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The Blurred Line: Balancing the Treatment of Personality Disorders, Personal Trauma, and Cultural Trauma Among Individuals Who Have Sexually Offended

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Introduction

Understanding what factors place an individual at greater risk to reoffend, adopting intervention strategies which consider this risk, and targeting intervention to factors which have been empirically identified as changeable and related to a greater likelihood to commit new offense are all elements of the Risk-Need-Responsivity model (RNR) (Andrews and Bonta 1991; Bonta and Andrews 2016). In recent years, RNR has been widely adopted as the prevailing theory guiding the assessment and treatment of individuals in the criminal justice system, and

Names and details in the three cases presented in this chapter have been altered to ensure the confidentiality of those discussed.

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this model has also benefited the treatment of sexually abusive behavior problems (Hanson et al. 2009). In short, the RNR model advises the consideration of who is in need of higher or lower intensity intervention (risk), intervening on factors which are specifically relevant to reducing the likelihood of future criminal behavior (need), and tailoring interventions to maximize the benefit an individual receives from treatment (responsivity).

The role of trauma in light of the RNR context is complicated. Trauma is not considered a traditional criminogenic risk factor (compared to criminal history; cf. Andrews and Bonta 1991), which is a factor which is directly related to reducing or exacerbating an individual's likelihood to commit a new offense. On one hand, trauma, or more specifically post-traumatic reactions, has been indirectly connected to aggressive behavior through hypervigilance and increased reactive aggression (Barrett et al. 2011; Fritzon et al. 2021; Orth and Wieland 2006). On the other hand, more direct interventions in justice-involved situations have shown less efficacy when not addressing underlying trauma (Sadeh and McNiel 2015).

While it is tempting to consider trauma from a risk principle perspective, trauma can also be thought of as a responsivity factor. Addressing responsivity can maximize the benefits of interventions after an individual's treatment needs are accounted. Originally, accounting for responsivity focused largely on intellectual ability and scholastic achievements (Andrews and Bonta 1991); more recent studies of responsivity have included factors such as mental health and cultural context as part of this (Bogue et al. 2004; Mattson et al. 2012). Ultimately, addressing responsivity means interventions take into account an individual's barriers to learning and behavior change, and take necessary steps to account for these factors so that interventions can be successful.

Addressing trauma has gained considerable attention in the treatment of sexually abusive behavior (e.g., Fritzon et al. 2021; Levenson 2014; Levenson et al. 2016; Stinson et al. 2016). In recent years, the integration of trauma-informed care into the treatment of sexually abusive behavior problems has become more prevalent (Levenson et al. 2016; Wilson et al. 2020). At the same time, the way in which we define trauma continues to evolve. Psychology generally defines trauma as the response

to an unexpected and frightening event that threatens one's safety and challenges one's coping skills (SAMHSA 2014). Less well-defined in the psychological literature, but more so in sociological literature, is also the idea of cultural trauma (Alexander 2004). Cultural trauma can take on many forms, related to climate change (Brulle and Norgaard 2019), major health crises such as COVID-19 (Demertzis and Eyerman 2020), and LGBTQ experiences (Hartal and Misgav 2021). In the context of sexual offending and criminal behavior overall, it is necessary to address the potential for cultural trauma when addressing race-related issues (DeGruy 2017; Rodi-Risberg 2018; Simko 2020). Recently, the relevance of cultural trauma has been theorized as a relevant application of trauma-informed cognitive-behavioral therapy for individuals of historically disadvantaged racial groups; however, most of the literature concerning this focuses on practice-based evidence rather than utilizing evidence-based practices (Metzger et al. 2021; Phipps and Thorne 2019).

Whether considering more typically established forms of trauma such as those in psychological literature or less typical traumatic reactions like cultural trauma, there is similarity with those manifestations to personality disorders. Is a person experiencing relationship disruption, impulsivity, and intermittent dissociative episodes because of their borderline personality traits or because of their experiences with childhood abuse? Is a person exhibiting aggressive and angry outbursts because of antisocial personality disorder or because of ongoing cultural and personal maltreatment? This type of question requires professionals to make assessments of the individuals in their care based on the etiology of the client's specific behavior.

