

Sex Offender Rehabilitation

A Five-Phase Body-Mind Model

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ABSTRACT

Sex offender treatment has changed and evolved drastically since its inception. Relapse prevention, behaviorism, and cognitive behavioral therapy currently dominate what is considered best practice in the field. While effective, these treatments can be enhanced with the integration of body psychotherapy, a holistic organism-focused form of clinical treatment. Together, body psychotherapy and cognitive behavioral therapy create a mutually beneficial theoretical orientation that emphasizes the client's self-awareness, skill-building, and greater ability to regulate affect and impulses. A five-phase model of the treatment progression of clients who have committed a sex offense is presented alongside the primary therapeutic goals of each phase, and how the skills of cognitive behavioral therapy and body psychotherapy apply. It is hypothesized that the implementation of this model with the confluence of theoretical orientations therein might lead to greater therapeutic success in sex offense treatment.

Keywords: sex offender, adverse childhood experience, rehabilitation, body-mind model

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Over the years, the literature discussing the treatment of those who have committed sexual offenses has grown and shifted. Today, cognitive behavioral therapy (CBT) is considered the dominant form of treatment for those who have committed a sexual offense (Maletzky & Steinhauser, 2002; Moster, Wnuk & Jeglic, 2008). It focuses primarily on aspects of the mind, logical contradictions, and self-control (Beck, 2011). This has been shown to reduce recidivism in sexually-offending populations (Maletzky & Steinhauser, 2002; Moster, Wnuk & Jeglic, 2008). However, there are some opportunities to improve upon CBT's application to this population. The efficacy of this treatment can be enhanced by integrating other treatment modalities.

Due to high levels of Adverse Childhood Experiences in sexually-offending populations (Levenson, Willis & Prescott, 2015; Levenson, Willis & Prescott, 2016), the treatment of those who have committed sexual offenses can be deepened and enriched by integrating a theoretical orientation that emphasizes Trauma-Informed Care (TIC) (Levenson, 2014). Trauma-Informed Care is a three-part value system that emphasizes the importance of familiarity with and sensitivity to the presence of trauma alongside other mental health issues (Bath, 2008). If CBT is to remain the primary mode of treatment for sexually-offending populations, then it is important that its practitioners familiarize themselves with forms of treatment that emphasize the acknowledgement of trauma and effective ways to treat it – such as body psychotherapy.

Body psychotherapy is a form of mental health treatment that has made large contributions to the clinical literature regarding

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trauma (Herman, 2015; Eckberg 2000; Parker, Doctor, & Selvam, 2008). While the body psychotherapy literature regarding traumatic victims has been extensive and helpful, the somatic literature in general has not yet adequately addressed how the treatment of trauma relates to offending populations. The aim of this paper is to propose a union of CBT and body psychotherapy in the form of a five-phase model of treatment progression of those who have committed a sexual offense.

By bringing both CBT's and body psychotherapy's own strengths and theoretical lenses, a more balanced and well-rounded mental health treatment can be delivered to clients. Using a treatment model developed from this perspective has the potential to further decrease the recidivism rate of those who have committed a sexual offense as a result of successful treatment.

Societal Attitudes

Societal attitudes toward general criminal behavior ranges from apathy to outrage. Within the population of criminal behavior, societal attitudes regarding people who commit sexual offenses are viewed more negatively by the general population (Lees, & Tewksbury, 2006; Petrunik, 2003). As a result, laws regarding control and monitoring of convicted sex offenders, such as GPS monitoring, sex offender registry boards, and public notifications, have been in effect for over three decades (LaFond, 2005). In a nationwide study conducted by the University of Texas at Tyler (Klein, 2015), an inverse relationship was found between an individual's accurate information about sex offenders and the intensity of their disdain towards them – i.e., if an individual has a lower level of accurate beliefs about sex offenders, then it is more likely that they have a stronger, more negative view towards them. With these societal preoccupations and stigmas in mind, it may be difficult to envision those who have sexually abused others as human beings with emotional strife, traumatic histories, or deserving of compassion.

