts to practice realities. Many participants in this study related their dissatisfaction with programs that utilized a one-size-fits-all approach. The principles of effective correctional rehabilitation require case planning based on individualized risks, needs, and responsivity factors (Andrews & Bonta, 2010; Hanson et al., 2009; Jung, 2017). Not all clients present the same level of risk for reoffense, and not all possess the same risk factors or treatment needs. Responsivity principles call for a treatment provider to be prepared with a flexible repertoire of strategies to empower the capacity to benefit from treatment. It is important to distinguish client motivation (which is about the client's readiness for change) from responsivity (which is about the clinician reducing engagement barriers and enabling an environment conducive for change) (Ward et al., 2004).

Interestingly, attempts to apply RNR directly to sex offending treatment practice (Jung, 2017) have largely neglected trauma knowledge. For instance, although adverse childhood experiences are briefly discussed in Jung's (2017) list of specific responsivity factors (p. 63), no tangible examples follow to describe assessing for trauma and conceptualizing how it might interfere with treatment engagement or amenability. Likewise, current RNR models lack tools for building in trauma-informed case planning and trauma-responsive interventions. In order to improve treatment services, we need an integrative bio-psycho-social conceptualization of personality pathology, dysregulation, cognitive schemas, dynamic risk, criminogenic needs, and client strengths -- all in the context of clients' collective life experiences (Levenson et al., 2022; Swaby et al., 2020).

Dynamic risk factors include antisocial attitudes, behaviors, or peers, sexual entitlement or preoccupation, intimacy deficits, impulsivity, substance abuse, lack of prosocial activities, negative moods, or hostility (Hanson & Harris, 1998; Ward & Fortune, 2016). These factors can stem from dysregulation and maladaptive patterns related to trauma, so the link between traumagenic life experiences and dynamic risk should be considered (Grady, Levenson, Glover, & Kavanagh, 2022). Practitioners should also recognize the intersectionality of disempowering life experiences (e.g. child maltreatment, family dysfunction, poverty, structural racism, oppression of marginalized groups, and incarceration) to inform our understanding of the client's response to treatment (Anda et al., 2006; Bryant-Davis, 2019; Glantz et al., 2017; Pettus-Davis et al., 2019; Scott & Jenney, 2022; Swaby et al., 2020; Western et al., 2015).

Traditional cognitive-behavioral relapse prevention programs been deficit-focused. They strongly emphasized assumptions of paraphilic disorders, repetitive offense cycles with predictable elements, and offense-related distorted cognitions and attitudes. A broader construction of individual risks and needs could be re-envisioned in the following ways. Treatment goals should focus not only on thinking errors about sexual abuse, but also on early maladaptive schemas about self and others (Young et al., 2003) that thereby shape offense-supportive beliefs. Attending to relational and attachment patterns (Alexander, 2013; Birrell & Freyd, 2006; Tosone, 2013) can address intimacy deficits. Reoffense prevention should be re-imagined as a broader scope of general, emotional, and sexual self-regulation skills along with applicable interpersonal boundaries rather than a prescribed template of cyclical factors and avoidance tactics (Levenson et al., 2017; Yates et al., 2010). Finally, strengths-based models should identify and build protective factors (de Vries Robbé et al., 2015) and healthy sexuality (Watter & Hall, 2020). Programs can transform interventions from being content-driven and psychoeducational to a more collaborative, flexible, process-oriented, and corrective experience that guides clients to meet relational needs in healthy ways.

Implications for research and policy

Qualitative research can elucidate what works to prevent recidivism from the perspective of service users. Consumer research can inform the integration of trauma-

responsive and client-centered practices into RNR models of treatment for sex offending. Policymakers should reconsider social policies that unnecessarily impede protective factors, and allow research evidence to guide individualized application of relevant restrictions (Hanson et al., 2018; Levenson et al., 2016). Legislators, sex offender management boards, and licensing or certification bodies should consider qualitative research in addition to quantitative data when formulating clinical program design, implementation, delivery to clients, and training for mental health professionals. Interdisciplinary partnerships between researchers, community supervision officers, judges, and clinicians would facilitate collaboration about treatment goals and individualized case planning.

Limitations

A limitation of our research is that it lacked a rich diversity of participants and therefore may not be representative of the sex-offense treatment client population across the U.S. Our online survey required Internet access which some registrants may be prohibited from accessing. The registry reform advocacy groups who helped us recruit participants seem to be populated by more educated, affluent, and resourceful families. Minority groups are under-represented in this study but over-represented in criminal justice systems, and therefore we recognize the need to reach diverse racial and ethnic groups, those from other marginalized (e.g., LBGTQ+), underserved, or impoverished communities, and female clients. The sample might reflect self-selection bias, and we have no way to confirm their self-reported experiences. Those with a grievance to vent might be more motivated to seek an opportunity to engage in survey research. On the other hand, many participants shared positive treatment experiences, and these are informative in our efforts to understand what was helpful.

Conclusion

The voices of service users can contribute valuable knowledge about treatment interventions. We should welcome and embrace the participation of clients in narrative data collection to inform the effectiveness of treatment to prevent sexual reoffending. As with other consumer communities, who declare "nothing about us without us!" (Charlton, 1998), justice system clients should be empowered to play a crucial role in improving service delivery (Ahmed et al., 2021; McCartan et al., 2021). Qualitative criminology research is limited, but there is a need to give voice to the personal experiences of justice-involved persons to enhance correctional and rehabilitative services (Copes et al., 2020; LeBel & Richie, 2018; Waldram, 2007).

It is unsurprising that we sometimes grapple with engaging or believing our clients. The dilemma of strengths-based rehabilitation requires us provide humane treatment while reckoning with the harm caused by our clients' egregious acts. There is a need to disentangle treatment, which should be empowering and client-centered, from the criminal legal system and its duty to punish wrong-doers (Kewley, 2017). The burden

of trust is on mental health professionals to create safe environments for clients to share without fearing (as one participant eloquently described) that clinicians will use their words as "ammunition to shoot at me instead of help me." If we want to continue to move forward to enhance effectiveness, risk reduction, and sexual harm prevention, we need to be willing to hear and believe what our clients tell us about their experiences in treatment (Waldram, 2007).

Author's Note

In this paper, in accordance with journal and APA guidelines, we strive to use person-first language. We use the term "sex offender" in the abstract, however, knowing that potential readers might search for that keyword when seeking relevant literature. Otherwise, we used the term only when it was a quote from a participant, part of a reference/citation, or describing a public policy (e.g. sex offender registry).

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Note

1. Because the question asked participants to "describe your experience in any treatment, counseling, or therapy that you received related to the sex offense (positive and/or negative)" we conducted word counts on those two words as a first step in looking for themes. The vocabulary used to describe these two themes was so diverse that further word counts were less informative. Frequencies of thematic content are noted in Table 2.

References

Ahmed, Y., Windle, J., & Lynch, O. (2021). *Introduction: 'Nothing about us without us,' A history and application for criminology*. Policy Press.

Alexander, P. C. (2013). Relational trauma and disorganized attachment. In J. D. Ford, & C. A. Courtois (Eds), *Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models* (pp. 39–61). Guilford Press.

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., Dube, S. R., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, *256*(3), 174–186. https://doi.org/10.1007/s00406-005-0624-4

Andrews, D. A., & Bonta, J. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law*, *16*(1), 39–55. https://doi.org/10.1037/a0018362

Ansbro, M. (2008). Using attachment theory with offenders. *Probation Journal*, *55*(3), 231–244. https://doi.org/10.1177/0264550508092812

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *The American Psychologist*, *61*(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Association for the Treatment and Prevention of Sexual Abuse. (2022). https://www.atsa.com/practice

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*(6), 842–852. https://doi.org/10.1037/0022-006X.75.6.842

Beech, A., & Fordham, A. (1997). Therapeutic climate of sexual offender treatment programs. *Sexual Abuse: A Journal of Rsearch and Treatment*, *9*(3), 219–237. https://doi.org/10.1007/bf02675066

Beech, A., & Hamilton-Giachritsis, C. E. (2005). Relationship between therapeutic climate and treatment outcome in group-based sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment*, *17*(2), 127–140. https://doi.org/10.1177/107906320501700204

Binder, J., & Strupp, H. (1997). Negative process: A recurrently discovered and underestimated facet of therapeutic process and outcome in the individual psychotherapy of adults. *Clinical Psychology: Science and Practice*, *4*(2), 121–139. https://doi.org/10.1111/j.1468-2850.1997.tb00105.x

Birrell, P. J., & Freyd, J. J. (2006). Betrayal trauma: Relational models of harm and healing. *Journal of Trauma Practice*, *5*(1), 49–63. https://doi.org/10.1300/j189v05n01_04

Blagden, N., & Wilson, K. (2020). "We're all the same Here"—investigating the rehabilitative climate of a re-rolled sexual offender prison: A qualitative longitudinal study. *Sexual Abuse: A Journal of Research and Treatment*, *32*(6), 727–750. https://doi.org/10.1177/1079063219839496

Blagden, N. J., Winder, B., & Hames, C. (2016). "They treat us like human beings"—experiencing a therapeutic sex offenders prison: Impact on prisoners and staff and implications for treatment. *International Journal of Offender Therapy and Comparative Criminology*, *60*(4), 371–396. https://doi.org/10.1177/0306624x14553227

Blasko, B. L., & Jeglic, E. L. (2016). "Sexual offenders' perceptions of the client–therapist relationship: The role of risk. *Sexual Abuse: A Journal of Research and Treatment*, *28*(4), 271–290. https://doi.org/10.1177/1079063214529802

Bonta, J., & Andrews, D. A. (2017). *The psychology of criminal conduct* (6th ed.). Routledge.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bryant-Davis, T. (2019). The cultural context of trauma recovery: Considering the posttraumatic stress disorder practice guideline and intersectionality. *Psychotherapy*, *56*(3), 400–408. https://doi.org/10.1037/pst0000241

Burla, L., Knierim, B., Barth, J., Liewald, K., Duetz, M., & Abel, T. (2008). From text to codings: Intercoder reliability assessment in qualitative content analysis. *Nursing Research*, *57*(2), 113–117. https://doi.org/10.1097/01.NNR.0000313482.33917.7d

Charlton, J. I. (1998). Nothing about us without us In: *Nothing about us without us*. University of California Press.

Cheng, J., O'Connell, M. E., & Wormith, J. S. (2019). Bridging neuropsychology and forensic psychology: Executive function overlaps with the central eight risk and need factors. *International Journal of Offender Therapy and Comparative Criminology*, *63*(4), 558–573. https://doi.org/10.1177/0306624x18803818

Cooley, C. H. (1902). Looking-glass self. *Human Nature and the Social Order*, *6*, 179–185.

Copes, H., Beaton, B., Ayeni, D., Dabney, D., & Tewksbury, R. (2020). A content analysis of qualitative research published in top criminology and criminal justice journals from 2010 to 2019. *American Journal of Criminal Justice*, *45*(6), 1060–1079. https://doi.org/10.1007/s12103-020-09540-6

Craig, L. A., & Rettenberger, M. (2018). An etiological approach to sexual offender assessment: CAse formulation incorporating risk assessment (CAFIRA). *Current Psychiatry Reports*, *20*(6), 43. https://doi.org/10.1007/s11920-018-0904-0

de Vries Robbé, M., de Vogel, V., Koster, K., & Bogaerts, S. (2015). Assessing protective factors for sexually violent offending with the SAPROF. *Sexual Abuse: A Journal of Research and Treatment*, *27*(1), 51–70. https://doi.org/10.1177/1079063214550168

Douglass, M. D., Hillyard, S., & Macklin, A. (2022). Sexual Offending: The impact of the juxtaposition between social constructions and evidence-based approaches. *Journal of Forensic Psychology Research and Practice*, 1–25. https://doi.org/10.1080/24732850.2022.2054392

Drisko, J. W., & Grady, M. D. (2019). *Evidence-based practice in clinical social work: Essential clinical social work series* (2nd ed.). Springer Science and Buisiness Media.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change: Delivering what works in therapy.* American Psychological Association.

Ellman, I. M., & Ellman, T. (2015). "Frightening and high": The supreme court's crucial mistake about sex crime statistics. *Constitutional Commentary*, *30*, 495–667.

Gannon, T. A., Olver, M. E., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical Psychology Review*, *73*, 101752. https://doi.org/10.1016/j.cpr.2019.101752

Glantz, T., Harrison, J., & Cable, A. (2017). Trauma and recidivism: Informing assessment and treatment options for incarcerated men. *International Review of Modern Sociology*, *43*(1), 95–118. http://www.jstor.org/stable/44510056

Glaser, B. G. (1965). The constant comparative method of qualitative analysis. *Social Problems*, *12*(4), 436–445. https://doi.org/10.2307/798843

Grady, M. D., & Brodersen, M. (2008). In their voices: Perspectives of incarcerated sex offenders on their treatment experiences. *Sexual Addiction and Compulsivity*, *15*(4), 320–345. https://doi.org/10.1080/10720160802516310

Grady, M. D., Edwards, D., & Pettus-Davis, C. (2017). A longitudinal outcome evaluation of a prison-based sex offender treatment program. *Sexual Abuse: A Journal of Research and Treatment*, *29*(3), 239–266. https://doi.org/10.1177/1079063215585731

Grady, M. D., Levenson, J. S., & Bolder, T. (2017). Linking adverse childhood effects and attachment A theory of etiology for sexual offending. *Trauma, Violence, and Abuse*, *18*(4), 433–444. https://doi.org/10.1177/1524838015627147

Grady, M. D., Levenson, J. S., Glover, J., & Kavanagh, S. (2022). Is sex-offending treatment trauma-informed? Exploring perspectives of clinicians and clients. *Journal of Sexual Aggression*, *28*(1), 60–75. https://doi.org/10.1080/13552600.2021.1942572

Grady, M. D., Levenson, J. S., Glover, J., Kavanagh, S., & Carter, K. (2022). "Hurt people hurt other people": The link between past trauma and sexual offending. *Sexual Offending: Theory, Research, and Prevention*, *17*, 1–28. https://doi.org/10.5964/sotrap.7361

Grady, M. D., Levenson, J. S., & Prescott, D. (2017). Empirically informed forensic social work practice. In T. Maschi, & G. S. Leibowitz (Eds.), *Forensic practice: Psychosocial and legal issues across diverse populations and settings*. Springer.

Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and Behavior*, *36*(9), 865–891. https://doi.org/10.1177/0093854809338545

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, *14*(2), 169–194. https://doi.org/10.1177/107906320201400207

Hanson, R. K., Harris, A. J. R., Letourneau, E., Helmus, L., & Thornton, D. (2018). Reductions in risk based on time offense free in the community: Once a sexual offender, not always a sexual offender. *Psychology, Public Policy, and Law*, *24*(1), 48–63. https://doi.org/10.1037/law0000135

Hardeberg Bach, M., & Demuth, C. (2018). Therapists' experiences in their work with sex offenders and people with pedophilia: A literature review. *Europe's Journal of Psychology*, *14*(2), 498–514. https://doi.org/10.5964/ejop.v14i2.1493

Harris, D. A. (2017). *Desistance from sexual offending: Narratives of retirement, regulation and recovery.* Springer.

Harris, D. A., & Levenson, J. S. (2021). Life on "the list" is a life lived in fear: Post-conviction traumatic stress in men convicted of sexual offenses. *International Journal of Offender Therapy and Comparative Criminology*, *65*(6-7), 763–789. https://doi.org/10.1177/0306624x20952397

Jenkins-Hall, K. (1994). Outpatient treatment of child molesters: Motivational factors and outcome. In N. J. Pallone (Ed), *Young victims, young offenders* (pp. 139–150). Haworth Press.