Indeed, it is possible for one individual to have both post-traumatic reactions and dysfunctional personality traits; however, the challenge for professionals working with individuals who have sexually offended (ISOs) is that personality disorders (antisocial personality disorder in particular) have been used to explain many behaviors which defy social norms (Ahlmeyer et al. 2003; Sorrentino et al. 2018). In order to promote improved assessment of the role of trauma as a responsivity factor, this chapter will discuss some major presentations of trauma and the parallels with personality disorders. While this is not meant to be a

definitive guide to broadly address the differentiation of these two issues, it can be considered a template for decision-making when professionals are confronted with such situations.

Personality Disorders

The 5th Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (APA 2013a: 645). While the DSM-5 describes 11 primary personality disorders, the context of sexual offending behavior often focuses on the four Cluster B personality disorders: antisocial (ASPD), borderline (BPD), histrionic (HPD), and narcissistic (NPD). These personality types are typically marked by poor emotion regulation, dramatic or erratic behavior, and poor adherence to law or social norms. In studies examining incarcerated ISOs (Chen et al. 2016) civilly committed ISOs (Stinson et al. 2008), more than half met criteria for a Cluster B personality disorder. More than a third met the criteria for ASPD, and another quarter exhibited traits of antisocial personality (note: the presence of personality disorder traits, without meeting the full criteria for a specific personality disorder, may be used in the diagnosis of "other specified personality disorder").

Several treatment options exist for Cluster B personality disorders. Among individuals with ASPD, cognitive-behavioral treatments have shown benefits in reducing aggressive tendencies and contemporary psychodynamic approaches show promise (Meloy and Yakeley 2020). The "gold standard" for the treatment of BPD for several years is Dialectical Behavior therapy (DBT; Linehan 1993). DBT involves the integration of mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance skills while employing behavioral analysis of problem behaviors associated with personality disorders. The treatment of HPD and NPD are not well supported in the literature; however, there are mixed results documented for employing cognitive-behavioral

measures and DBT specifically (Blagov et al. 2007; Caligor et al. 2015; Neacsiu and Tkachuck 2016). Including atypical antipsychotics, medications have also been shown to benefit the treatment of Cluster B personality disorders (Findling 2008; Linehan et al. 2008).

Personality traits are generally stable over time, particularly in adulthood. This presents a fundamental challenge to the treatment of a disordered personality, and given that there are interventions to manage the behavioral manifestations of personality disorders, it is difficult in a modern context to even define these disorders' stability (Morey and Hopwood 2013). However, the ease at which these personality disorders can be used to explain persistent rule-breaking behavior or interpersonal problems (e.g., APA 2013a) make a mindful consideration of how to attribute motivations for behavior crucial.

Trauma

Similar to personality disorders, trauma requires a mindful approach in conceptualization—one must carefully consider the history and stability of an individual's presentation to appropriately attribute behavior as a post-traumatic presentation. As noted above, psychological definition of trauma is the response to an unexpected and frightening event that threatens one's safety and challenges one's coping skills (SAMHSA 2014). Since the 1990s, the understanding of trauma, such as in the cases of childhood abuse and neglect and exposure to violence as an adult, has radically grown in the professional literature (Castellvi et al. 2017; Felitti et al. 1998; Levenson 2014; Stinson et al. 2016). Beginning with DSM-III in 1980, trauma was originally conceptualized as an "event that is generally outside the range of usual human experience" and that "would evoke significant symptoms of distress in most people," and as has been reframed in each edition of the DSM since then (APA 2013b; Weathers and Keane 2007). Factors distinguishing the current DSM-5 (2013) criteria of trauma include the recognition of the impact of recurrent trauma, the role of memory in the experience of trauma, and an acknowledgment that the response to an event need not elicit feelings of fear or anxiety during the event (APA 2013b).