ACE Research and the Prevalence of Trauma in Sex Offenders

A somewhat common societal assumption about those who have committed a sexual offense is that they are former victims of sexual abuse themselves; this conclusion is varied in its statistical support (Levenson, Willis & Prescott, 2016). While the evidence for the presence of early sexual abuse is somewhat inconclusive, the prevalence of early childhood trauma is not. This can be seen by examining research regarding ACEs and their presence in criminal offending populations.

Adverse Childhood Experiences (ACEs) are potentially traumatic events that are experienced during the developmental ages of a minor (ages 0-17) (Centers for Disease Control & Prevention, 2013). The presence of ACEs

in adults is associated with illicit drug use (Dube et. al., 2003; Schilling, Aseltine & Gore, 2007), prescription drug abuse (Anda, Brown, Felitti, Dube & Giles, 2008) depressive symptoms, antisocial behavior (Schilling, Aseltine & Gore, 2007), chronic disease (Centers for Disease Control & Prevention, 2020) and sexual offending (Levenson, Willis & Prescott, 2015; Levenson, Willis & Prescott, 2016). The association between ACEs and sex offenses identifies a potential source of emotional/behavioral patterns that may contribute to committing not only a sexual offense, but other forms of criminal offense, as an adult. This association is the pathway suggesting that body psychotherapy modalities, which are known to effectively address trauma, have great potential for people with past trauma who have committed sexual abuse.

Acknowledging this association in sexually-offending populations opens up a need for treatment that incorporates the treatment of trauma into clinical practice. While treatments that do not stress the presence of trauma can, and have, lowered recidivism rates, there will always be the potential for important clinical issues to go unaddressed – even if the client has successfully completed treatment. Thus, the recidivism rate stands to potentially be lowered even further than it already has. Body psychotherapy and its integration of TIC offers a way to fill this need.

The Role of Body Psychotherapy in Treating Adverse Childhood Experiences

The presence of ACEs can be thought of as the presence of traumatic experience in childhood. Through the works of Levine, Van der Kolk, and many similar researchers, the idea of Trauma-Informed Care (TIC) has developed in the field of body psychotherapy. TIC practitioners recognize the adverse effects of trauma in the development of individuals, and honor the subjective experience of trauma as integral to the healing process (Levenson, Willis & Scott, 2016). Using the perspective of TIC, as well as the clinical skills of body psychotherapy, can contribute to a more holistic form of treatment than is currently utilized with the sex offender population.

When treating trauma through the lens of body psychotherapy, the development of self-awareness and self-regulatory skills are heavily emphasized (Levine, 2010; Van der Kolk, 2015) as the initial goal in treatment before exploring the client's history or story regarding traumatic events. In this way, the therapist is bolstering the client's ability to regulate their emotional state so that the traumatic experience can be explored without causing the client to become dangerously distressed (Rothschild, 2003). The skills needed will vary from client to client, based on their personal history and the skills they have managed to develop throughout their lives.

Contemporary literature regarding sex offender treatment has begun to stress the importance of individualized treatment plans that cater to each client's individual sets of needs and risks for reoffending (Andrews & Bonta, 2010; Colorado Sex Offender Management Board, 2020). The Good Lives Model (GLM) is a theory that has gained some attention in sexual offense treatment literature. As a theory of why sexual offenders offend, the model posits that a sexual offense is the product of a maladaptive coping strategy attempting to fulfill a basic human need (Ward & Brown, 2004; Ward, Yates & Willis, 2012). The Good Lives Model emphasizes client self-actualization while building affective and behavioral self-regulation skills (Ward & Brown, 2004; Ward, Yates & Willis, 2012). While The Good Lives Model comes close to being considered TIC, its treatment modality is more in line with positive psychology due to its emphasis on strength-based treatment (Ward & Brown, 2004).