Jennings, J. L., & Sawyer, S. (2003). Principles and techniques for maximizing the effectiveness of group therapy with sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, *15*(4), 251–267. https://doi.org/10.1177/107906320301500403

Jung, S. (2017). *RNR principles in practice in the management and treatment of sexual abusers*. Safer Society Press.

Kåven, A. S., Maack, J. K., Flåm, A. M., & Nivison, M. (2019). " It's my responsibility, but…" A qualitative study of perpetrators' understanding of child sexual abusse, A qualitative study of perpetrators' understanding of child sexual abuse. *Journal of Child Sexual Abuse*, *28*(2), 240–258. https://doi.org/10.1080/10538712.2018.1523815

Kewley, S. (2017). Strength based approaches and protective factors from a criminological perspective. *Aggression and Violent Behavior*, *32*, 11–18. https://doi.org/10.1016/j.avb.2016.11.010

Kolb, S. (2012). Grounded theory and the constant comparative method: Valid research strategies for educators. *Journal of Emerging Trends in Educational Research and Policy Studies*, *3*(1), 83–86.

Kuckartz, U., & Rädiker, S. (2019). *Analyzing qualitative data with MAXQDA*. Springer.

Långström, N., Enebrink, P., Laurén, E. M., Lindblom, J., Werkö, S., & Hanson, R. K. (2013). Preventing sexual abusers of children from reoffending: Systematic review of medical and psychological interventions. *BMJ (Clinical Research ed.)*, *347*, f4630. https://doi.org/10.1136/bmj.f4630

LeBel, T. P., & Richie, M. (2018). The psychological effects of contact with the criminal justice system In: *Handbook on the consequences of sentencing and punishment decisions* (pp. 122–142). Routledge.

Levenson, J. S., Grady, M. D., & Leibowitz, G. (2016). Grand challenges: Social justice and the need for evidence-based sex offender registry reform. *Journal of Sociology and Social Welfare*, *43*(2).

Levenson, J. S., Macgowan, M. J., Morin, J. W., & Cotter, L. P. (2009). Perceptions of sex offenders about treatment: Satisfaction and engagement in group therapy. *Sexual Abuse: A Journal of Research and Treatment*, *21*(1), 35–56. https://doi.org/10.1177/1079063208326072

Levenson, J. S., & Prescott, D. (2009). Treatment experiences of civilly committed sex offenders: A consumer satisfaction survey. *Sexual Abuse: A Journal of Research and Treatment*, *21*(1), 6–20. https://doi.org/10.1177/1079063208325205

Levenson, J. S., & Prescott, D. (2014). Déjà vu: From furby to Långström and the evaluation of sex offender treatment effectiveness. *Journal of Sexual Aggression*, *20*(3), 257–266. https://doi.org/10.1080/13552600.2013.867078

Levenson, J. S., Prescott, D., & D'Amora, D. (2010). Sex offender treatment: Consumer satisfaction and engagement in therapy. *International Journal of Offender Therapy and Comparative Criminology*, *54*(3), 307–326. https://doi.org/10.1177/0306624X08328752

Levenson, J. S., Prescott, D. S., & Willis, G. M. (2022). Trauma-informed treatment practices in criminal justice settings. In E. Jeglic, & C. Calkins (Eds), *Handbook of issues in criminal justice reform in the United States* (pp. 483–502). Springer International Publishing. https://doi.org/10.1007/978-3-030-77565-0_24

Levenson, J. S., Willis, G., & Prescott, D. (2017). *Trauma-informed Care: Transforming treatment for people who sexually abuse*. Safer Society Press.

Levenson, J. S., Willis, G. M., & Prescott, D. (2018). Incorporating principles of trauma-informed care into evidence-based sex offending treatment. In E. L. Jeglic, & C. Calkins (Eds), *New frontiers in offender treatment: The translation of evidence-based practices to correctional settings* (pp. 171–188). Springer International Publishing. https://doi.org/10.1007/978-3-030-01030-0_9

Levenson, J. S., Willis, G. M., & Prescott, D. S. (2020). Evidence-based practice and the role of trauma-informed care in sex offending treatment. In H. Swaby, B. Winder, R. Lievesley, K. Hocken, N. Blagden, & P. Banyard (Eds), *Sexual crime and trauma* (pp. 197–224). Palgrave Macmillan.

Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science: A Journal of the Association for Psychological Science*, *2*(1), 53–70. https://doi.org/10.1111/j.1745-6916.2007.00029.x

Marques, J. K., Wiederanders, M., Day, D. M., Nelson, C., & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's sex offender treatment and evaluation project (SOTEP). *Sexual Abuse: A Journal of Research and Treatment*, *17*(1), 79–107. https://doi.org/10.1177/107906320501700108

Marshall, W. L. (1996). The sexual offender: Monster, victim, or everyman? *Sexual Abuse*, *8*(4), 317–335. https://doi.org/10.1177/107906329600800406

Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment*, *17*(2), 109–116. https://doi.org/10.1177/107906320501700202

Marshall, W. L., Fernandez, Y. M., Serran, G. A., Mulloy, R., Thornton, D., Mann, R. E., & Anderson, D. (2003). Process variables in the treatment of sexual offenders: A review of the relevant literature. *Aggression and Violent Behavior*, *8*(2), 205–234. https://doi.org/10.1016/s1359-1789(01)00065-9

Marshall, W. L., Serran, G. A., Moulden, H., Mulloy, R., Fernandez, Y. M., Mann, R. E., & Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behaviour change. *Clinical Psychology and Psychotherapy*, *9*(6), 395–405. https://doi.org/10.1002/cpp.335

Marshall, W. L., Thornton, D., Marshall, L. E., Fernandez, Y., & Mann, R. (2001). Treatment of sexual offenders who are in categorical denial: A pilot project. *Sexual Abuse: A Journal of Research and Treatment*, *13*(3), 205–215. https://doi.org/10.1177/107906320101300305

Maruna, S., LeBel, T. P., Mitchell, N., & Naples, M. (2004). Pygmalion in the reintegration process: Desistance from crime through the looking glass. *Psychology, Crime and Law*, *10*(3), 271–281. https://doi.org/10.1080/10683160410001662762

Masten, A. S., & Cicchetti, D. (2010). Developmental cascades. *Development and Psychopathology*, *22*(3), 491–495. https://doi.org/10.1017/S0954579410000222

McCartan, K. F., Harris, D. A., & Prescott, D. S. (2021). Seen and not heard: The service user's experience through the justice system of individuals convicted of sexual offenses. *International Journal of Offender Therapy and Comparative Criminology*, *65*(12), 1299–1315. https://doi.org/10.1177/0306624X19851671

Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change*. Guilford press.

National Academies of Sciences, E. (2022). *The limits of recidivism: Measuring success after prison*. The National Academies Press. https://doi.org/10.17226/26459

National Association of Social Workers. (2018). *National association of social Workers code of ethics*. NASW.

Olson, J. D., McAllister, C., Grinnell, L. D., Gehrke Walters, K., & Appunn, F. (2016). Applying constant comparative method with multiple investigators and inter-coder reliability. *The Qualitative Report*, *21*(1), 26–42. https://doi.org/10.46743/2160-3715/2016.2447

Pattyn, E., Verhaeghe, M., Sercu, C., & Bracke, P. (2014). Public stigma and self-stigma: Differential association with attitudes toward formal and informal help seeking. *Psychiatric Services*, *65*(2), 232–238. https://doi.org/10.1176/appi.ps.201200561

Pettus-Davis, C., Renn, T., Lacasse, J. R., & Motley, R. (2019). Proposing a population-specific intervention approach to treat trauma among men during and after incarceration. *Psychology of Men and Masculinities*, *20*(3), 379–393. https://doi.org/10.1037/men0000171

Prescott, D., Maeschalck, C. L., & Miller, S. D. (2017). *Feedback-informed treatment in clinical practice: Reaching for excellence*. American Psychological Association.

Prescott, D., & Wilson, R. J. (2013). *Awakening motivation for difficult changes*. NEARI Press.

Raja, S., Hasnain, M., Hoersch, M., Gove-Yin, S., & Rajagopalan, C. (2015). Trauma informed care in medicine: Current knowledge and future research directions. *Family and Community Health*, *38*(3), 216–226. https://doi.org/10.1097/FCH.0000000000000071

Reid, K., Flowers, P., & Larkin, M. (2005). *Exploring lived experience*. The psychologist.

Rogers, C. (1961). *A therapist's view of psychotherapy: On becoming a person*. Houghton Mifflin.

Saber, M., Nodeland, B., & Wall, R. (2022). Exonerating DNA evidence in overturned convictions: Analysis of data obtained from the national registry of exonerations. *Criminal Justice Policy Review*, *33*(3), 256–272. https://doi.org/10.1177/08874034211033327

Schmucker, M., & Lösel, F. (2015). The effects of sexual offender treatment on recidivism: An international meta-analysis of sound quality evaluations. *Journal of Experimental Criminology*, *11*(4), 597–630. https://doi.org/10.1007/s11292-015-9241-z

Scott, K. L., & Jenney, A. (2022). Safe not soft: Trauma- and violence-informed practice with perpetrators as a means of increasing safety. *Journal of Aggression, Maltreatment and Trauma*, 1–20. https://doi.org/10.1080/10926771.2022.2052389

Segal, S., & Hayes, S. (2016). Consumer-run services research and implications for mental health care. *Epidemiology and Psychiatric Sciences*, *25*(5), 410–416. https://doi.org/10.1017/S2045796016000287

Seligman, M. E., & Csikszentmihalyi, M. (2000). *Positive psychology: An introduction* (*55*). American Psychological Association.

Seligman, M. E., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *The American Psychologist*, *61*(8), 774–788. https://doi.org/10.1037/0003-066X.61.8.774

Serran, G. A., Fernandez, Y., Marshall, W. L., & Mann, R. (2003). Process issues in treatment: Application to sexual offender programs. *Professional Psychology: Research and Practice*, *34*(4), 368–374. https://doi.org/10.1037/0735-7028.34.4.368

Stevenson, B. (2014). *Just mercy: A story of justice and redemption*. One World, a division of Random House.

Stinson, J. D., & Clark, M. D. (2017). *Motivational interviewing with offenders: Engagement, rehabilitation, and reentry*. Guilford Publications.

Substance Abuse and Mental Health Services Administration. (2011). *Consumer-operated services: Building your program*. Substance Abuse and Mental Health Services Administration. (HHS Pub. No. SMA-11–4633).

Swaby, H., Winder, B., Lievesley, R., Hocken, K., Blagden, N., & Banyard, P. (2020). *Sexual crime and trauma*. Springer.

Teyber, E., & Teyber, F. H. (2017). *Interpersonal process in therapy: An integrative model* (7 ed.). Cengage Learning.

Tosone, C. (2013). On being a relational practitioner in an evidence-based world. *Journal of Social Work Practice*, *27*(3), 249–257. https://doi.org/10.1080/02650533.2013.818941

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences*, *15*(3), 398–405. https://doi.org/10.1111/nhs.12048

van der Kolk, B. (2006). Clinical implications of neuroscience research in PTSD. *Annals of the New York Academy of Sciences*, *1071*(1), 277–293. https://doi.org/10.1196/annals.1364.022

Van Manen, M. (2016). *Researching lived experience: Human science for an action sensitive pedagogy*. Routledge.

Vaske, J. C. (2017). Policy implications of biosocial criminology: An introduction to the special issue. *Criminal Justice and Behavior*, *44*(8), 989–992. https://doi.org/10.1177/0093854817714017

Wakeling, H. C., Webster, S. D., & Mann, R. E. (2005). Sexual offenders' treatment experience: A qualitative and quantitative investigation. *Journal of Sexual Aggression*, *11*(2), 171–186. https://doi.org/10.1080/13552600412331321323

Waldram, J. B. (2007). Everybody has a story: Listening to imprisoned sexual offenders. *Qualitative Health Research*, *17*(7), 963–970. https://doi.org/10.1177/1049732307306014

Wampold, B. E. (2010). The research evidence for common factors models: A historically situated perspective. In B. Duncan, S. D. Miller, B. E. Wampold, & M. Hubble (Eds), *The heart and soul of change: Delivering what works in therapy* (Second ed., pp. 49–82). American Psychological Association.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, *14*(3), 270–277. https://doi.org/10.1002/wps.20238

Wampold, B. E. (2019). *The basics of psychotherapy: An introduction to theory and practice*. American Psychological Association.

Ward, T., & Brown, M. (2004). The good lives model and conceptual issues in offender rehabilitation. *Psychology, Crime and Law*, *10*(3), 243–257. https://doi.org/10.1080/10683160410001662744

Ward, T., Day, A., Howells, K., & Birgden, A. (2004). The multifactor offender readiness model. *Aggression and Violent Behavior*, *9*(6), 645–673. https://doi.org/10.1016/j.avb.2003.08.001

Ward, T., Yates, P. M., & Willis, G. M. (2012). The good lives model and the risk need responsivity model A critical response to Andrews, Bonta, and wormith (2011). *Criminal Justice and Behavior*, *39*(1), 94–110. https://doi.org/10.1177/0093854811426085

Watson, R., Thomas, S., & Daffern, M. (2017). The impact of interpersonal style on ruptures and repairs in the therapeutic alliance between offenders and therapists in sex offender treatment. *Sexual Abuse: A Journal of Research and Treatment*, *29*(7), 709–728. https://doi.org/10.1177/1079063215617514

Watter, D. N., & Hall, K. S. K. (2020). Healthy sexuality for sex offenders. *Current Psychiatry Reports*, *22*(11), 55. https://doi.org/10.1007/s11920-020-01180-1

Western, B., Braga, A. A., Davis, J., & Sirois, C. (2015). Stress and hardship after prison. *AJS; American Journal of Sociology*, *120*(5), 1512–1547. https://doi.org/10.1086/681301

Willemsen, J., Seys, V., Gunst, E., & Desmet, M. (2016). "Simply speaking your mind, from the depths of your soul": Therapeutic factors in experiential group psychotherapy for sex offenders. *Journal of Forensic Psychology Practice*, *16*(3), 151–168. https://doi.org/10.1080/15228932.2016.1172423

Winn, M. E. (1996). The strategic and systemic management of denial in the cognitive/behavioral treatment of sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, *8*(1), 25–36. https://doi.org/10.1007/bf02258014

Yalom, I. (1995). *The theory and practice of group psychotherapy* (4th ed.). Basic Books, Inc.

Yates, P. M., Prescott, D., & Ward, T. (2010). *Applying the good lives and self-regulation models to sex offender treatment: A practical guide for clinicians*. Safer Society Press.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. Guilford Press.

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CLINICAL CASE REPORT SERIES

Diagnostic Differential Between Pedophilic-OCD and Pedophilic Disorder: An Illustration with Two Vignettes

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Abstract

Despite the prevalence of atypical sexual thoughts in OCD presentations, research suggests that treatment providers often misclassify OCD with pedophilic obsessions (P-OCD) as pedophilic disorder. Such misdiagnoses can have adverse effects including inappropriate treatment, worsening of symptoms, and potential legal complications. Given these iatrogenic effects, clinicians must be competent in differentiating between these two conditions. To clarify the difficult differential between P-OCD and pedophilic disorder, the current paper provides readers with two vignettes that illustrate the differential process. These vignettes highlight important distinctions in symptom presentations and common pitfalls when assessing for P-OCD and pedophilic disorder. The first vignette describes a 32-year-old married woman who experienced pedophilic-themed intrusive thoughts, leading her to avoid children and certain interactions with her daughter. The second vignette describes a 42-year-old married man who experienced ego-dystonic attraction toward minors, particularly 8–10-year-old girls. Following these vignettes, treatment implications and forensic implications are discussed. Finally, recommendations for future clinical and empirical work are made.