The various editions of the DSM and its accompanying materials have concerned the specific diagnosis of PTSD, with traumatic experience(s) being one of the crucial criteria of this disorder. At the same time, some of the most notable research on trauma relevant to issues of sexual offending (e.g., Hall et al. 2018; Levenson et al. 2016, 2020; Puszkiewicz and Stinson 2019) involves the concept of adverse childhood experiences (ACEs; Felitti et al. 1998). The concept of ACEs originated from a study of nearly 10,000 adults by Kaiser Permanente, a health insurance organization in the United States. The elements which continue to be examined since that study include childhood exposure to emotional, physical, or sexual abuse, emotional or physical neglect, and various forms of domestic disruption (domestic violence, divorce, death of a parent, incarceration of a household member, or the presence of a substance-abuse or mental illness in the home). The presence of each ACE is cumulatively considered one's ACE score. ACE scores have been linked to long-term risks for physical diseases such as cancer, diabetes, and heart disease (Felitti et al. 1998), as well as various psychological conditions such as anxiety, depression, personality disorders, and suicidal ideation (Chapman et al. 2007; Dube et al. 2002; Felitti et al. 1998).

The original Kaiser Permanente study found that about half of respondents experienced at least one ACE. A quarter of the population reported only one ACE and an eighth reported two ACEs; only six percent reported four or more ACEs (Felitti et al. 1998). However, individuals involved in the criminal justice system or involved in forensic psychiatric care have shown a higher prevalence of ACEs. Two more contemporary studies have examined the rate of ACEs in both adult and adolescent males who have sexually offended (Hall et al. 2018; Levenson et al. 2016). To briefly contrast groups exclusively made up of those who have offended with the general public, offending groups skew toward increasing numbers of ACEs, whereas the general population skews toward fewer ACEs (Fig. 12.1).

Although the redefinition of PTSD in the DSM-5 occurred at the same time as much of the recent research on ACEs, the assessment of ACE frequency was not included in updates to the PTSD criteria and the experiential criterion of PTSD is inclusive of adult experiences. Each approach to conceptualizing trauma and its impact has strengths, and the

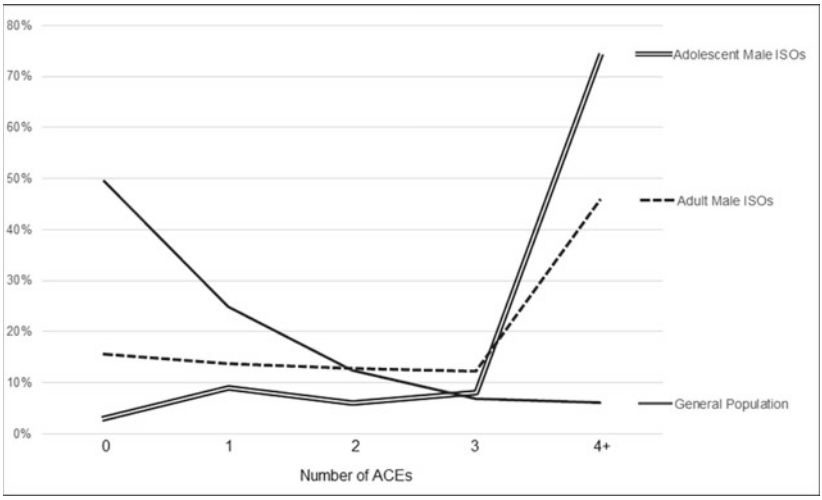

Fig. 12.1 Comparison of ACE rates between the general population, adult male individuals who have sexually offended, and adolescent male individuals who have sexually offended (*Note* General population sample: Felitti et al. [1998]; Adult male ISO sample: Levenson et al. [2016]; Adolescent male IS sample: Hall et al. [2018])

utility of each will depend on the context in which trauma is assessed and addressed. However, the research on ACEs provides a considerable insight to the relationship between trauma and sexual offending behavior. While it is difficult to attribute problem behaviors to causal factors, recently it has been suggested that sexual abuse and other sexually related adverse experiences are directly linked with the early onset of new sexually abusive behavior, and other ACEs related to household dysfunction were statistically linked to the likelihood of engaging in any contact sexual offending behaviors (Puszkiewicz and Stinson 2019).