While strength-based treatment is an important part of TIC and body psychotherapy, an emphasis on strengths does not address the full experience of trauma from the client's perspective. Both TIC and body psychotherapy respect the profound impact of childhood trauma, but body psychotherapy in particular integrates both the psychic and somatic impacts of trauma (Levine, 2010; Smith, 2010; Van der Kolk, 2015).

With this in mind, the implementation of a form of therapy that addresses identifying mental, emotional, and behavioral patterns, and building emotional awareness, emotional regulation, and the ability to identify, access, understand, and respond appropriately to the patterns of internal signals known as interoceptive awareness may be helpful in continuing to refine mental health treatment for those who have committed a sexual offense. This paper argues that this form of treatment includes the integration of body psychotherapy.

Body Psychotherapy: A Holistic View

Despite its relative obscurity, the field of body psychotherapy has been present in one form or another since the writings of Freud (Smith, 2010). Since then, the field has seen a wide berth of different theories and modes of treatment. However, its fundamental perspective has maintained that the proper way to view humans in both physical and mental health is organismic, and with a particular emphasis on the body rather than solely the mind (Smith, 2010). This particular perspective has allowed writers within the field, such as Peter Levine, to develop new theories regarding trauma's inception within an organism, as well as clinical practices to treat it. In doing so, the field of body psychotherapy has contributed its own insights into traumatic experience: sexual abuse, domestic violence (Herman, 2015), political violence, torture, societal trauma (Eckberg, 2000), and natural disasters (Parker, Doctor, & Selvam, 2008). From these perspectives, the treatment of trauma is primarily the development of emotional awareness while

simultaneously building emotional coping tools that allow the client to effectively manage distressing affect (Van der Kolk, 2015). As these skills are already present in CBT treatments, body psychotherapy offers a way to deepen through developing the client's understanding of their interoceptive shifts in emotional state and dexterity in using coping skills by tracking sensations and movement impulses.

Cognitive Behavioral Therapy in Sex Offense Treatment and Its Limitations

Historically, sex offense treatment has taken the form of relapse prevention, using similar treatment techniques to addiction therapy (Laws, 1989). This, combined with CBT, is the current prevailing mode of treatment for those who have committed a sexual offense. While this method has been shown to lower recidivism in sex offenders (Maletzky & Steinhauer, 2002; Moster, Wnuk & Jeglic, 2008), this type of treatment is geared mainly towards symptom reduction and relapse prevention, and potentially overlooks other process-oriented factors of treatment that might contribute to greater therapeutic change (Miller, Duncan & Hubble, 1997).

In recent years, CBT research has begun to acknowledge the importance of emotional processing and its role in therapeutic change (Goldfried & Samoilov, 2000). For example, exposure therapy is predicated on intentionally raising levels of emotional distress in order to facilitate therapeutic change (Foa & Kozak, 1998). For example, a client who experiences extreme arachnophobia, a fear of spiders, might choose to be exposed to images, or even live specimens of, spiders in order to "rewrite" the emotional structure in their brain that maintains the arachnophobia through desensitization (Samoilov & Goldfried, 2000). In a meta-analysis of exposure therapy carried out by Parsons & Rizzo (2008), 300 participants across twenty-one studies examining the effectiveness of exposure therapy carried out through virtual reality technology showed that exposure therapy is effective in reducing the intensity of phobias in all areas examined. However, the treatment does not work for everybody, and each individual in these studies experienced different degrees of improvement from this treatment. What makes this treatment more effective for some than others?

For those experiencing post-traumatic stress disorder (PTSD), exposure to the initial trauma may re-traumatize them, causing massive emotional distress (Dirks, 2004). Depending on the client, exposure therapy might or might not be an effective form of treatment. However, therapy aimed at resolving trauma does involve exposure to and confrontation with traumatic material. Before going into traumatic material, therapists from the body psychotherapy perspective work to build up the client's self-awareness and self-regulation tools so that the client can navigate exposure to the emotionally-charged material (Rothschild, 2003). This is done

by emphasizing awareness of many internal domains at once: cognitive, emotions, interoceptive, movement impulses, and sensory input. This creates a level of mastery and familiarity in the client regarding their internal landscape. This is the primary contribution that body psychotherapy can bring to CBT sex offense treatment.