Keywords Obsessive–compulsive disorder (OCD) · Pedophilic-OCD (P-OCD) · Pedophilic disorder · DSM-5

Introduction

Obsessive–compulsive disorder (OCD) is a functionally impairing mental illness with a lifetime prevalence of 2.3% and a 12-month prevalence of 1.2% (Ruscio et al., 2010). Although OCD symptom categories such as contamination, symmetry, and order are widely researched (Bloch et al., 2008), other symptom dimensions such as "sexually repugnant" obsessions are less understood (Bruce et al., 2018). These obsessions include deviant or non-normative sexual thoughts, as defined by Western cultural standards, such as the fear of developing an attraction to children. As many as 20–30% of individuals with OCD report these atypical sexual thoughts as their primary obsessional concern (Fernández de la Cruz et al., 2013; Moulding et al., 2014).

Despite the prevalence of these distressing, atypical sexual thoughts in OCD presentations, treatment providers may misunderstand these presentations and misdiagnose sexual themes in OCD as paraphilias, especially in the case of pedophilia-themed thoughts known as pedophilia-themed OCD (P-OCD). In a random sample of 2550 American Psychological Association members, 360 providers (14.1%) completed a survey providing their diagnostic impressions of five OCD vignettes (Glazier et al., 2013). Four of these vignettes asked about taboo thoughts, and one vignette asked about contamination obsessions. Results indicated that over one-third of these clinicians (42.9%) misclassified P-OCD as pedophilia. These results underscore the difficulty clinicians may face when tasked with differential diagnosis of P-OCD and pedophilia and suggest that further guidance may be needed.

Due to the high levels of stigma and criminal associations with pedophilia (Jahnke, 2018), misidentifications can trigger a devastating cascade of events that can cause serious harm to clients such as practitioners inappropriately referring individuals with P-OCD symptoms to Child Protective Services (Bruce et al., 2018). In such instances, misdiagnoses

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may result not only in inappropriate treatment but also false reports of sexual abuse, worsening of symptoms, undue trauma to clients and their families, and potential legal complications. More broadly, misdiagnosis of these disorders and subsequent negative experiences in the mental health system can deepen mistrust of the system, increasing reluctance to disclose symptoms and decreasing desire to seek treatment (Grady et al., 2019; Levenson & Grady, 2019; Parr & Pearson, 2019). Given the gravity of these consequences, it is imperative that treatment providers understand the differences between P-OCD and pedophilic disorder and refine their differential diagnostic skills.

Diagnostic Criteria

The diagnostic criteria for P-OCD and pedophilic disorder on their face differ significantly. A general OCD diagnosis requires the presence of obsessions, compulsions, or both (American Psychiatric Association [APA], 2013). The APA defines obsessions as intrusive or unwanted, repetitive, and persistent thoughts, images, or urges that frequently cause intense anxiety or distress. For P-OCD, obsessions may involve intrusive thoughts of children in sexual situations. Individuals with P-OCD typically fear the social and occupational consequences of having these thoughts revealed to others. Compulsions are defined as repetitive, illogical behaviors that an individual feels driven to perform in order to reduce anxiety or prevent a dreaded event. P-OCD compulsions may involve checking for signs of physiological arousal when presented with child stimuli and/or avoidance of children.

In contrast, pedophilic disorder contains three major criteria: (A) the presence of a paraphilic interest in prepubescent children; (B) that interest resulting in distress, impairment, or harm to others; and (C) the person must be over the age of 16 and more than five years older than the child or children noted in the first criterion (APA, 2013). As the criteria illustrate, pedophilic interests alone are not inherently clinically significant and do not constitute a pedophilic disorder without the second and third criterion. Contrary to popular belief, the second criterion also illustrates that a diagnosis of pedophilic disorder does not necessitate the presence of any criminal offending behavior. For example, a person with pedophilic interests may experience distress over those interests and receive a pedophilic disorder diagnosis without the presence of offending behavior. This diagnostic profile is sometimes referred to as non-offending pedophilia (Cantor & McPhail, 2016). Additionally, although some people diagnosed with pedophilic disorder may engage in criminal offending behavior, this offending behavior might not encompass contact child sexual abuse. For example, many offending pedophiles engage solely in non-contact offenses such as possession of child sex abuse material (CSAM) and a significant portion of child sex abuse is not committed by people with pedophilic disorder (Gerwinn et al., 2018).

These differences between pedophilic interests, non-offending pedophilic disorder, offending pedophilic disorder, and child sexual abuse underscore the importance of specificity of language when discussing this population and highlight difficulties when diagnosing this disorder. Distorting the distinction between pedophilic interest and non-offending pedophilia with child sex abuse only serves to confuse and conflate mental health issues with criminal offending behavior. Therefore, when considering a diagnosis of pedophilic disorder, it is important for clinicians to not base a diagnosis solely on the presence of offending behavior, to be aware of these terms, and to intentionally use language that reflects these distinctions. Due to the stigma associated with the term pedophile and the inaccurate conflation of the term pedophile with child sex offender, a collaboration of treatment providers and consumers have suggested the term minor-attracted person (MAP) as an alternative to pedophile (Levenson & Grady, 2019). Because this paper specifically examines the differential between P-OCD and pedophilic disorder, and because the term MAP includes minor attraction more broadly (i.e., attraction to individuals up to the age of 18), this paper will not use the term MAP. Nevertheless, clinicians should consider use of the MAP term to encourage de-stigmatization and precision of language when discussing pedophilic disorder.

Diagnostic Differential

Although P-OCD and pedophilic disorder have markedly different diagnostic criteria, their presentations can appear similar and difficult to differentiate. Bruce et al. (2018) provided a framework for differentiating P-OCD and pedophilic disorder. In their framework, they note one of the key differentiators between P-OCD and pedophilia is the degree to which intrusive thoughts are ego-syntonic or ego-dystonic. In psychoanalytic theory, ego-syntonic refers to thoughts, emotions, and behaviors that are consistent with an individual's perception of themselves and their values, whereas ego-dystonic captures thoughts and behaviors that are in conflict with an individual's ideal self-image (Fenichel, 1946). In P-OCD, intrusive sexual thoughts are ego-dystonic and produce severe shame, anxiety, disgust, and distress, whereas sexual thoughts in pedophilic disorder may be ego-syntonic and produce enjoyment and sexual arousal (Bruce et al., 2018; Ferris, 2012). Bruce et al. also note that P-OCD clients tend to avoid or minimize contact with the feared sexual stimuli, whereas clients with ego-syntonic pedophilic interests will desire and seek out sexual stimuli in the hopes of receiving some degree of sexual gratification.

To determine the classification of sexual thoughts as OCD obsessions versus pedophilic interests, Bruce et al. (2018) suggest using structured and open-ended methods. Symptom measures including the Yale–Brown Obsessive–Compulsive Disorder Scale—Second Edition (Storch et al., 2010), the Obsessive–Compulsive Inventory—Revised (Foa et al., 2002), and the Dimensional Obsessive–Compulsive Scale (Abramowitz et al., 2010) may help identify the presence of P-OCD. Furthermore, semi-structured diagnostic interviews such as the Anxiety and Related Disorders Interview Schedule for DSM-5 (Brown & Barlow, 2014) may be useful. Although structured and semi-structured interviews may be sufficient to detect P-OCD symptoms, unstructured clinical interviews may prove the most fruitful method when clients present with difficult-to-classify sexual thoughts (Bruce et al., 2018). Unstructured clinical interviews allow clients to share their thoughts in an open-ended, non-restrictive manner. This opportunity may facilitate assessment and allow clinicians to probe for the presence of ego-syntonicity versus ego-dystonicity.

Through these methods suggested by Bruce et al. (2018), ego-syntonic pedophilic disorder may be easily distinguished from P-OCD particularly if some degree of offending behavior has taken place; however, it is often unclear how to distinguish P-OCD from ego-dystonic pedophilic disorder. Although some individuals with pedophilic disorder or pedophilic interests may not experience any distress, newer research suggests that a number of individuals with pedophilic disorder do experience distress or ego-dystonicity (Elchuk et al., 2022). For these individuals, ego-dystonicity may arise through conflicts with moral/religious beliefs or in response to stigmatization of their sexual interests (Cranney, 2017; Elchuk et al., 2022). In these cases, feelings and thoughts (e.g., shame, embarrassment) about an individual's legitimate pedophilic interests may mirror ego-dystonic qualities of P-OCD. In such situations, Bruce et al. (2018) suggest providers directly assess sexual arousal in response to the purported sexual interest to determine the presence of a true pedophilic interest; however, this assessment may prove challenging for community providers who lack access to typical measures of sexual arousal such as a penile plethysmograph. Although Bruce et al. (2018) laid a strong foundation for the diagnostic differential between P-OCD and pedophilic disorder, given the complexity of the differential process and the limited availability of sexual arousal measures, there is continued need for practical guidance on making the distinction.

Vignettes

In this paper, we aim to expand upon the foundation established by Bruce et al. (2018). Below, we provide clinicians with vignettes based on an amalgamation of selected cases that illustrate the clinical differential between pedophilic disorder and P-OCD. The first vignette concerns a 32-year-old married woman with pedophilia-themed intrusive thoughts and avoidance of children, including certain interactions with her daughter. The second vignette discusses a 42-year-old married man who sought help for his attraction toward minors, in particular 8–10-year-old girls. These vignettes highlight common pitfalls when assessing for P-OCD and pedophilic disorder and illustrate important distinctions in symptom presentations.

Additionally, we present an assessment technique consisting of five elements that may guide clinicians throughout the process of differential diagnosis. The five elements of this technique include: (1) Assess for the presence and characteristics of obsessional thoughts; (2) assess for the presence and characteristics of compulsive behavior; (3) consider the functional purpose of avoidance, if present; (4) assess sexual arousal in response to the purported sexual interest(s); and (5) combine results from assessment of these elements to form conceptualization and make differential diagnosis. This proposed technique has not been empirically tested; therefore, we caution evaluators to use their best clinical judgment when diagnosing clients. However, we believe that clinicians may find a semi-structured method helpful when approaching these cases. We have illustrated the use of this technique in the vignettes that follow.

Scenario 1

Ms. L, a 32-year-old married woman with one child, presented to the local outpatient psychiatric clinic seeking help for intrusive sexual thoughts and images about her 2-year-old daughter and other children. She was referred to the clinic by her primary care physician after reporting significant distress related to the thoughts.

Throughout her adulthood, Ms. L experienced bouts of anxiety and described herself as a "worrywart." When her daughter was born, she began to experience intrusive sexual thoughts about her daughter and, in turn, started to question whether she was "sick, a deviant, a pedophile." When queried about the thoughts, Ms. L described recurrent images of sexually molesting her youngest daughter while giving her baths and changing her diapers, accompanied by concerns regarding whether she would become physically aroused by these behaviors. Ms. L reported that each time she bathed her daughter, she worried whether she was enjoying the act sexually. To reassure herself that she was not in fact aroused, Ms. L frequently examined herself for signs of arousal (e.g., physical sensations in the groin) while bathing her daughter. She (erroneously) interpreted these sensations as evidence of minor attraction. When asked hypothetically whether she would enjoy sexual contact with children if no harm came

to the child and there were no negative legal consequences for her, Ms. L vehemently denied any potential enjoyment.

As time progressed, it became increasingly difficult for Ms. L to engage with her daughter at all. She refused to bathe her daughter unless someone was with her, and she closed her eyes while changing her daughter's diaper. She eventually requested the presence of her husband for all contact with her daughter. As these avoidance practices escalated, Ms. L began to worry that she was not only a danger to her own daughter, but all children. She started taking a longer route to the local grocery store so she could bypass a neighborhood playground. Ms. L reported that she believed that her recurring sexual thoughts about children meant that she was "a pedophile, and therefore a bad person." Ms. L's husband, who has known her for over 20 years, described her as a kind, caring, and hardworking woman.

Assessment

Cases of OCD with pedophilia-themed thoughts are often difficult to differentiate from individuals with pedophilic interests (Bruce et al., 2018; Glazier et al., 2013)**.** To clarify this diagnostic issue, we suggest clinicians assess the following clinical elements (though not necessarily in the presented order) as previously mentioned. We have illustrated this assessment technique in the case of Ms. L:

Assess for the Presence and Characteristics of Obsessional Thoughts

Ms. L described thoughts of inappropriately touching and molesting her daughter. The thoughts' recurrence and intrusiveness, along with the fact that they produced anxiety, are characteristic of obsessions. Ms. L's obsessions worsened during times of contact with her daughter (e.g., while giving her daughter a bath, changing diapers) and eventually generalized to other children. Importantly, Ms. L's thoughts were characterized by fear and shame; she reported concern over these thoughts and was disturbed by their presence. This fear is suggestive of ego-dystonicity and aligns with OCD. Even so, as mentioned, ego-dystonicity may arise in certain cases of pedophilia and thus further assessment in Ms. L's case is helpful.

Assess for the Presence and Characteristics of Compulsive Behavior

Ms. L reported frequently examining herself for signs of physical arousal around her daughter and other children. She also repeated the phrase "I am not a pedophile" in her head several times throughout the day. These behaviors served to reassure Ms. L that she was not genuinely attracted to children, and therefore not a pedophile nor a "bad person." According to Ms. L, the purpose of these behaviors was to reduce anxiety elicited by her sexual thoughts. When the primary function of repetitive behaviors is to reduce anxiety rather than increase pleasure, these behaviors are likely P-OCD compulsions and not pedophilic compulsive sexual behaviors. Thus, Ms. L appeared to display compulsions consistent with OCD. Further assessment will be used to confirm a diagnosis of OCD, and to rule-out anxiety related to legitimate pedophilic interest.

Consider the Functional Purpose of Avoidance, If Present

Avoidance may be understood as a form of OCD-like compulsive behavior, or it may be used to legitimately reduce risk of harm in the case of pedophilia. In Ms. L's case, she initially avoided circumstantial contact with her daughter (e.g., closing her eyes while changing diapers) and eventually avoided being alone with her daughter at all. She also avoided potential contact with other children at the playground despite the inconveniences this caused her. Similar to the functional purpose of her compulsive behaviors, it appeared that Ms. L's avoidance practices serve to reduce triggers for her obsessional sexual thoughts as well as the anxiety that may result from those thoughts. This avoidance differs from that of an individual with pedophilia, as pedophilia-related avoidance may serve to reduce the onset of sexual arousal and/or reduce legitimate risk of harm to children. This assessment supports a diagnosis of OCD for Ms. L.

Assess Sexual Arousal in Response to the Purported Sexual Interest(s)

In cases where the differential between pedophilia and OCD remains unclear even after the assessing the aforementioned elements, clinicians may assess sexual arousal in response to child stimuli. Without direct access to physiological measures of sexual arousal (e.g., penile plethysmography, clitoral photoplethysmography), clinicians may rely on client self-report of sexual arousal. Bruce et al. (2018) suggest asking questions such as "Do your sexual fantasies include young children?" and gauging the use of child pornography. We support these recommendations generally, but caution clinicians to remain cognizant of mandatory reporting practices in their jurisdictions. In certain jurisdictions, the current possession of child pornography may require mandatory reporting (Lasher & Stinson, 2017). In clinical settings within these jurisdictions, it may be advantageous to avoid questions about child pornography use. Therefore, we suggest phrasing other hypothetical questions in a way that does not trigger mandatory reporting practices. For example, questions like "Would you enjoy having sex with a child?" are hypothetical in nature and elicit responses that would not trigger mandatory reporting.