Cultural Trauma

Until this point, we have discussed trauma from the typical psychological perspective, largely influenced by the criteria for trauma in the DSM-5: directly experiencing the traumatic event, witnessing the event as it

occurred to others, learning that the traumatic event occurred to a close family member or friend, or experiencing repeated or extreme details of a traumatic event. This perspective is largely reflective of the bias toward trauma as an individually experienced phenomenon, and the use of this individualistic or experiential conceptualization of trauma has influenced our research on trauma, such as in the case of ACEs (e.g., Felitti et al. 1998; Levenson et al. 2016) to the criteria for PTSD (APA 2013a).

"When members of a collectivity feel they have been subjected to a horrendous event that leaves indelible marks upon their group consciousness, marking their memories forever and change their future identity in fundamental and irrevocable ways" (Alexander 2004). In recent years, the social and cultural discussions of trauma have considered how social disadvantage, historical oppression, and pervasive stigma have cumulative negative effects. There is no shortage of sociological sins in the story of America, often in the context of how people of European origin maintain their dominant sociocultural presence. This includes the treatment of the first peoples of North America, to the increasing restrictions on immigration in the late twentieth and early twenty-first centuries. In many ways, there are opportunities for cultural assimilation: when a minority group takes on the values, beliefs, or behaviors of the dominant group. In some cases, minority groups have succeeded in their assimilation into the dominant group so well that the distinction between the two are at most marginally noticeable in a contemporary context. For other groups, though, the line dividing them from the dominant group is virtually inerasable, either due to their physical attributes like the color of their skin or their seemingly irreparable history (Clark 2003; Ignatiev 2009; Waters and Jiménez 2005).

From an American perspective, one of the most salient sociocultural divisions is between people of African origin and those of European origin. This chapter is not meant to be a comprehensive review of African-American studies; the formal study of African-American culture has warranted the publication of libraries. Instead, we will briefly discuss here the psychological impact of the sociocultural experience of being of African descent in America for the context of its impact on case conceptualization in assessment and psychotherapy.

One readily accessible theory of cultural trauma in the African-American experience is Post Traumatic Slave Syndrome (PTSS) (DeGruy 2017). This phenomenon is described as "trans-generational adaptations associated with traumas, past and present, from slavery and ongoing oppression" (p. 8). While slavery was not unique to people of African origin, it has become primarily associated with the narrative of African-American experience as opposed to other sociocultural groups. In the PTSS perspective, the salience of this dual historical and contemporary context reinforces the experience of multigenerational trauma which began with the process of enslavement, continued with institutional discrimination following emancipation (such as in the case of Jim Crow laws), and sustains with sociocultural narratives today with imagery of subordination and objectification correlated with the origins of the cultural maltreatment.

The foundation of PTSS includes three primary components. First is the idea of vacant esteem. Here, esteem concerns the idea of how one values his or her worth as a member of a cultural group. The idea of having vacant esteem suggests that one's value is seen as empty, and in the context of cultural identity, one sees himself or herself as being inferior due to a combination family, community, and societal messages. Familial influence includes how one's primary messages about how to function and views of one's self are internalized as a function of learning; if parents (or parental figures) do not see their close social network as having values, then they risk teaching this to their children as an implicit message. One's community reinforces this issue of undervaluation, including under-representing positive role models in the media (Richardson-Stovall 2012), diverting fewer resources to schools where these children learn, and decreased opportunity to rise out of socioeconomic disadvantage (Saegert et al. 2011).