Body Psychotherapy and Cognitive Behavioral Therapy

In a study conducted by Drapeau, Körner, & Brunet (2004), it was found that those undergoing sexual offense treatment considered their therapeutic relationship with their therapist more important than the type of treatment provided. Using body psychotherapy as a supplementary treatment to CBT can deepen the quality of the therapeutic relationship by using body psychotherapy's focus on nonverbal communication and sensation tracking. While both CBT and body psychotherapy therapists work to build a therapeutic relationship with their clients, the information tracked, and skills used by body psychotherapists stand to deepen the relationship in a way that is similar to how attachment roles are established between caretakers and newborns.

Diana Fosha (2000) asserts that our emotional expression is integral not only to self-regulation, but also to the regulation of others. This relationship can be seen in newborns and their mothers – the emotional expression of the infant demands a particular response from their mother, and her ability to fulfill this demand is what quiets or exacerbates the newborn's signals of distress. This is the foundation of attachment theory – the mother may respond with a material need such as milk or a new diaper, but the mother responds with affective signals that show the newborn that their emotional state is recognized, and that it will be resolved with the support of another, hopefully resulting in an emotional pattern which enables the developing newborn to generally trust that other humans will recognize their needs and help fulfill them (Bowlby, 1978).

As previously stated, body psychotherapy is a particular mental health clinical theory that stresses the holistic relationship of body and mind. Nonverbal communication tracking is taken into account alongside verbal communication to form a more comprehensive understanding of the client's overall affective state. In this way, body psychotherapists attempt to attune to their clients in ways that are similar to a caregiver attuning to their child.

Self-awareness and self-regulatory skills are heavily emphasized in body psychotherapy treatment (Levine, 2010; Van der Kolk, 2015). Being cued into the somatic nonverbal cues of the client is how body psychotherapy clinicians develop an awareness of their client's emotional state, which then gives them important information to relay back to the client, assisting them in building emotional management tools. These skills fos-

ter an affective awareness in the client that may help them process emotional content as well as proactively regulate their affective state towards a less distressing state, thus giving them the emotional resources to make healthier choices that aren't motivated by a desperate drive to fulfill a particular need. Similarly, CBT stresses the identification of and changes to thoughts and behavioral patterns that might not be consciously known to the client (Beck, 2011). However, changing longstanding behaviors that have fulfilled particular needs in unhealthy or harmful ways can be emotionally distressing to the client. It is important that these identification and behavior-changing treatments are supplemented with providing the client with self-regulatory tools that help them navigate new behavioral territory. These are the very skills that body psychotherapy has to offer in a union with CBT.

A Body-Mind Model of Behavioral Change

Sex offense treatment has evolved into using various modalities and theoretical approaches. In this section, a five-phase body-mind model is posited. Body psychotherapy orientations and techniques are infused within a CBT-laden frame as a means to address treatment components missing in current sex offense treatment.

The previously mentioned The Good Lives Model is a theory of why individuals may sexually offend. Simply stated, the model identifies nine to twelve "Goods" such as, life, agency, peace of mind, intimacy and sex, community, and creativity. When these Goods are not achieved in an individual's life, they will find a way to fulfill these needs, and depending on their individual flaws or weaknesses, the strategies they choose to fulfill them may be either unhealthy or harmful to others and themselves (Ward & Brown, 2004; Ward, Yates & Willis, 2012). For those who have committed a sexual offense, their offense was a response to the lack of fulfillment in one of these Goods, according to the GLM. For some, their offending behavior is a long-term coping strategy that, though unhealthy and harmful, succeeded in helping them feel as though their needs were being met. In this model, the GLM will be used as an orienting tool for both the client and therapist to find direction and focus in the treatment.