In Ms. L's case, when asked whether she would enjoy sexual contact with children in any context without negative consequences, she strongly denied any possible enjoyment. This finding further supports a diagnosis of OCD over pedophilic disorder.

Combine Results from Assessment of These Elements to Form Conceptualization and Make Differential Diagnosis

Ms. L's symptom presentation—obsessive worry about attraction to children and compulsive efforts to neutralize this anxiety—is consistent with OCD. Her sexual thoughts about children are ego-dystonic in nature and produce a great deal of distress and worry. Ms. L did not experience a genuine and consistent sexual attraction toward children, but rather was preoccupied with doubts about whether she was unknowingly attracted to children, or whether she posed a danger to them. Her compulsive and avoidance behaviors precluded any safety learning and maintained her fears (McGuire et al., 2011). Given Ms. L's diagnosis of OCD, the recommended course of treatment would be combined Exposure and Response Prevention (ERP) therapy with medication management (Bruce et al., 2018).

Scenario 2

Mr. C is a 42-year-old male, married (to a 39-year-old woman) lawyer with no children. When he contacted the local outpatient clinic, he asked if he could "see somebody about some sexual issues." When queried over the telephone, Mr. C declined to elaborate on these "sexual issues" and asked to be seen in-person.

Upon intake, Mr. C described a long-standing "scary and hugely problematic" interest in prepubescent children. He reported being physiologically aroused at the thought and sight of 8–10-year-old girls. He explained that he "probably would never" act on this attraction, but that he often fantasized about sexual contact with young girls. Mr. C said that he was both "horrified" and "intrigued" by these fantasies.

Mr. C denied having ever disclosed his sexual interest in prepubescent girls to anybody including his wife. When asked why he was now sharing, Mr. C replied that he "couldn't live the lie" any longer and that the concealment was causing insomnia. He reported many sleepless nights that involved worrying about his "fate" if his wife or others found out about his attraction to children. For the past three years, Mr. C has been unwilling to engage in sexual activity with his wife. He noted that whenever his wife confronted him about this unwillingness, he became upset and "stormed off." As a result of these disputes, Mr. C and his wife had grown distant and have recently been considering divorce.

In order to mitigate the risk that Mr. C believed he posed to children, he avoided any place where he believed children would be present including playgrounds, parks, beaches, school zones, and ice cream shops. Mr. C reported that as a "reward" for avoiding these spaces, he would indulge his interests and allow himself to include prepubescent girls in his sexual fantasies while masturbating. He reported masturbating once or twice a week and did not report any other sexual activity. When asked if he would ever enjoy having sex with prepubescent girls in real life if there were no consequences, he responded in the affirmative, "Honestly, yes, I think I would."

Assessment

To clarify Mr. C's diagnosis, we will again demonstrate the assessment technique outlined above.

Assess for the Presence and Characteristics of Obsessional Thoughts

Mr. C reported "horrifying," "scary," and "hugely problematic" sexual thoughts about prepubescent girls. Although his thoughts were recurrent and appeared obsessional, it was unclear whether they qualified clinically as obsessions (i.e., whether the thoughts were intrusive and truly unwanted) or were the result of sexual fixations. We mentioned earlier that an important differential indicator between P-OCD and pedophilia is the extent to which thoughts and arousal patterns are ego-syntonic (generally indicative of pedophilia) versus ego-dystonic (generally P-OCD). On the surface, it appeared that Mr. C's description of the distress accompanying his thoughts (e.g., they are "scary," "problematic") indicated ego-dystonicity and therefore P-OCD. However, the seemingly straightforward ego-syntonic versus ego-dystonic distinction becomes complicated when genuine pedophilic thoughts are accompanied by a high degree of distress, which may arise due to conflict with religious/moral beliefs or a response to stigma. To further complicate matters, individuals with P-OCD or pedophilia may fear social repercussions over their thoughts being revealed to others. Either scenario may be the case for Mr. C, who reported concern about his "fate" if his thoughts were to be revealed to others. Thus, further assessment was needed.

Assess for the Presence and Characteristics of Compulsive Behavior

Mr. C did not report any repetitive behaviors characteristic of compulsions. His masturbation practices appear normative in frequency and do not serve to reduce distress related to sexual thoughts; on the contrary, these behaviors appeared to increase pleasure stemming from the thoughts. The absence

of compulsive behaviors may rule out P-OCD, which typically involve compulsions such as reassurance-seeking or checking for signs of arousal. However, the mere absence of compulsive symptoms is insufficient to rule out an OCD diagnosis as some OCD presentations may only involve obsessions without observable compulsions, so further assessment was needed.

Consider the Functional Purpose of Avoidance, If Present

Another complicated aspect of the differential between P-OCD and pedophilic disorder in Mr. C's case was his avoidance behaviors. As mentioned, avoidance may be a form of OCD-like compulsive behavior, or it may be used to legitimately reduce risk of harm or onset of sexual arousal. Mr. C believed he posed a risk to children and therefore avoided areas where children would be present. This rationale for avoidance is also seen in OCD presentations; however, unlike avoidance seen in OCD, Mr. C's avoidance appeared to reduce not only his anxiety but also the onset of sexual arousal. Therefore, further assessment of Mr. C's sexual interest was needed.

Assess Sexual Arousal in Response to the Purported Sexual Interest(s)

Assessing Mr. C's sexual arousal in response to prepubescent girls was instrumental in forming a diagnosis. Despite his hesitancy to share his sexual thoughts about prepubescent girls with friends and family, Mr. C was relatively open and forthright when sharing with clinicians. He described a long-standing, genuine attraction to young girls and reported masturbating to fantasies that involve these children. To be certain about this attraction, clinicians asked Mr. C directly whether he would hypothetically enjoy sex with young girls, to which Mr. C replied that he would. These assessment data provided evidence that Mr. C experienced true attraction to children.

Combine Results from Assessment of These Elements to Form Conceptualization and Make Differential Diagnosis

Despite a challenging differential, it appeared that Mr. C met criteria for pedophilic disorder and not P-OCD. In order to meet diagnostic criteria for pedophilic disorder, three DSM criteria must be fulfilled, as outlined earlier; Mr. C reported over six months of recurrent, sexually arousing fantasies involving sexual activity with prepubescent children (Criterion A) and he is also over the age of 16 and more than five years older than those children (Criterion C). With respect to Criterion B, it appeared that Mr. C's fantasies and attractions produce both distress, as evidenced by insomnia, anxiety, and worry, and interpersonal difficulty, as evidenced by arguments and divorce considerations with his wife. Additionally, because Mr. C experienced genuine attraction toward children, his avoidance behaviors likely reflect attempts to mitigate legitimate risk and the onset of sexual arousal rather than to avoid triggering P-OCD obsessions.

Although Mr. C meets criteria for pedophilic disorder, he has not engaged in criminal activity related to his diagnosis. Therefore, in order to emphasize this lack of criminal behavior, the term non-offending pedophile better captures Mr. C's specific presentation in a way that distinguishes between his pedophilic disorder and risk for child sex abuse behavior. Given Mr. C's lack of criminal behavior as well as his openness to discussing his minor attraction with clinicians, the recommended course of treatment would be supportive and/or cognitive behavioral therapy (CBT) with potential medication management.

Discussion

Treatment Implications

As these vignettes emphasize, accurate diagnosis of P-OCD and pedophilic disorder requires careful consideration of symptoms. Because effective treatment for P-OCD differs greatly from effective treatment for pedophilic disorder, misdiagnosis can lead to ineffective or harmful clinical outcomes. Both OCD and paraphilias show positive responses to selective serotonin reuptake inhibitors (SSRI) treatment; however, pharmacological treatment typically occurs in conjunction with other methods that differ significantly between diagnoses (Chow & Choy, 2002; Cottraux et al., 2005). Although OCD with atypical sexual thoughts such as P-OCD is more treatment-resistant than other forms of OCD (Williams et al., 2014), the gold standard treatment for all forms of OCD is CBT and ERP, which involves exposure to feared stimuli and subsequent blocking of compulsive behavior (Hofmann & Smits, 2008; Olatunji et al., 2013).

Conversely, pedophilic disorder shows limited response to general psychotherapeutic interventions which, unlike OCD treatment, focus mainly on cognitive distortions and denial, empathy training, and sexual impulse control training (Cohen & Galynker, 2002). Although general supportive therapy has shown some benefits in reducing distress symptoms of pedophilic disorder and environmental interventions aimed at managing urges have shown some success, particularly in forensic settings, there still remains a lack of non-forensic, pedophilia-specific interventions (Cantor & McPhail, 2016). A few specialized programs, such as Project Dunkelfeld in Germany, offer psychotherapeutic services specifically designed for community treatment of people with pedophilic disorder, but have shown mixed results and are limited in their availability (Mokros & Banse, 2019). Online resources and helplines such as Get Help (Stop it Now!) and Help Wanted

and online support groups such as Virtuous Pedophiles offer more accessible support to those struggling with pedophilic interests and typically offer education on healthy sexual relationships and consent; however, they are limited in their ability to deliver therapeutic services due to their online nature (Nielsen et al., 2020; Shields et al., 2020; Van Horn et al., 2015). Additionally, the Association for the Treatment of Sexual Abusers has recently started the Eradicating Child Sexual Abuse initiative aimed at preventing child sexual abuse and treating individuals with pedophilia; however, research on the effectiveness of the initiative is currently limited (Eradicating Child Sexual Abuse, 2020). Because of limited community treatment options for pedophilic disorder, most treatment for pedophilia is delivered in forensic settings to individuals with pedophilia and offending histories (Cantor & McPhail, 2016). These forensic interventions may include incarceration, parole supervision, and testosterone-reducing interventions such as chemical castration (Hall et al., 2007; Schober et al., 2005).

Although both ERP and psychotherapy for pedophilic disorder operate on cognitive-behavioral principles, the behavioral change strategies employed in either treatment fundamentally differ and, in the context of misdiagnosis, could lead to worsening symptoms. ERP requires exposure to distressing sexual stimuli which, for individuals with pedophilic disorder, may only reinforce and increase desire for the stimuli. For example, if Mr. C in Scenario 2 were to receive a P-OCD diagnosis and ERP treatment, such treatment would be largely ineffective. His attraction to children would likely remain, and his fantasization of children and resulting distress would likely increase. This increase in fantasization could also place Mr. C at increased risk for sexual offending behavior, particularly possession of child sex abuse material, which could then lead to further negative social and legal consequences.

Similarly, because clients with OCD already engage in suppression and avoidance techniques to feared sexual stimuli, teaching suppression techniques through pedophilia psychotherapy would only serve to reinforce that fear and avoidance. For instance, in Scenario 1, had Ms. L been misdiagnosed as having a pedophilic disorder, she would have been inappropriately referred to a specialized pedophilic treatment center. Referral to such treatment would likely reinforce her excessive worries and doubts, increasing her obsessional fear about being identified as a pedophile. Increase in these fears and anxiety could then exacerbate compulsive behavior.

These divergent outcomes underscore the need for accurate diagnosis to assure better and more effective treatment. Furthermore, when considering the serious, life-long physiological effects of certain forensic treatments for pedophilic disorder (e.g., testosterone suppression, chemical castration) the importance of accurate diagnosis becomes even more clear.

Forensic Implications

In addition to general clinical concerns, P-OCD and pedophilic disorder present a number of unique forensic considerations as well. As mentioned previously, treatment providers' reporting of actual or perceived child sexual abuse is required by current mandated reporter laws (Bruce et al., 2018). Although necessary in most instances, reporting concerns about child sexual abuse when a client presents with P-OCD may needlessly involve the client in the criminal justice system. This involvement can then lead to investigations that may strain a client's interpersonal relationships and potentially threaten their employment (Carbino, 1991; Plummer & Eastin, 2007). If the client has children, such as Ms. L in Scenario 1, involvement could threaten child custody, particularly for clients undergoing divorce proceedings (Houston et al., 2017). Similarly, reporting a non-offending individual with pedophilic interests may make that individual less likely to disclose symptoms or seek treatment in the future (Grady et al., 2019). If Mr. C in Scenario 2 were reported, he may develop distrust of mental health professionals and be less likely to seek out treatment, despite his distress, potentially leading to a worsening of his symptoms and increased risk for offending behavior.

Although no studies have examined the prevalence of P-OCD misdiagnosis in practice, given Glazier et al.'s (2013) finding on the high rate of vignette misdiagnosis, it is likely that misdiagnosis occurs in practice. Bruce et al. (2018) described a case at their clinic where a client with pedophilia-themed obsessions was previously admitted to an emergency room and referred to Child Protective Services, resulting in contact restrictions with his daughter. That client was fortunate enough to later receive a proper P-OCD diagnosis and treatment, but it is unclear how many similar cases are unreported and how many individuals never receive a proper diagnosis. Given the lack of research on this topic, the full extent of these negative consequences is unclear.

Future Directions

Given the seriousness of misdiagnosis and the limited research on this topic, future research is needed to address several current gaps in knowledge. Although some evidence suggests that clinicians have difficulty making the distinction between P-OCD and pedophilic disorder (Glazier et al., 2013), more research should examine misdiagnosis rates across different types of providers including social workers, nurses, and other mental health professionals. Relatedly, research should examine knowledge of these diagnoses across provider groups and education materials should be designed to increase diagnostic accuracy and decrease provider stigma. Although we present a plausible method for structuring assessment of the diagnostic differential, more

research is needed to uncover the best method of performing that assessment in multiple types of mental health settings. Given the potential legal consequences of misdiagnosis, research should also examine the legal effects of misdiagnosis to gain a more accurate picture of the associated negative consequences.

At a conceptual level, more research on differences between true pedophilia and general minor attraction (i.e., attraction to anyone under 18) is needed. Because many in the public do not make a distinction between pedophilia and minor attraction and conflate both with offending (Jahnke, 2018), data on specific differences between minor attraction and pedophilia are needed. This includes differences in identification/diagnosis, connection to offending, mental health provider reactions, and treatment outcomes. Similarly, although P-OCD conceptually refers to OCD revolving around obsessions toward prepubescent children, no research has examined whether the same or similar presentation could develop for obsessions involving pubescent or postpubescent minors or whether providers take minor age into account when assigning a P-OCD diagnosis.

Finally, more research should address risk factors for the development of P-OCD. Although several studies have examined risk factors for the development of pedophilic disorder and OCD generally (Brander et al., 2016), none have examined risk factors for the development of P-OCD. Sociodemographic factors such as socioeconomic level, religious background, and education level may be significant risk factors that could potentially lead to the development of P-OCD. Research on the effects of media and Internet exposure may also be helpful in understanding the development of P-OCD and pedophilic disorder.

Summary

The differential between P-OCD and pedophilic disorder may be difficult for many clinicians regardless of experience level. Although any misdiagnosis is problematic, misdiagnosing P-OCD and pedophilic disorder may affect civil and criminal proceedings and outcomes in ways that lead to lifelong negative consequences. In this sense, misdiagnoses are not just problems of assessment and conceptualization but also potentially life-altering problems that perpetuate a cycle of fear and mistrust in clinical care.