However, it is not enough to simply identify what need is not being met, or to hypothesize new, more healthy behaviors for the client. The immediate change of these behaviors is likely to cause emotional distress in the client – their need will not be met with the same degree of satisfaction as before the change in behavior. Even if an individual recognizes the harm that they cause and attempts to change their behavior, if they cannot navigate the emotional distress caused by discarding a coping strategy, they may fall back into offending behaviors just to experience emotional relief.

CBT excels at behavior and cognitive pattern recognition as well as in planning ways to enact change in the client's life. Body psychotherapy excels in developing physiological and emotional awareness to use in developing healthy coping skills. Together, these two perspectives form a more holistic treatment than either of them used individually.

The following section identifies different phases of therapeutic development in sex-offense treatment. In these stages, the skills of both CBT and body psychotherapy will be used to create five phases with clear goals for the client to strive for in order to advance through treatment. In all stages, the mental awareness and forward thinking/strategizing of CBT as well as the self-regulatory skills of body psychotherapy are present and directed by The Good Lives Model.

Five Phases

1. Acknowledgement

Client goal: Accountability and responsibility

The primary goal during this initial point in treatment is to help the client not only understand the severity of their actions, but also accept responsibility for these actions as well as accountability for changing their behaviors. Clients who begin sex-offense treatment rarely enter into treatment by choice. Clients who do come to treatment present differing levels of remorse for their actions, and/or empathy towards their victims. Some clients spend very little time in this phase, while others may spend months or even years in this phase. For the client, this means acknowledging that they chose to sexually offend, causing harm to others, as well as accepting that there is a great need to change their behavior for the good of others and themselves.

The presence of trauma is often the result of a disempowering relational pattern directed towards the traumatized. These disempowering patterns experienced in childhood elicit anxiety, anger, helplessness, and depression (Felitti, 2002; Felitti *et al.*, 1998; Whitfield, 1998). Poor affective-regulation patterns combined with strong negative affect may have led to desperate coping strategies and behaviors that the client has learned to use to get their needs met. For the person who has committed a sexual offense, these feelings likely have resulted in coping strategies that return their sense of agency to them at the expense of others.

The therapist treating sexual offending populations has the opportunity to demonstrate compassion and understanding while maintaining healthy boundaries that contradict the client's previous patterns of relating with others. As the therapist establishes their sincere compassion and respect for the client's agency, the client learns that their abusive pattern is not necessary to have the psychological safety that they desire. Establishing this relationship with the client lowers their psycholog-

ical defenses and creates safe opportunities to practice more confrontational therapeutic techniques that contribute to positive emotional changes and developing new prosocial social skills.

A body psychotherapist may utilize body language mirroring, quality of eye contact (attentive vs. confrontational), as well as an awareness of the client's physiological arousal that emulates the caregiver bond and gives the therapist valuable information about whether or not the client is emotionally overwhelmed while exploring content. Additionally, the therapist may also consider attempting to see the client's position from their perspective and try to communicate this through basic reflections. Though treatment will ultimately attempt to challenge the client's denial and/or lack of empathy towards their victim, the client may show higher levels of resistance if they do not feel understood by the therapist. Using such subtleties, the therapist can more effectively *ally* with the client, and move towards collaboration rather than court-mandated direction.

2. Information Gathering

Client Goal: Exploration

After the client has taken responsibility, and the therapeutic alliance between therapist and client has been given time to develop, then it is time to identify what unmet needs contributed to the client choosing to offend. If ACEs are present in the client's developmental history, then learning about these events is necessary if the therapist is to deliver TIC. However, exploration of traumatic material must be done with care on the clinician's part. While this information may be useful in directing treatment, revisiting traumatic events may present varying levels of discomfort to the client that range from uncomfortable to completely dysregulating their affective state. In this and all future phases, it is important that the therapist begins by helping the client learn to "pump the brakes" when discussing distressing material, enacting new relational patterns, and using new emotional coping strategies (Rothschild, 2000).

When approaching traumatic material, a body psychotherapist should track the physiological state of the client. Has their quality of eye contact changed significantly? Have they become unexpectedly fidgety or deathly still? Has their breathing pattern shortened or seemingly stopped all together? These are some signs that indicate a change in physiological state that indicates the client feels as though they might be in danger. When these behaviors manifest, the therapist can help the client navigate the affective states by coaching them through coping strategies. These strategies can be deep breathing, asking the client to describe the room with their five senses, or simply getting out of the chair and moving throughout the room to indicate that the client is not trapped in their current state. If a client responds in this way, then it is most beneficial to stop the exploration of the story, and instead to explore the affective

shift with the client before moving forward. This affective shift may indicate the need that the client has attempted to fulfill in the past with their abusive behavior. Exploration of the client's process may prove to be more helpful than historical facts about the client's life. As the therapist learns about these events and emotional processes, they might be able to understand how the client's abusive behavioral patterns were adaptive at one point in their lives. Communicating this understanding is important in further developing the therapeutic alliance between the therapist and client.

Using The Good Lives Model can be helpful in guiding the client to develop an understanding of their primary needs (or "Goods"), as well as identifying which unmet needs may have contributed to their choice to offend. Educating the client about the Goods as a whole before fully delving into any one of them can help the client feel more secure and oriented in their exploration. Providing structure for the exploration will help the client remain grounded and prevent them from getting too "lost in the weeds." Without the structure provided by a theory like the GLM, a thorough investigation of the quality and strategy of need fulfillment in the client's life can feel somewhat amorphous and difficult to begin.

After the client has been made familiar with the Goods, the use of homework can be helpful in this phase of treatment. At the beginning, it can be beneficial to move slowly, assigning one exploratory writing assignment per week that focuses on a single Good. These can be as simple as a stream-of-consciousness journal entry shared with the therapist, or a formal worksheet prepared by the therapist. Examples of prompts include: What does creativity mean to you? How have you found ways to fulfill this need in the past? Can you think of times in your life where you have felt very creative or not creative at all? Additionally, you can introduce Likert scales that rate the client's self-perceived importance of these Goods in their lives before, during, and after their offense. These can be used to gather measurable data that can be referred to later in treatment. The purpose of these prompts is to facilitate exploration within the overarching structure provided by theories like the GLM.

Therapists may use this as an opportunity to ask more confrontational questions that were not as easily addressed in the previous phase. After the client has assumed accountability and responsibility, they might be more receptive to confrontational questions as well as education about thinking errors and accept that their old beliefs and behaviors might need to change.

A body psychotherapy must pay close attention to many aspects of the way a client shows up in discussing their Goods. Sensorimotor Psychotherapy, a body psychotherapy treatment modality, stresses the importance of tracking what is called the five core organizers: cognitions, emotions, somatic sensations, sensory information, and impulses to move (Ogden, Kekuni, &

Pain, 2006). As the therapist tracks this information, they may choose to use these as investigative tools by prompting the client to consider them as new memories or topics arise in treatment. This technique deepens the client's analysis of their Goods into a more experiential body experience by accessing more internal information and weaving it into a more personally meaningful exploration.

This step in the process might not move linearly – that is, the client might already know what was lacking in their life but be unsure of the coping strategy they used to fulfill it. Likewise, the client might have some understanding of their coping strategy, but little awareness of the need the behavior is attempting to address. At this point, the therapist's main goal is to facilitate exploration into the client's history related to the GLM set of Goods. For example, have they always felt satisfied with their need for sex and intimacy? Did they feel unsatisfied during the time of their offense? If they found themselves feeling unsatisfied, how would they go about fulfilling their need for sex and intimacy? Keeping the Goods in mind, the therapist can begin to collect and organize information for the client as they begin exploring their past and their behavioral patterns.

3. Orienting

Client Goal: Strategizing

The goal for this phase is to begin strategizing ways to integrate new behavioral patterns into the client's life while transitioning out of old behavioral patterns. It is important to consider the client's ability to manage distress tolerance during this phase. Before introducing radically different modes of being into the client's life, the therapist must be certain that the client has access to internal and external resources that allow them to manage the distress that may arise from replacing behaviors that may have served as effective (though harmful) coping strategies. Much in the way that a scuba-diving instructor checks their students' oxygen tanks, the therapist must be certain that the client is able to breathe through the distress.