Given the dearth of research on the critical diagnostic differential between P-OCD and pedophilic disorder, there is little empirical guidance to aid clinicians through the assessment process. The steps outlined in the scenarios above offer a semi-structured method of performing this diagnostic differential. Although lacking in empirical support, our method may increase clinician awareness of potential misdiagnosis and help protect against perfunctory diagnoses. Increased awareness may also help reduce stigma among clinicians and help avoid unnecessary and harmful negative forensic consequences. By taking these actions, clinicians can increase diagnostic accuracy and treatment effectiveness while reducing harm and building trust in the communities they serve.

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References

Abramowitz, J. S., Deacon, B. J., Olatunji, B. O., Wheaton, M. G., Berman, N. C., Losardo, D., Timpano, K. R., McGrath, P. B., Riemann, B. C., Adams, T., Björgvinsson, T., Storch, E. A., & Hale, L. R. (2010). Assessment of obsessive-compulsive symptom dimensions: Development and evaluation of the Dimensional Obsessive-Compulsive Scale. *Psychological Assessment, 22*(1), 180–198. https://doi.org/10.1037/a0018260

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (Fifth ed.). American Psychiatric Publishing.

Bloch, M., Landeros-Weisenberger, A., Rosario, M., Pittenger, C., & Leckman, J. (2008). Meta-analysis of the symptom structure of obsessive-compulsive disorder. *American Journal of Psychiatry, 165*(12), 1532–1542. https://doi.org/10.1176/appi.ajp.2008.08020320

Brander, G., Pérez-Vigil, A., Larsson, H., & Mataix-Cols, D. (2016). Systematic review of environmental risk factors for obsessive-compulsive disorder: A proposed roadmap from association to causation. *Neuroscience and Biobehavioral Reviews, 65*, 36–62. https://doi.org/10.1016/j.neubiorev.2016.03.011

Brown, T. A., & Barlow, D. H. (2014). *Anxiety and related disorders interview schedule for DSM-5 (AIDS-5)-Adult and lifetime version: Clinical manual*. Oxford University Press.

Bruce, S. L., Ching, T. H., & Williams, M. T. (2018). Pedophilia-themed obsessive–compulsive disorder: Assessment, differential diagnosis, and treatment with exposure and response prevention. *Archives of Sexual Behavior, 47*(2), 389–402. https://doi.org/10.1007/s10508-017-1031-4

Cantor, J. M., & McPhail, I. V. (2016). Non-offending pedophiles. *Current Sexual Health Reports, 8*(3), 121–128. https://doi.org/10.1007/s11930-016-0076-z

Carbino, R. (1991). Advocacy for foster families in the United States facing child abuse allegations: How social agencies and foster parents are responding to the problem. *Child Welfare: Journal of Policy, Practice, and Program, 70*(2), 131–149. PMID: 2036869.

Chow, E. W., & Choy, A. L. (2002). Clinical characteristics and treatment response to SSRI in a female pedophile. *Archives of Sexual Behavior, 31*(2), 211–215. https://doi.org/10.1023/a:1014795321404

Cohen, L. J., & Galynker, I. (2002). Clinical features of pedophilia and implications for treatment. *Journal of Psychiatric Practice, 8*(5), 276–289. https://doi.org/10.1097/00131746-200209000-00004

Cottraux, J., Bouvard, M. A., & Milliery, M. (2005). Combining pharmacotherapy with cognitive-behavioral interventions for obsessive-compulsive disorder. *Cognitive Behaviour Therapy, 34*(3), 185–192. https://doi.org/10.1080/16506070510043750

Cranney, S. (2017). Why did God make me this way? Religious coping and framing in the virtuous pedophile community. *Journal for the Scientific Study of Religion, 56*(4), 852–868. https://doi.org/10.1111/jssr.12480

Elchuk, D. L., McPhail, I. V., & Olver, M. E. (2022). Stigma-related stress, complex correlates of disclosure, mental health, and loneliness in minor-attracted people. *Stigma and Health, 7*, 100-112. https://doi.org/10.1037/sah0000317.supp

Eradicating Child Sexual Abuse (2020). *The Eradicating Child Sexual Abuse (ECSA) Project*. Retrieved from https://www.lucyfaithfull.org.uk/ecsa-project.htm

Fenichel, O. (1946). *The psychoanalytic theory of neurosis*. Routledge.

Fernández de la Cruz, L., Barrow, F., Bolhuis, K., Krebs, G., Volz, C., Nakatani, E., Heyman, I., & Mataix-Cols, D. (2013). Sexual obsessions in pediatric obsessive-compulsive disorder: Clinical characteristics and treatment outcomes. *Depression and Anxiety, 30*(8), 732–740. https://doi.org/10.1002/da.22097

Ferris, T. S., Mills, J. P., & Hanstock, T. L. (2012). Exposure and response prevention in the treatment of distressing and repugnant thoughts and images. *Clinical Case Studies, 11*(2), 140–151. https://doi.org/10.1177/1534650112439240

Foa, E. B., Yadin, E., & Lichner, T. K. (2002). *Exposure and response (ritual) prevention for obsessive-compulsive disorder: Therapist guide* (2nd ed.). Oxford University Press.

Gerwinn, H., Weiß, S., Tenbergen, G., Amelung, T., Födisch, C., Pohl, A., Massau, C., Kneer, J., Mohnke, S., Kärgel, C., Wittfoth, M., Jung, S., Drumkova, K., Schiltz, K., Walter, M., Beier, K. M., Walter, H., Ponseti, J., Schiffer, B., & Kruger, T. H. C. (2018). Clinical characteristics associated with paedophilia and child sex offending—Differentiating sexual preference from offence status. *European Psychiatry, 51*, 74–85. https://doi.org/10.1016/j.eurpsy.2018.02.002

Glazier, K., Calixte, R., Rothschild, R., & Pinto, A. (2013). High rates of OCD symptom misidentification by mental health professionals. *Annals of Clinical Psychiatry, 25*(3), 201–209. PMID: 23926575.

Grady, M. D., Levenson, J. S., Mesias, G., Kavanagh, S., & Charles, J. (2019). 'I can't talk about that': Stigma and fear as barriers to preventive services for minor-attracted persons. *Stigma and Health, 4*(4), 400–410. https://doi.org/10.1037/sah0000154

Hall, R. C., & Hall, R. C. W. (2007). A profile of pedophilia: Definition, characteristics of offenders, recidivism, treatment outcomes, and forensic issues. *Mayo Clinic Proceedings, 82*(4), 457–471. https://doi.org/10.4065/82.4.457

Hofmann, S. G., & Smits, J. A. (2008). Cognitive-behavioral therapy for adult anxiety disorders: A meta-analysis of randomized placebo-controlled trials. *Journal of Clinical Psychiatry, 69*(4), 621–632. https://doi.org/10.4088/jcp.v69n0415

Houston, C., Bala, N., & Saini, M. (2017). Crossover cases of high-conflict families involving child protection services: Ontario research findings and suggestions for good practices. *Family Court Review, 55*(3), 362–374. https://doi.org/10.1111/fcre.12289

Jahnke, S. (2018). The stigma of pedophilia: Clinical and forensic implications. *European Psychologist, 23*(2), 144–153. https://doi.org/10.1027/1016-9040/a000325

Lasher, M. P., & Stinson, J. D. (2017). Adults with pedophilic interests in the United States: Current practices and suggestions for future policy and research. *Archives of Sexual Behavior, 46*(3), 659–670. https://doi.org/10.1007/s10508-016-0822-3

Levenson, J. S., & Grady, M. D. (2019). Preventing sexual abuse: Perspectives of minor-attracted persons about seeking help. *Sexual Abuse: Journal of Research and Treatment, 31*(8), 991–1013. https://doi.org/10.1177/1079063218797713

McGuire, J. F., Storch, E. A., Lewin, A. B., Price, L. H., Rasmussen, S. A., & Goodman, W. K. (2011). The role of avoidance in the phenomenology of obsessive-compulsive disorder. *Comprehensive Psychiatry, 53*(2), 187–194. https://doi.org/10.1016/j.comppsych.2011.03.002

Mokros, A., & Banse, R. (2019). The "Dunkelfeld" project for self-identified pedophiles: A reappraisal of its effectiveness. *Journal of Sexual Medicine, 16*(5), 609–613. https://doi.org/10.1016/j.jsxm.2019.02.009

Moulding, R., Aardema, F., & O'Connor, K. P. (2014). Repugnant obsessions: A review of the phenomenology, theoretical models, and treatment of sexual and aggressive obsessional themes in OCD. *Journal of Obsessive-Compulsive and Related Disorders, 3*(2), 161–168. https://doi.org/10.1016/j.jocrd.2013.11.006

Nielsen, M. H., Aaskov, L., & Larsen, J. E. (2020). When virtuous paedophiles meet online: A sociological study of a paedophile community. *Sexualities*. https://doi.org/10.1177/1363460720979306

Olatunji, B. O., Davis, M. L., Powers, M. B., & Smits, J. A. J. (2013). Cognitive-behavioral therapy for obsessive-compulsive disorder: A meta-analysis of treatment outcome and moderators. *Journal of Psychiatric Research, 47*(1), 33–41. https://doi.org/10.1016/j.jpsychires.2012.08.020

Parr, J., & Pearson, D. (2019). Non-offending minor-attracted persons: Professional practitioners' views on the barriers to seeking and receiving their help. *Journal of Child Sexual Abuse, 28*(8), 945–967. https://doi.org/10.1080/10538712.2019.1663970

Plummer, C. A., & Eastin, J. (2007). The effect of child sexual abuse allegations/investigations on the mother/child relationship. *Violence Against Women, 13*(10), 1053–1071. https://doi.org/10.1177/1077801207305931

Ruscio, A. M., Stein, D. J., Chiu, W. T., & Kessler, R. C. (2010). The epidemiology of obsessive-compulsive disorder in the National Comorbidity Survey Replication. *Molecular Psychiatry, 15*(1), 53–63. https://doi.org/10.1038/mp.2008.94

Schober, J. M., Kuhn, P. J., Kovacs, P. G., Earle, J. H., Byrne, P. M., & Fries, R. A. (2005). Leuprolide acetate suppresses pedophilic urges and arousability. *Archives of Sexual Behavior, 34*(6), 691–705. https://doi.org/10.1007/s10508-005-7929-2

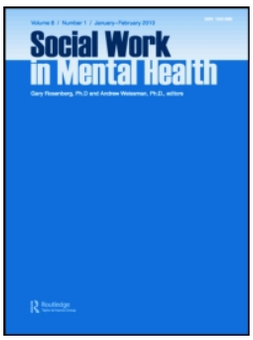
Shields, R. T., Murray, S. M., Ruzicka, A. E., Buckman, C., Kahn, G., Benelmouffok, A., & Letourneau, E. J. (2020). Help wanted: Lessons on prevention from young adults with a sexual interest in prepubescent children. *Child Abuse & Neglect, 105*(6), 104416. https://doi.org/10.1016/j.chiabu.2020.104416

Storch, E. A., Rasmussen, S. A., Price, L. H., Larson, M. J., Murphy, T. K., & Goodman, W. K. (2010). Development and psychometric evaluation of the Yale-Brown Obsessive-Compulsive Scale-second edition. *Psychological Assessment, 22*(2), 223–232. https://doi.org/10.1037/a0018492

Van Horn, J., Eisenberg, M., Nicholls, C. M., Mulder, J., Webster, S., Paskell, C., Brown, A., Stam, J., Kerr, J., & Jago, N. (2015). Stop it now! A pilot study into the limits and benefits of a free helpline

preventing child sexual abuse. *Journal of Child Sexual Abuse, 24*(8), 853–872. https://doi.org/10.1080/10538712.2015.1088914

Williams, M. T., Farris, S. G., Turkheimer, E. N., Franklin, M. E., Simpson, H. B., Liebowitz, M., & Foa, E. B. (2014). The impact of symptom dimensions on outcome for exposure and ritual prevention therapy in obsessive–compulsive disorder. *Journal of Anxiety Disorders, 28*(6), 553–558. https://doi.org/10.1016/j.janxdis.2014.06.001



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Viewing psychopathology through a trauma lens

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ABSTRACT

Many symptoms and behaviors associated with a range of psychiatric disorders, including those not designated as trauma- or stressor-related, result from unprocessed and unintegrated traumatic experiences, requiring therapeutic assessments and interventions that consider the complex dynamics brought on by trauma. While the focus on symptoms in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) may lead practitioners away from a consideration of etiology when choosing interventions, the exclusions of "disorders of extreme stress not otherwise specified" in *DSM-IV* and "developmental trauma disorder" from *DSM-5* may further predispose practitioners to disregard traumatic etiology and symptoms when assessing, diagnosing, and treating clients. Because a majority of recipients of public mental health services suffer deleterious effects from trauma exposure, social work and other mental health professionals have an ethical responsibility to incorporate trauma-based screenings, assessments, and interventions with clients. Thus, trauma-informed evaluation and treatment approaches must be included in graduate curricula, practitioners must seek continuing education to supplement their knowledge and practice skills, and agency administrators must provide inservice training to professional staff.

KEYWORDS

Mental health; psychosocial intervention; social work

The proliferating field of trauma studies indicates that many individuals with psychiatric diagnoses from a range of disorders are exhibiting relational, brain, and body-based symptomatology as a result of trauma (Anda et al., 2006; Chapman, Dube, & Anda, 2007). These individuals' symptoms and functional impairments can mimic those of non-trauma disorders, and can also cut across established diagnostic categories, causing many survivors of trauma to be given diagnoses and treatments that do not address the origins or consequences of trauma.

Exposure to trauma has been associated with a variety of negative outcomes, including identity disturbances, impaired interpersonal relationships, increased health risks, substance abuse, eating disorders, self-mutilation, increased risk for suicide, and increased victimization (Briere, Hodges, & Godbout, 2010). The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*)

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(American Psychiatric Association [APA], 2013a) continues to exclude diagnoses reflective of complex trauma, such as "disorders of extreme traumatic stress not otherwise specified" (DESNOS) and "developmental trauma disorder" (DTD). This omission results in many individuals with severe trauma histories and symptoms, who nonetheless do not fully meet the criteria for a trauma and stressor related disorder, being sorted into any of a number of diagnoses not identified as trauma-related. Such clients often are diagnosed with depressive and bipolar disorders, personality disorders, somatic disorders, disruptive, impulse and conduct disorders, and substance abuse. Many symptoms and functional impairments across a wide range of non-trauma *DSM-5* diagnoses may be reflective of traumatic etiology. The *DSM-5*'s primary focus on symptoms, rather than etiology, may serve to obscure recognition of the salient role of trauma in the development of psychopathology. This may lead clinicians to use interventions that do not address traumatic etiology, but focus instead on decreasing what may appear to be non-trauma symptoms.

The prevalence of trauma exposure and its deleterious effects on brain, body, families, and communities is staggering, with cumulative annual costs estimated to be in excess of $300 billion annually (Dolezal, McCollum, & Callahan, 2009). Ensuring that mental health practitioners are competently trained in trauma assessment and treatment is a professional imperative (Council on Social Work Education [CSWE], 2012). Given that most persons who present themselves to mental health and other social service settings have experienced multiple traumas (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Kilpatrick et al., 2013; Norris, 1992), social workers and other mental health practitioners have an ethical responsibility to incorporate trauma-based assessments and interventions with clients from a wide range of psychiatric diagnosis.