In the case of a client who sexually abused adolescents, seeking an age-appropriate relationship may present emotional difficulties that the client is not prepared to experience. For example, an age-appropriate partner may perceive the client with a more critical lens – the eyes of an adult – than a partner who is an adolescent. If the client struggles with low self-worth or high levels of self-criticism, then the client may experience strong emotional distress, and choose to reoffend another adolescent, who will not trigger the same level of distress.

A cognitive behavioral therapist may use this time to engage in role play. The CBT therapist could initiate role play of the client's adult partner while engaging the client in a relationship context, possibly triggering feelings of emotional distress. A body psychotherapist

could extend this opportunity to help the client begin to build internal awareness skills if they haven't already used the five core organizers of Sensorimotor Psychotherapy. The body psychotherapist may pay attention to different elements of the client's experience: information about the client's cognitive, emotional, somatic, sensory, and movement sensations are all prompted by questions from the therapist, which links them together in a way that more easily facilitates a "meaning-making" response from the client (Ogden, Kekuni, & Pain, 2006). This can begin by asking the client to notice what emotions are felt when they think of a certain need, or Good, and their relationship to it.

An example of a client considering their relationship to the Good of Relatedness:

- *Cognitive response:* My parents were both addicts, and their addictions didn't leave much room for me in their life.
- *Emotional response:* I didn't really notice until I got older, but I spent my whole childhood feeling alone, sad, and tossed aside.
- *Somatic sensation:* When I think of them, I feel as though my whole body is collapsing in on itself – like I'm getting so small that nobody will notice me.
- *Sensory information:* I can hear the sound of their pill bottles rattling in the bathroom.
- *Movement impulse:* There is no impulse to move. I just want to curl up on the floor and stay still.

By linking these different sensations, the therapist can help the client develop a sense of familiarity and mastery over not only the cognitive memory, but all of the subjective experiential characteristics of the therapeutic topic in question (Ogden, Kekuni, & Pain, 2006). Depending on the client's response to these memories, the therapist may have to educate the client about the body's stress response and begin practicing down-regulating techniques such as deep breathing and mindfulness meditation. Additionally, the therapist can also educate the client about using external resources – such as using information gathered by the five senses in the present moment. The therapist can ask the client to visually describe the office space, to physically touch their own arms, describe the smells in the air, etc. These techniques deepen the feeling of mastery within the client as they explore their relationship to the Goods in their lives.

Social resources are useful to emphasize as well. As a consequence of being charged with a sexual offense, the client might find themselves in a situation where they have less access to supportive friends, family, or significant others than they did before their conviction. As group therapy is the primary form of treatment for those who have committed a sexual offense, it may be beneficial to encourage the group members to exchange contact information, and to use each other as informational and emotional resources outside of treatment.

After sufficient exploration identifies areas that need development, and emotional distress and emotional regulation techniques are known and available to the client, then the therapist and client can collaboratively work to form plans and strategies for implementation into real scenarios. This can be practiced with further role play of varying intensity, depending on the client's current ability to regulate themselves, or homework assignments that involve practicing these techniques at home or in situations that are only mildly emotionally distressing.

It is important that the therapist is certain that the client is able to handle emotional distress as it arises. If the client is not appropriately equipped to handle this distress, they might regress to using old behaviors that, while harmful to others, helped them find temporary emotional satisfaction. Since those who commit sexual offenses have negatively affected others (victims), it is a matter of public safety to ensure that the client has the ability to manage their emotional distress while making positive changes in their lives. If a client does not have sufficient knowledge of what emotional regulation skill to use in most situations, then they might not be ready to advance to the next phase.

4. Implementation

Client goal: Taking action

After the client is educated in and has practiced using emotional-regulation techniques, then it is time for them to begin using their replacement behaviors out in the world. At this point in treatment, the therapist may find homework activities that involve the use of these behaviors helpful. Ideally, these would be collaboratively chosen by the therapist and client. They could include finding community by joining a group of like-minded people with shared interests, reigniting an old hobby, abstaining from porn use, abstaining from substance use, etc. The primary goal of treatment in this phase is to begin actively engaging in (or abstaining from, in some cases) these behaviors, and reporting back to the therapist about the challenges that arise from attempting these changes. Further practice in emotional management skills can be practiced during treatment, but at this point in treatment, the client is expected to know enough about them to use what is appropriate when difficulty arises. The work of the client is to begin using these skills outside of treatment in an effort to begin positive personal change. The therapist's job is to continually monitor the client's ability to self-regulate, as well as the changes they are making in their lives. Is the client making genuine efforts to develop healthy social relationships? Are they, with intent, using behaviors that fulfill the unmet needs that contributed to their offense? Are they showing effective skill in navigating any emotional distress that comes up when making these changes? These are all signs that the client is approaching completion of treatment and is ready to move on to the final phase.

5. Maintaining

Client and Therapist goal: Vigilance

In this phase, the client has developed an awareness of behavioral changes, internal cues that signal when to regulate themselves, and has also demonstrated an ability to do so outside of treatment. As the name of this phase suggests, the main goal of this phase is to continue practicing and perfecting the changes that were implemented in the previous phase of treatment. Feedback from the therapist regarding the client's successes and failures is used to further refine the interventions.

Clients must remain vigilant for anything that may upset the changes they have worked so hard to achieve. While the client has developed strong emotional management, social resourcing, and a healthier lifestyle by this point in treatment, a sudden and emotionally disruptive life event – such as the loss of a loved one – could still potentially disrupt the client if their new coping skills are still relatively new. The job of the therapist is to support the client through these difficult challenges, and educate the client on the power of large, unexpected events, as well as the strength of new behaviors growing over time, so as to emphasize that new patterns may be vulnerable to disruption. The client may be resistant to consider these events because they believe they have truly changed for good, or the thought of these events may be uncomfortable. The client may regress to old behaviors, thinking that how they coped in the past was successful. Depending on whether or not the client chooses to continue treatment after their parole/probation is complete, the therapist may not be present to help the client manage unexpected stressors in life as they arise. So then, the therapist must focus on keeping the unexpected within the client's frame of mind, as well as continue to check in with the client to see how they are using their new skills outside of treatment to be sure that the skills remain in use as the client eventually transitions out of treatment.

Conclusion

In sum, both cognitive behavioral therapy and body psychotherapy in conjunction with one another can form a well-rounded, holistic mode of treatment. Cognitive behavioral therapy offers a wide array of tools that facilitate deep, questioning cognitive thought and personal investigation, as well as an emphasis on future planning and homework assignments that keep the client engaged in treatment outside of the office. Body psychotherapy provides physiological awareness tools that integrate into emotional management skills that deepen introspective exploration, as well as equip the client to maintain new behaviors over an extended period of time.

This body-mind model provides a roadmap for treatment that therapists can use to guide and track treatment of those who have committed a sexual offense. Future research regarding this model would develop ways to measure progress in each phase of treatment, so that the client's progression through treatment could be better structured and understood. Average time taken to complete treatment, clinical effectiveness, and comparisons to other forms of treatment for those who have committed sexual offenses are all areas of study that could be investigated in this way.

This model is predicated on the assumption that those of us who have committed a sexual offense have done so because of poor emotional regulation skills, and unmet needs that were desperately fulfilled in short-sighted ways that harm other people. It is the hope of the author that further work will be done by others in the field of sex offense treatment to emphasize these elements that contribute to sexual offenses. In this way, the social stigma around this topic may be lessened somewhat so that constructive dialogue about sexual offense prevention and recovery can continue to be had, and the frequency of sexual offense recidivism can ultimately drop over time.



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