Advanced social work practice in trauma

Recognizing the importance of infusing content on trauma into social work curricula, in 2011, the CSWE commissioned a task force of social work administrators, faculty, and trauma experts to develop a list of competencies and advanced practice skills needed to support trauma-informed social work practice. The final report, posted to the CSWE website in 2012, asserted that social workers, as the predominant service providers for trauma survivors, had ethical obligations to deliver trauma-informed services to individuals and families. Within the scope of its recommendations, the report advised social workers to consider trauma-informed diagnoses that fall outside of the *DSM*, such as complex stress disorder, when assessing and treating clients.

This directive is important because many clients seeking help in public agencies present with histories of severe, complex, relational trauma, or persistent abuse, maltreatment and neglect during child development. In the *DSM-5*, there are no diagnoses providing specifications for symptom

configurations likely to result from such histories, not even under the trauma- and stressor-related disorders (APA, 2013a). As evidenced by their decision not to include DESNOS in *DSM-IV* (APA, 1994; Błaż-Kapusta, 2008; van der Kolk et al., 2005), or developmental trauma disorder in *DSM-5* (APA, 2013a; Bremness & Polzin, 2014; van der Kolk et al., 2009), the two latest *DSM*s failed to legitimize expanded definitions of trauma, despite numerous field trials attesting to the utility and reliability (van der Kolk et al., 2009) of complex trauma diagnoses. This does a severe disservice to the many survivors of complex trauma and the practitioners who treat them. Researchers and clinicians have long recognized the ubiquitous presence of traumatic experience and its deleterious effects on large segments of the population and have pressed for additional DSM trauma diagnoses.

Understanding trauma and its potential consequences

Among trauma specialists, cumulative (Kahn, 1963, 1964) or micro traumas (Crastnopol, 2015), such as suffering repeated humiliation from an elementary school teacher (characterized by some researchers as a non-trauma stress event), as well as those that reflect more traditional definitions of single-incident trauma, such as military combat, catastrophic loss, or sexual assault, can result in persistent posttraumatic symptoms. Moreover, even so-called single incident traumas often precipitate a cascading series of associated traumatic events, each of which is capable of creating additional, discrete, trauma symptomatology.

For example, victims of sexual assault must often endure involvement in a not-so-sympathetic legal system, which requires the administration of rape kits, facing one's attacker in court, and undergoing cross-examination by defense counsel, among other stress-inducing experiences. Combat veterans with posttraumatic stress and/or flashbacks may face inadequate public mental health systems, potentially predisposing them to acts of domestic violence, job loss, prosecution, and the dissolution of their families. Moreover, many individuals with a range of psychiatric diagnoses have experienced or witnessed chronic abuse, neglect, and maltreatment within their primary family relationships (Jonson-Reid, Kohl, & Drake, 2012; Widom, DuMont, & Czaja, 2007).

At the extreme end of the continuum are individuals and families who present with the most difficult-to-treat behaviors and symptoms. While some of these clients may only have experienced single incident and/or vicarious trauma, they are more likely to have undergone prolonged, repeated, and severe abuse and neglect. Often they have suffered maltreatment by attachment figures during early developmental years. These individuals and families are often seen in agency-based and residential treatment settings by front-line mental health and human service workers.

Children who are victimized are at greater risk for committing violence and being held in juvenile and criminal justice facilities (Widom, 1989; Widom & Maxfield, 1996). Exposure to violence and psychological trauma increases the risk of suicide in adolescents (Flannery, Singer, & Wester, 2003) and the development of substance abuse (Felitti et al., 1998; National Child Traumatic Stress Network, 2008) and eating disorders (Root & Fallon, 1988). Findings from a newly completed 30-year longitudinal study revealed that the intergenerational transmission of violence (ITV) from parents to children was more likely to occur with sexual abuse and neglect, while physical abuse was more associated with violence against others, but not against one's own children (Widom, Czaja, & DuMont, 2015).

Even individuals who merely hear about traumatic experiences, such as mental health workers, can suffer from debilitating vicarious or secondary trauma symptoms. In a 2013 study of 253 therapists in the United Kingdom, 70% of workers were found to be at high risk of secondary traumatic stress. Therapists at greatest risk of burnout were younger workers and those who did not feel supported by managers or supervisors. Conversely, maturity, involvement in research and development activities, and greater support by administrators were predictive of higher job satisfaction (Sodeke-Gregson, Holttum, & Billings, 2013).

Individuals who experience traumatic symptomatology may also present themselves to health care settings, due to the proclivity of unprocessed trauma to be expressed in bodily held, somatic experience (van der Kolk, 1994). In addition to psychosomatic presentations, chronic stress and its associated production of neurobiological toxic stress hormones can lead to compromised immune systems, destruction of brain cells, and the breakdown of bodily systems. The over secretion of glucocorticoids, for example, a substance essential for an effective stress response, has been found to compromise plasticity in the hippocampal region of the brain, and is associated with the development of Cushing's disease, major depressive disorder, and posttraumatic stress disorder (PTSD) (Conrad, 2009). Indeed, both single incident and chronic trauma can affect biological systems. The studies of Adverse Childhood Experiences (ACE) have found that childhood events of abuse and emotional trauma are highly correlated with many medical disorders affecting neuroregulatory systems, and may increase risky health behaviors and lead to many of the principle causes of death (Felitti & Anda, 2010; Felitti et al., 1998).

Classification systems for trauma

Terr (1991) proposed that disorders related to trauma be categorized into Type I, resulting from a single traumatic event, and Type II, deriving from severe and persistent relational and developmental trauma, such as physical abuse, neglect

and maltreatment, and poverty. While individuals with Type I disorders often meet the criteria for PTSD, and PTSD often co-occurs with other disorders, such as depressive and anxiety disorders (Briere & Scott, 2015), there is currently no diagnosis that encompasses Type II traumas.

Moreover, while severe abuse and maltreatment can lead to a diagnosis of dissociative identity disorder (DID), the most common presentations for survivors of complex trauma are dissociative disorders without full amnesia between personified self-states or borderline personality disorder (BPD). Many also meet criteria for several other diagnoses, including schizophrenia, bipolar disorder, anxiety disorders, depressive disorders, PTSD, and substance abuse. When clinicians do not have training in assessing and treating trauma, they often apply one or more of these diagnoses and neglect to treat the trauma.

Critics of the current *DSM-5* (APA, 2013a) nomenclature argue that no existing diagnoses identify adequately or lead to treatments that address comprehensively the serious and debilitating symptoms associated with complex trauma, which include the panoply of dissociation, affect dysregulation, attention difficulties, somatization (van der Kolk, Pelcovitz, Roth, Mandel, & McFarlane, & Herman, 1996), dysfunctional avoidance, (Briere et al., 2010), identity disturbance, and relational issues (Pearlman & Courtois, 2005). The specification of dissociative subtype within the *DSM-5* diagnosis of PTSD, which includes either derealization or depersonalization symptoms (APA, 2013a p. 272), begins to approach a diagnostic construct of Complex PTSD, but more research is required for the creation of a separate diagnosis (Courtois, 2013).

A diagnostic construct for extreme stress

DSM diagnoses have not always coincided with actual client presentations in clinical practice. This has led trauma researchers and practitioners to develop and use alternate diagnostic constructs that have greater clinical utility. For example, the proposed DESNOS diagnosis, derived through an extensive *DSM-IV* field trial by a PTSD subcommittee, did not make it into *DSM-IV*, but, practitioners, due to its clinical utility, incorporated it into use (Błaż-Kapusta, 2008; van der Kolk et al., 2005). Eventually, DESNOS was included in *DSM-IV* "under the rubric of associated and descriptive features of PTSD (APA, 1994, p. 425)" (van der Kolk et al., 2005, p. 396).

van der Kolk et al. (2005) explained that "the DESNOS construct, although still a work in progress, is an attempt to capture the multidimensional [i.e., 'disturbances in perception, information processing, affect regulation, impulse control, and personality development'] nature of breakdown of adaptation in the face of trauma" (p. 366). Herman (1992) earlier coined the term complex posttraumatic stress disorder to describe the same phenomena.

Developmental trauma disorder

In the years leading to the development of *DSM-5*, trauma researchers pressed again for the inclusion of a new diagnosis, DTD, for persons with a history of chronic and repeated interpersonal and developmental trauma. Despite providing data sets from thousands of children to support DTD's predictive and clinical utility, prevalence, and the reliability of its diagnostic criteria (Bremness & Polzin, 2014; van der Kolk et al., 2005), the scholars' efforts were ultimately rebuked by the *DSM-5* leadership (van der Kolk et al., 2009). Some reasons for DTD's non-inclusion in *DSM-5* have been attributed to: (a) an over reliance on cross-sectional studies; (b) a focus on etiology, which does not conform to current DSM or International Classification of Disorders descriptive classification systems; and (c) insufficient consideration of biological and genetic variables or comorbid diagnoses (Schmid, Petermann, & Fegert, 2013).

The continuing absence of a diagnosis for interpersonal and developmental trauma increases the likelihood that many children will fall through the cracks, and receive either no diagnosis and no treatment, or an inaccurate diagnosis and the wrong treatment. Without a comprehensive trauma assessment and appropriate interventions, these children are at risk of becoming adults with poor health and mental health outcomes, and a greater likelihood of incarceration or homelessness (Larkin, Fellitti, & Anda, 2014).

The long road to *DSM-5*

The development of *DSM-5* was protracted, stretching over the course of 14 years, and also controversial, eliciting obstreperous critique from all quarters. Critics charged that meetings were conducted in secret and lacked transparency. The task force responded by allowing public discourse on proposed changes, ostensibly to create a more democratizing process. Others alleged rampant conflicts of interest among task force members, many of whom had ties to pharmaceutical companies. The APA Board of Trustees responded by disqualifying some task force members with industry ties. Nonetheless, in the end, 69% of task force members with ties to industry remained (Cosgrove & Krimsky, 2012).

Allen Frances, chair of the *DSM-IV* task force, and Tom Insel, former director of the National Institute of Mental Health (NIMH) were two of *DSM-5*'s most ardent and venerable detractors. Frances (2012, 2013) objected to the *DSM-5*'s extreme overreach in medicalizing normal human experience, such as by eliminating the bereavement exclusion in Major Depression. Frances (2012) also charged that because the *DSM* was a bestseller and huge profit maker for APA, they rushed to publication before undertaking the final field-testing procedures that would have provided quality controls.

Moreover, the APA refused to heed a petition from "more than 50 mental health professional associations" who had demanded an outside review of *DSM-5* in order "to provide an independent judgment of its supporting evidence and to evaluate the balance between its risks and benefits" (Frances, 2012, p. 1). Frances advised clinicians to ignore, or, at the very least, employ with extreme caution a number of diagnostic additions included in *DSM-5*.

Initially, Insel went so far as to reject entirely the *DSM-5* as a basis for National Institute of Mental Health (NIMH)-funded research (NIMH, 2013). He alleged that current diagnostic classification systems are symptom-based and imprecise and obviate the development of research studies that either identify etiology or translate into effective clinical interventions. Indeed, instead of using *DSM-5* diagnoses as a basis for funded research, Insel directed NIMH to institute the new Research Domain Criteria (RDoC) Project "to transform diagnosis by incorporating genetics, imaging, cognitive science, and other levels of information to lay the foundation for a new classification system" (NIMH, 2013).

According to Insel, the RDoC Project would fund studies that cut across accepted diagnostic categories or developed sub-categories, in order to create a more precise diagnostic system with better outcomes. Interestingly, 1 month later, in an apparent effort to quell sensationalized media and public reaction to his statements, both he and APA president Jeffrey A. Lieberman, *DSM-5*'s cosponsors, issued a joint statement, which characterized the RDoC project and *DSM-5* as complementary (APA, 2013b). Nonetheless, since that time and despite Insel's disclaimer to the contrary, the RDoC Project operates as originally conceived; that is, "to develop a more precise diagnostic system."

In addition to disallowing a diagnosis for DTD, *DSM-5* continues to be based on symptom cluster prevalence. This is expedient for a common international language and useful for epidemiological purposes, but a predominant focus on symptoms sheds little light on etiology. Thus, the current diagnostic system may still lend itself to psychopharmacologic and evidence-based practice approaches that favor symptom reduction as the sine qua non of sound clinical practice, rather than developing more sociocultural and neurobiological theories of mind (Castiglioni & Laudisa, 2015). Critics of *DSM* charge that the classification system, in its reliance on categorical and dimensional aspects of mental disorders, inherently ignores the dynamic roles played by genetics, development, attachment, environment, culture, neuroscience, plasticity, and systems theory in shaping mental illness and resilience (Bremness & Polzin, 2014; Carrey, 2008; Carrey & Gregson, 2008). Also, the greatly expanded number of psychiatric diagnoses in *DSM-5*

provides a growing market for pharmaceutical companies eager to expand their customer base (Frances, 2013). Moreover, at least twice, trauma researchers have tried unsuccessfully to convince the DSM leadership to include diagnoses that are inclusive of severe and persistent trauma—DESNOS and DTD.

Recognizing traumatic symptomatology among a range of disorders in *DSM-5*

The failure of *DSM-5* to acknowledge traumatic etiology among diagnoses other than Trauma and Stress–Related Disorders may predispose those mental health practitioners who are not adequately trained to underestimate the effects of trauma and not recognize its symptomatic and behavioral manifestations in a wide range of diagnoses. For example, emotional lability, a diagnostic criterion of BPD, may reflect oscillating states of hyper- and hypo-arousal emanating from prolonged traumatic stress (Howell & Blizard, 2009), while auditory hallucinations, a diagnostic criterion of schizophrenia, may reflect dissociated identities indicative of DID (Ross, 2014; Schafer et al., 2012). Without knowledge of trauma and its effects, social workers and other professionals may misdiagnose individuals and provide treatments that do not address traumatic etiology and that may even exacerbate symptoms.

The introduction to *DSM-5* notes that numerous studies on comorbidity and disease transmission have found that the boundaries between many disorder categories are more fluid than *DSM-IV* recognized, and that many symptoms assigned to a single disorder may occur across many other disorders (APA, 2013a). However, *DSM-5* classifications have not provided sufficient ways to introduce dimensional approaches to mental disorders that cut across current categories. The *DSM-5* supplements the explicit diagnostic criteria with a brief digest of information about risk factors, associated features, research advances, and various expressions of the disorder, in order to fulfill the needs of clinicians and patients (APA, 2013a). In light of these caveats, cross-references to diagnoses that are either closely related, or are unrelated but have similarities in symptoms, are sorely lacking in many sections.

For example, there is an extensive literature on trauma as a risk factor, if not a primary cause, in many disorders not included within the category of Trauma- and Stressor-Related Disorders, notably, the schizophrenia spectrum (Moskowitz, Read, Farrelly, Rudegeair, & Williams, 2009; Read, van Os, Morrison, & Ross, 2005; Schafer et al., 2012), dissociative disorders (van der Kolk et al., 1996), BPD (Ball & Links, 2009; Golier et al., 2003; van der Kolk,

Hostetler, Herron, Fisler, 1994), somatic disorders (van der Kolk et al., 1996), and substance abuse (Khoury, Tang, Bradley, Cubells, & Ressler, 2010; Somer, 2009). There is also evidence for trauma as a risk factor in some diagnoses under the following categories of disorders: bipolar, depressive, and anxiety (Gilman, Ni, Breslau, McLaughlin, Smoller, & Perlis, 2015; Heim & Nemeroff, 2001); feeding and eating (Connors & Morse, 1993); sexual dysfunction (Maltz, 2002); paraphilia (Arrigo & Purcell, 2001; Bollas, 1995); impulse-control and conduct disorders (Widom & Maxfield, 1996); and personality disorders (Afifi et al., 2011; Tyrka, Wyche, Kelly, Price, & Carpenter, 2009). Moreover, there is significant overlap among the symptoms of dissociative disorders and schizophrenia (Kluft, 1987; Read, van Os, Morrison, & Ross, 2005; Ross, 2014; Ross et al., 1990).

Admittedly, the *DSM-5* sections on trauma- and stressor-related disorders and dissociative disorders have been significantly updated, with detailed descriptions of symptoms and risk factors, as well as comparisons with a wide variety of other disorders under differential diagnosis. For example, within Dissociative Disorders, there is a detailed section on differential diagnosis of DID that considers major depressive disorder, bipolar disorders, PTSD, psychotic disorders, personality disorders, conversion, psychogenic seizures, substance/medication induced disorders, and malingering or factitious disorders (APA, 2013a, pp. 297–297), but the same cautions for making the distinctions do not appear under bipolar and related disorders or depressive disorders.

Likewise, the importance of distinguishing flashbacks from the illusions, hallucinations, and perceptual disturbances seen in schizophrenia is discussed under PTSD (APA, 2013a, p. 279), and the relationship of these symptoms to a traumatic event is detailed under acute stress disorder (p. 286). However, within the section on schizophrenia spectrum and other psychotic disorders, there is no reference to the possibility of hallucinations being posttraumatic flashbacks, except under brief psychotic disorder where specification of whether there have been marked stressors is required (p. 94), and there is no discussion of how it compares with acute stress disorder under differential diagnosis.

This absence is striking in light of the literature on the heightened prevalence of trauma in the histories of persons with schizophrenia spectrum disorders (Moskowitz et al., 2009; Read et al., 2005; Schafer et al., 2012). A study of outpatients diagnosed with severe mental illness, primarily schizophrenia and schizoaffective disorder, found that the content of the subjects' delusions and hallucinations was based on traumatic events in their lives (Muenzenmaier et al., 2015; Reiff, Castille, Muenzenmaier, & Link, 2012).

There is also no acknowledgment in *DSM-5* about the significance of trauma in the histories of persons with BPD, despite an extensive literature demonstrating the history of chronic trauma, especially relational trauma, in the majority of persons diagnosed with BPD (Freyd, DePrince, & Zurbriggen, 2001; Kaehler & Freyd, 2009; McLean & Gallop, 2003; Silk, Nigg, Westen, & Lohr, 1997; Yen et al., 2002; Zanarini, Ruser, Frankenburg, Hennen, & Gunderson, 2000). Also, none of the understanding of how chronic trauma can affect mood, affect dysregulation, instability of identity, self-image, and ability to maintain relationships has been applied to the section on borderline personality, despite the discussion of these effects under PTSD in the *DSM-5* (APA, 2013a). Moreover, authors have argued for years, long before DSM-IV was published, that borderline personality might be better described by new diagnostic terms such as complex trauma disorder (Davies & Frawley, 1994; Freyd et al., 2001; Herman, 1992; Herman & van der Kolk, 1987; Kroll, 1993; McLean & Gallop, 2003; Ross, 1989; Terr, 1994; van der Kolk, 1996) or chronic relational trauma disorder (Howell & Blizard, 2009).

Other disorders may have a clear neurological basis, but the symptom picture may closely resemble posttraumatic symptoms. Without a careful guide for differential diagnosis, along with asking about a trauma history, some clinicians may mistake posttraumatic hyperarousal, distractibility, difficulty concentrating, and explosive anger for attention deficit hyperactivity disorder. Major depression is common among persons suffering from posttraumatic stress or dissociative disorders. Without inquiring about a trauma history, it may be treated solely as a biological disorder, eclipsing appropriate trauma treatment. Less common diagnostic mistakes occur when a person with BPD or DID has a self-state with flat affect that could be characterized as zombie-like or "soldiering on." The clinician may assume they are on the autism spectrum if other, more flexible, emotional self-states have not been observed.

Assessing for trauma histories in children and adults

Mental health students and practitioners need to be trained and supported in the use of trauma assessments in order to identify the presence of a trauma etiology with persons from a wide range of *DSM-5* diagnoses. For example, The National Child Traumatic Stress Network (NCTS) recommends a step-wise assessment process for ascertaining the presence of complex stress. These assessment steps included:

- Assess for a wide range of traumatic events. Determine when they occurred so that they can be linked to developmental stages.
- Assess for a wide range of symptoms (beyond PTSD), risk behaviors, functional impairments, and developmental derailments.

- Gather information using a variety of techniques (clinical interviews, standardized measures, and behavioral observations.
- Gather information from a variety of perspectives (child, caregivers, teachers, other providers, etc.).
- Try to make sense of how each traumatic event might have impacted developmental tasks and derailed future development. Note: this may be challenging given the number of pervasive and chronic traumatic events a child may have experienced throughout his or her young life.
- Try to link traumatic events to trauma reminders that may trigger symptoms or avoidant behavior. Remember that trauma reminders can be remembered both in explicit memory and out of awareness in the child's body and emotions (NCTS, n.d.).

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), in their comprehensive report entitled "A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services," offered a list of recommendations to workers when conducting trauma assessments with adults. These recommendations included:

- Ask all clients about any possible history of trauma; use a checklist to increase proper identification of such a history (see the online Adverse Childhood Experiences Study Score Calculator [http://acestudy.org/ace_score] for specific questions about adverse childhood experiences).
- Use only validated instruments for screening and assessment.
- Early in treatment, screen all clients who have histories of exposure to traumatic events for psychological symptoms and mental disorders related to trauma.
- When clients screen positive, also screen for suicidal thoughts and behaviors.
- Do not delay screening; do not wait for a period of abstinence or stabilization of symptoms.
- Be aware that some clients will not make the connection between trauma in their histories and their current patterns of behavior (e.g., alcohol and drug use and/or avoidant behavior).
- Do not require clients to describe emotionally overwhelming traumatic events in detail.
- Focus assessment on how trauma symptoms affect clients' current functioning.
- Consider using paper-and-pencil instruments for screening and assessment as well as self-report measures when appropriate; they are less threatening for some clients than a clinical interview.[1]

[1]Some clients with histories of severe, chronic trauma may be greatly triggered by paper-and-pencil instruments. To guard against their being flooded with traumatic memories when they are at home alone, these assessments may be better administered in the office, preferably just before a therapy session.

- Talk about how you will use the findings to plan the client's treatment, and discuss any immediate action necessary, such as arranging for interpersonal support, referrals to community agencies, or moving directly into the active phase of treatment. It is helpful to explore the strategies clients have used in the past that have worked to relieve strong emotions.
- At the end of the session, make sure the client is grounded and safe before leaving the interview room. Readiness to leave can be assessed by checking on the degree to which the client is conscious of the current environment, what the client's plan is for maintaining personal safety, and what the client's plans are for the rest of the day (SAMHSA, 2014, p. 77).

In addition to recommending the Life Events Checklist (LEC) as a self-administered questionnaire to identify a trauma history, SAMHSA and the Health Services Research Administration (HSRA) also recommend the use of additional self-administered trauma questionnaires, such as the Abbreviated PTSD checklist, Civilian Version (PCL-C) (Lang & Stein, 2005), and the Trauma History Questionnaire (THQ) (Green, 1996; SAMHSA-HRSA, n.d.). The International Society for Traumatic Stress Studies (ISTSS) recommended additional assessment tools, including the Acute Stress Checklist for Children (Kassam-Adams, 2006), the Child PTSD Symptom Scale (Foa, Johnson, Feeny, & Treadwell, 2001), the UCLA Post-Traumatic Stress Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004), and the Acute Stress Disorder Structured Interview (ASDI) (Bryant, Harvey, Dang, & Sackville, 1998; International Society for Traumatic Stress Studies, n.d.).

Implications for research, education, and practice

Over the past three decades, there has been renewed interest among researchers, educators, and practitioners in understanding the role of trauma in the developmental trajectory of psychopathology. In addition to approaches that have been used effectively for single incident traumas for many years, including eye movement desensitization and reprocessing (EMDR) (Shapiro, 2001), cognitive processing therapy (Resick & Schnicke, 1992), prolonged exposure therapy (Foa et al., 1992), and trauma focused cognitive behavioral therapy (Cohen, Mannarino, Berliner, & Deblinger, 2000), there are several other promising approaches that continue to amass evidence for their effectiveness for complex stress disorder and are in use now by many trauma therapists. These approaches include internal family systems therapy (Schwartz, 1995), emotion focused therapy (Greenberg, 2011), accelerated experiential dynamic psychotherapy (Fosha, 2002), and transference-focused psychotherapy (Kernberg, Yeomans, Clarkin, & Levy, 2008).

The International Society for Traumatic Stress Studies (ISTSS) commissioned a report to identify best practice guidelines for complex PTSD in adults (Cloitre et al., 2012). The guidelines, which were developed in part through the administration of an "Expert Clinical Survey on Best Practices" (Cloitre et al., 2011) to 50 trauma experts, determined that a patient centered, three-phase approach to trauma treatment was preferred as "a first line treatment for Complex PTSD" (Cloitre et al., 2012, p. 3). In addition to specifying that interventions be targeted to specific trauma symptomatology, this approach follows a sequential focus on: (a) safety, stabilization, and self management skills; (b) processing and integrating past traumatic experiences; and (c) consolidation of gains and preparation to live in the world posttraumatic symptomatology (Chu, 2011; Courtois & Ford, 2012; Gold, 2000; van der Hart, Nijenhuis, & Steele, 2006).

In addition to fostering familiarity with evidence-based, promising approaches, and best practices for treating single incident and complex trauma, social work and other mental health faculty should work toward incorporating trauma-informed competencies into syllabi for all advanced practice courses, especially required courses, as recommended by CSWE's call for the inclusion of trauma content in social work curricula. Otherwise, graduate students preparing to work in mental health and other social service settings will not learn the necessary skills for conducting trauma-informed assessments with all clients.

Given that *DSM-5* seriously underestimates the significance of traumatic etiology in a wide range of diagnoses, it is incumbent on social work and other mental health practitioners to supplement *DSM-5* diagnostic procedures with trauma-informed assessments and interventions. Thus, practitioners should seek continuing education opportunities to ensure that they will be competently trained to assess and treat the effects of trauma. Administrators in human and social service agencies should also consider providing trauma-informed inservice training for professional staff. These recommendations are especially crucial given the fact that a vast majority of clients presenting to public agencies have been exposed to multiple episodes of trauma (Norris, 1992; Kilpatrick et al., 2013).

References

Afifi, T. O., Mather, A., Boman, J., Fleisher, W., Enns, M. W., MacMillan, H., & Sareen, J. (2011). Childhood adversity and personality disorders: Results from a nationally representative population-based study. *Journal of Psychiatric Research*, *45*(6), 814–822. doi:10.1016/j.jpsychires.2010.11.008

American Psychiatric Association (APA). (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Alexandria, VA: Author.

American Psychiatric Association (APA). (2013a). *Diagnostic and statistical manual of mental disorders* (5th ed.). Alexandria, VA: Author.

American Psychiatric Association (APA). (2013b). *Psychiatric news alert: Lieberman, Insel issue joint statement about DSM-5 and RDoC*. Retrieved from http://alert.psychnews.org/2013/05/lieberman-insel-issue-joint-statement.html

Anda, R. F., Felitti, V. J., Walker, J., Whitfield, C. L., Bremner, J. D., Perry, B. D., … Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neurosciences*, *56*(3), 174–186. doi:10.1007/s00406-005-0624-4

Arrigo, B. A., & Purcell, K. (2001). Explaining paraphilias and lust murder: Toward an integrated model. *International Journal of Offender Therapy and Comparative Criminology*, *45*(1), 6–31. doi:10.1177/0306624x01451002

Ball, J. S., & Links, P. S. (2009). Borderline personality disorder and childhood trauma: Evidence for a causal relationship. *Current Psychiatry Reports*, *11*(1), 63–68. doi:10.1007/s11920-009-0010-4

Błaż-Kapusta, B. (2008). Disorders of extreme stress not otherwise specified (DESNOS)—A case study. *Archives of Psychiatry and Psychotherapy*, *2*, 5–11. doi:10.3325/cmj.2011.52.505

Bollas, C. (1995). *Cracking up: The work of unconscious experience*. London, England: Routledge.

Bremness, A., & Polzin, W. (2014). Commentary: Development trauma disorder: A missed opportunity in *DSM-5*. *Journal of Canadian Academy of Child Adolescent Psychiatry*, *23*(2), 142–145.

Briere, J., Hodges, M., & Godbout, N. (2010). Traumatic stress, affect dysregulation, and dysfunctional avoidance: A structural equation model. *Journal of Traumatic Stress*, *23*(6), 767–774. doi:10.1002/jts.20578

Briere, J., & Scott, C. (2015). *Trauma treatment: A guide to symptoms, evaluation and treatment* (2nd ed.). Thousand Oaks, CA: Sage.

Bryant, R. A., Harvey, A. G., Dang, S. T., & Sackville, T. (1998). Assessing acute stress disorder: Psychometric properties of a structured clinical interview. *Psychological Assessment*, *10*, 215–220. doi:10.1037/1040-3590.10.3.215

Carrey, N. (2008). Guest editorial: Classification in child psychiatry. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *17*(2), 49.

Carrey, N., & Gregson, J. (2008). A context for classification in child psychiatry. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *17*(2), 50–57.

Castiglioni, M., & Laudisa, F. (2015). Toward psychiatry as a 'human'science of mind: The case of depressive disorders in *DSM-5*. *Frontiers of Psychology*, *5*, 2–12. doi:10.3389/fpsyg.2014.01517

Chapman, D. P., Dube, S. R., & Anda, R. F. (2007). Adverse childhood events as risk factors for negative mental health outcomes. *Psychiatric Annals*, *37*(5), 359–364. doi:10.1176/appi.ps.53.8.1001

Chu, J. A. (2011). *Rebuilding shattered lives: The responsible treatment of complex post-traumatic and dissociative disorders*. New York, NY: John Wiley & Sons.

Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. *Journal of Traumatic Stress*, *24*, 615–627. doi:10.1002/jts.20697

Cloitre, M., Courtois, C. A., Ford, J. D., Green, B. L., Alexander, P., Briere, J., … Van Der Hart, O. (2012). *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults*. Retrieved from https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf

Cohen, J. A., Mannarino, A. P., Berliner, L., & Deblinger, E. (2000). Trauma-focused cognitive behavioral therapy for children and adolescents: An empirical update. *Journal of Interpersonal Violence*, *15*(11), 1202–1223. doi:10.1177/088626000015011007

Connors, M. E., & Morse, W. (1993). Sexual abuse and eating disorders: A review. *International Journal of Eating Disorders*, *13*, 1–11. doi:10.1002/1098-108x(199301)13:1<1::aid-eat2260130102>3.0.co;2-p

Conrad, C. (2009). Chronic stress-induced hippocampal vulnerability: The glucocorticoid vulnerability hypothesis. *Reviews in the Neurosciences*, *19*(6), 395–411. doi:10.1515/revneuro.2008.19.6.395

Cosgrove, L., & Krimsky, S. (2012). A comparison of *DSM*-IV and *DSM-5* panel members' financial associations with industry: A pernicious problem persists. *PLOS Medicine*, *9*(3), e1001190. doi:10.1371/journal.pmed.1001190

Council on Social Work Education (CSWE). (2012). *Advanced trauma in social work practice*. Retrieved from http://www.cswe.org/File.aspx?id=63842

Courtois, C. (2013). *PTSD in the DSM-5. The annual meeting of the international society for the study of trauma and dissociation*. Retrieved from http://www.isstd.org/downloads/AnnualConference/2013/Courtois_PTSDintheDSM-5.pdf

Courtois, C. A., & Ford, J. D. (2012). *Treatment of complex trauma: A sequenced, relationship-based approach*. New York, NY: Guilford Press.

Crastnopol, M. (2015). *Micro traumas: A psychoanalytic understanding of cumulative psychic injury*. New York, NY: Routledge.

Davis, J. M., & Frawley, M. G. (1994). *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective*. New York, NY: Basic Books.

Dolezal, T., McCollum, D., & Callahan, M. (2009). *Hidden costs in healthcare: The economic impact of violence and abuse*. Eden Prairie, MN: Academy on Violence and Abuse.

Felitti, V. J., & Anda, R. F. (2010). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behavior: Implications for healthcare. In R. A. Lanius, E. Vermetten, & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic* (pp. 77–87). Cambridge, UK: Cambridge University Press.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., … Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine*, *14*(4), 245–258. doi:10.1016/s0749-3797(98)00017-8

Flannery, D. J., Singer, M. I., & Wester, K. (2003). Violence, coping, and mental health in a community sample of adolescents. *Violence and Victims*, *18*, 403–418. doi:10.1891/vivi.2003.18.4.403

Foa, E. B., Dancu, C. V., Hembree, E. A., Jaycox, L. H., Meadows, E. A., & Street, G. B. (1992). A comparison of exposure therapy, stress inoculation training, and their combination for reducing post traumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology*, *67*(2), 192–200. doi:10.1037/0022-006x.67.2.194

Foa, E. B., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. H. (2001). The child PTSD symptom scale (CPSS): A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology*, *30*, 376–384. doi:10.1207/s15374424jccp3003_9

Fosha, D. (2002). *The transforming power of affect: A model for accelerated change*. New York, NY: Basic Books.

Frances, A. (2012). *DSM-5* is a guide, not a bible: Simply ignore its 10 worst changes. *Huffington Post*. Retrieved from http://www.huffingtonpost.com/allen-frances/DSM-5_b_2227626.html

Frances, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma, and the medicalization of ordinary life*. New York, NY: Harper Collins.

Freyd, J. J., DePrince, A. P., & Zurbriggen, E. L. (2001). Self-reported memory for abuse depends upon victim-perpetrator relationship. *Journal of Trauma & Dissociation*, *2*(3), 5–17. doi:10.1300/j229v02n03_02

Gilman, S. E., Ni, M. Y., Breslau, J., McLaughlin, K. A., Smoller, J. W., & Perlis, R. H. (2015). Contributions of the social environment to first-onset and recurrent mania. *Molecular Psychiatry*, *20*, 329–336. doi:10.1038/mp.2014.36

Gold, S. N. (2000). *Not trauma alone: Therapy for child abuse survivors in family and social context*. Philadelphia, PA: Brunner-Routledge.

Golier, J. A., Yehuda, R., Bierer, L. M., Mitropoulou, V., New, A. S., Schmeidler, J., … Siever, L. J. (2003). The relationship of borderline personality disorder to posttraumatic stress disorder and traumatic events. *American Journal of Psychiatry*, *160*, 2018–2024. doi:10.1176/appi.ajp.160.11.2018

Green, B. L. (1996). Trauma history questionnaire. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 366–369). Lutherville, MD: Sidran Press.

Greenberg, L. S. (2011). *Emotion focused therapy*. Washington, DC: American Psychological Association.

Heim, C., & Nemeroff, C. B. (2001). The role of childhood trauma in the neurobiology of mood and anxiety disorders: Preclinical and clinical studies. *Biologic Psychiatry*, *49*, 1023–1039. doi:10.1016/s0006-3223(01)01157-x

Herman, J. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, *5*(3), 377–391. doi:10.1007/bf00977235

Herman, J. L., & van der Kolk, B. A. (1987). Traumatic antecedents of borderline personality disorder. In B. A. van der Kolk (Ed.), *Psychological trauma* (pp. 111–126). Washington, DC: American Psychiatric Press.

Howell, E. F., & Blizard, R. A. (2009). Chronic relational trauma: Toward a new diagnostic scheme for borderline personality and the spectrum of dissociative disorders. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 495–510). New York, NY: Routledge.

International Society for Traumatic Stress Studies. (n.d.). *Assessing trauma*. Retrieved from http://www.istss.org/assessing-trauma.aspx

Jonson-Reid, M., Kohl, P. L., & Drake, B. (2012). Child and adult outcomes of chronic child maltreatment. *Pediatrics*, *129*(5), 839–845. doi:10.1542/peds.2011-2529

Kaehler, L. A., & Freyd, J. J. (2009). Borderline personality characteristics: A betrayal trauma approach. *Psychological Trauma: Theory, Research, Practice and Policy*, *1*(4), 261–268. doi:10.1037/a0017833

Kahn, M. (1963). The concept of cumulative trauma. *Psychoanalytic Study of the Child*, *18*, 283–206.

Kahn, M. (1964). Ego distortion, cumulative trauma and the role of reconstruction in the analytic situation. *International Journal of Psychoanalysis*, *45*, 272–279.

Kassam-Adams, N. (2006). The acute stress checklist for children (ASC-Kids): Development of a child self-report measure. *Journal of Traumatic Stress*, *19*(1), 129–139. doi:10.1002/(ISSN)1573-6598

Kernberg, O. F., Yeomans, F. E., Clarkin, J. F., & Levy, K. N. (2008). Transference focused psychotherapy: Overview and update. *The International Journal of Psychoanalysis*, *89*, 601–620. doi:10.1111/j.1745-8315.2008.00046.x

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, *52*, 1048–1060. doi:10.1001/archpsyc.1995.03950240066012

Khoury, L., Tang, Y. L., Bradley, B., Cubells, J. F., & Ressler, K. J. (2010). Substance use, childhood traumatic experience, and posttraumatic stress disorder in an urban civilian population. *Depression and Anxiety*, *27*(12), 1077–1086. doi:10.1002/da.20751

Kilpatrick, D., Resnick, H. S., Milanak, M. E., Miller, M. W., Keys, K. M., & Friedman, M. J. (2013). National estimates of exposure to potentially traumatic events and PTSD prevalence using DSM-IV and *DSM-5* criteria. *Journal of Traumatic Stress*, *26*, 537–547. doi:10.1002/jts.21848

Kluft, R. P. (1987). First–rank symptoms as a diagnostic clue to multiple personality disorder. *American Journal of Psychiatry*, *144*(3), 293–298. doi:10.1176/ajp.144.3.293

Kroll, J. (1993). *PTSD/borderlines in therapy*. New York, NY: W. W. Norton & Co.

Lang, A. J., & Stein, M. B. (2005). An abbreviated PTSD checklist for use as a screening instrument in primary care. *Behaviour Research and Therapy*, *43*, 585–594. doi:10.1016/j.brat.2004.04.005

Larkin, H., Fellitti, V. J., & Anda, R. F. (2014). Social work and adverse childhood experiences research: Implications for practice and health policy. *Social Work Public Health*, *29*(1), 1–16. doi:10.1080/19371918.2011.619433

Maltz, W. (2002). Treating the sexual intimacy concerns of sexual abuse survivors. *Sexual and Relationship Therapy*, *17*(4), 321–327. doi:10.1080/1468199021000017173

McLean, L. M., & Gallop, R. (2003). Implications of childhood sexual abuse for adult borderline personality disorder and complex posttraumatic stress disorder. *American Journal of Psychiatry*, *160*(2), 369–371. doi:10.1176/appi.ajp.160.2.369

Moskowitz, A. K., Read, J., Farrelly, S., Rudegeair, T., & Williams, O. (2009). Are psychotic symptoms traumatic in origin and dissociative in kind? In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 521–533). New York, NY: Routledge.

Muenzenmaier, K. H., Seixas, A. A., Schneeberger, A. R., Castille, D. M., Battaglia, J., & Link, B. G. (2015). Cumulative effects of stressful childhood experiences on delusions and hallucinations. *Journal of Trauma & Dissociation*, *16*, 442–462. doi:10.1080/15299732.2015.1018475

National Child Traumatic Stress Network (NCTS). (n.d.). *How to conduct a comprehensive assessment of complex trauma*. Retrieved from http://www.nctsn.org/trauma-types/complex-trauma/assessment

National Institute on Mental Health (NIMH). (2013). *Transforming diagnosis: Director's blog*. Retrieved from http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtm

National Child Traumatic Stress Network. (2008). *Making the connection: Trauma and substance abuse*. Retrieved from http://www.nctsn.org/products/making-connection-trauma-and-substance-abuse-2008

Norris, F. H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology*, *60*(3), 409–418. doi:10.1037/0022-006x.60.3.409

Pearlman, L. A., & Courtois, C. A. (2005). Clinical application of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress*, *18*, 449–459. doi:10.1002/jts.20052

Read, J., van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, *112*, 330–350. doi:10.1111/j.1600-0447.2005.00634.x

Reiff, M., Castille, D. M., Muenzenmaier, K., & Link, B. (2012). Childhood abuse and the content of adult psychotic symptoms. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(4), 356–369. doi:10.1037/a0024203

Resick, P. A., & Schnicke, M. K. (1992, Oct 1992). Cognitive processing therapy for sexual assault victims, *Journal of Consulting and Clinical Psychology*, *60*(5), 748–756. doi:10.1037/0022-006x.60.5.748

Root, M. P., & Fallon, P. (1988). The incidence of victimization experiences in a bulimic sample. *Journal of Interpersonal Violence*, *3*, 161–173. doi:10.1177/088626088003002003

Ross, C. A. (1989). *Multiple personality disorder: Diagnosis, clinical features and treatment*. New York, NY: Wiley.

Ross, C. A. (2014). Dissociation in classical texts on Schizophrenia. *Psychosis*, *6*, 342–354. doi:10.1080/17522439.2013.806570

Ross, C. A., Miller, S. D., Reagor, P., Bjornson, L., Fraser, G., & Anderson, G. (1990). Schneiderian symptoms in multiple personality disorder and schizophrenia. *Comprehensive Psychiatry*, *31*, 111–118. doi:10.1016/0010-440x(90)90014-j

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *A treatment improvement protocol: Trauma-informed care in behavioral health services*. Retrieved from http://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.pdf

Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration (SAMHSA-HRSA). (n.d.). *Screening* tools. Retrieved from http://www.integration.samhsa.gov/clinical-practice/screening-tools#TRAUMA

Schafer, I., Fisher, H. L., Aderhold, V., Huber, B., Hoffman-Langer, L., Golks, D., … Harfst, T. (2012). Dissociative symptoms in patients with schizophrenia: Relationships with childhood trauma and psychotic symptoms. *Comprehensive Psychiatry*, *53*, 364–371. doi:10.1016/j.comppsych.2011.05.010

Schmid, M., Petermann, F., & Fegert, J. M. (2013). Developmental trauma disorder: Pros and cons of including formal criteria in the psychiatric diagnostic systems. *BMC Psychiatry*, *13* (3), 1–12. doi:10.1186/1471-244x-13-3

Schwartz, R. C. (1995). *Internal family systems therapy*. New York, NY: The Guilford Press.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing*. New York, NY: Guilford Press.

Silk, K., Nigg, J., Westen, D., & Lohr, N. (1997). Severity of childhood sexual abuse, borderline symptoms, and familial environment. In M. Zanarini (Ed.), *Role of sexual abuse in the etiology of borderline personality disorder* (pp. 131–164). Washington, DC: American Psychiatric Press.

Sodeke-Gregson, E. A., Holttum, S., & Billings, J. (2013). Compassion satisfaction, burnout, and secondary traumatic stress in UK therapists who work with adult trauma clients. *European Journal of Psychotraumatology*, *4*. doi:10.3402/ejpt.v4i0.21869

Somer, E. (2009). Opioid use disorder and dissociation. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 637–652). New York, NY: Routledge.

Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles post-traumatic stress disorder reaction index. *Current Psychiatry Reports*, *6*, 96–100. doi:10.1007/s11920-004-0048-2

Terr, L. C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry*, *148*(1), 10–20. doi:10.1176/ajp.148.1.10

Terr, L. C. (1994). *Unchained memories*. New York, NY: Basic Books.

Tyrka, A. R., Wyche, M. C., Kelly, M. M., Price, L. H., & Carpenter, L. L. (2009). Childhood maltreatment and adult personality disorder symptoms: Influence of maltreatment type. *Psychiatry Research*, *165*(3), 281–287. doi:10.1016/j.psychres.2007.10.017

van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. New York, NY: Norton.

van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry*, *1*(5), 253–265. doi:10.3109/10673229409017088

van der Kolk, B. A. (1996). The complexity of adaptation to trauma: Self-regulation, stimulus discrimination, and characterological development. In B. A. Van Der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society* (pp. 182–230). New York, NY: Guilford Press.

van der Kolk, B. A., Hostetler, A., Herron, N., & Fisler, R. E. (1994). Trauma and the development of borderline personality disorder. *Psychiatric Clinics of North America*, *17*(4), 715–730.

van der Kolk, B. A., Pelcovitz, D., Roth, S., Mandel, F. S., McFarlane, A., & Herman, J. L. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation of trauma. *American Journal of Psychiatry*, *153*(7), 83–93. doi:10.1176/ajp.153.7.83

van der Kolk, B. A., Pynoos, R. S., Cicchetti, D., Cloitre, M., Di'Andrea, W., Ford, J. D., & Teicher, M. (2009). *Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V*. Retrieved from http://www.traumacenter.org/announcements/DTD_NCTSN_official_submission_to_DSM_V_Final_Version.pdf

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S. & Spinazzola. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, *18*(5), 389–399.

Widom, C. S. (1989). Child abuse, neglect, and adult behavior: Research design and findings on criminality, violence, and child abuse. *American Journal of Orthopsychiatry*, *59*, 355–367. doi:10.1111/j.1939-0025.1989.tb01671.x

Widom, C. S., Czaja, S. L., & DuMont, K. A. (2015). Intergenerational transmission of child abuse and neglect: Real or detection bias? *Science*, *27*, 1480–1485. doi:10.1126/science.1259917

Widom, C. S., DuMont, K., & Czaja, S. J. (2007). A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up. *Archives of General Psychiatry*, *64*(1), 49–56. doi:10.1001/archpsyc.64.1.49

Widom, C. S., & Maxfield, M. G. (1996). A prospective examination of risk for violence among abused and neglected children. *Annals of the New York Academy of Sciences*, *794*, 224–237. doi:10.1111/j.1749-6632.1996.tb32523.x

Yen, S., Shea, M. T., Battle, C. L., Johnson, D. M., Zlotnick, C., Dolan-Sewell, R., … McGlashan, T. H. (2002). Traumatic exposure and post traumatic stress disorder in borderline, schizotypal, avoidant, and obsessive-compulsive personality disorders: Findngs from the collaborative longitudinal personality disorders study. *Journal of Nervous and Mental Disorders*, *190*, 510–518.

Zanarini, M. C., Ruser, T. F., Frankenburg, F. R., Hennen, J., & Gunderson, J. G. (2000). Risk factors associated with the dissociative experiences of borderline patients. *Journal of Nervous and Mental Disorders*, *188*, 26–30.