A second component of PTSS is "racist socialization." Similar to the issue of vacant esteem, there is the concern of how the identity or characteristics of the dominant sociocultural group—people of European origin—is internalized as of greater value than one's own group identity (e.g., people of African origin). This may include the idea that having physical attributes more closely associated with European features is more desirable. It may also manifest as seeing stereotypical or historically

defined qualities of one's own sociocultural group as being inferior or less affluent when compared to the stereotypical attributes of the dominant group. For example, one might endorse the act of "code-switching," or adapting one's speech or presentation to better integrate into a variety of contexts. The act of code-switching has been proposed as a perceived requirement of socioeconomic mobility, from academic achievement to success in politics (Morton 2014). The process of socialization associated with these factors risks the presence of significant cognitive dissonance. It is not surprising that the third component of PTSS is that of "ever-present anger." In this context, anger is defined as "a response to the frustration of blocked goals and the fear of failure" (DeGruy 2017: 115). In the context of PTSS, this anger is not limited to a single situation, a single encounter, or a single family story. It is the cumulative anger resulting from intergeneration disadvantage, devaluation, institutional or societal marginalization, and within-group conflict regarding how the collective identity should be determined separate from or in step with the dominant sociocultural group. All of this is tied together by the power of belief: belief that one's opportunities are limited, belief that what they have learned about their subordinate role in society is appropriate, correct, or real, and even the people of European origin actually wish them harm.

To conclude this discussion of cultural trauma within the African-American community, let us consider the Black Lives Matter movement, and the counter-movement to Black Lives Matter is the idea of "All Lives Matter." As told within the context of some voices, the idea of "all lives" includes the subset of "black lives." However, this assumes that the movement focuses on the preservation of life, which has deep cultural and religious significance to the sacredness of all life. Instead, one should look at this through the context that one's identity as a person of African origin has value, that one's Afrocentric attributes are not inferior to European culture or genetics, and that individuals of African origin are as entitled to the same opportunity as the dominant sociocultural group (Carney 2016; Gallagher et al. 2018). In this sense, the Black Lives Matter movement serves as a call to overcome the cultural trauma endured by the African-American community.

Beyond the experience of African Americans, cultural trauma has been correlated with increased health disparities due to increased stress, stigma, and both material and social barriers to health resources (Phelan and Link 2015; Subica and Link 2022). It is an effect which has practical implications for the individual, but is both underrepresented in our understanding of the etiology of disruptive behavior as well as underemphasized in our interventions. While it may be easy to draw some direct lines from cultural trauma to overt protest, it has been repeatedly (if not loudly) theorized that cultural trauma plays a role in crime and delinquency either as a covert protest, a survival strategy, or maladaptive coping (Phipps and Thorne 2019; Tatum 2002). Indeed, maladaptive coping has been much attended to in the literature about intervening on sexually abusive behavior (e.g., Stinson et al. 2008, 2016). In this sense, accounting for one's trauma, cultural or otherwise, becomes a key component in understanding the etiology of sexually dysregulated behavior and developing interventions tailored to the individual's specific, intersecting needs.

Trauma-Informed Care

In response to the increased understanding of trauma in our society, the greater community of mental health service providers has begun to move toward integrating an improved awareness of trauma's impact on individuals, and the need to consider trauma both when intervening and be aware of its relevance when intervening. In this sense, addressing trauma becomes more than reducing symptoms, but it is also relevant in conceptualizing the way an individual has developed and responds to people and situations.

Taking this into consideration when providing mental health services reflects the contemporary concept of trauma-informed care (TIC). SAMHSA's (2014) approach to TIC considers four major pillars: a realization of the impact of trauma and paths for recovery, recognition of signs and symptoms of trauma, responding by integrating knowledge and understanding of trauma into both practice and policy, and reducing the chance of re-traumatization within the context of treatment and beyond

treatment as much as is reasonably possible. TIC does not explicitly advocate for the categorization of trauma or the diagnosis of a specific disorder, instead it is taking into consideration those factors which a person has learned to avoid threats, consciously or not, in response to generalized historical experiences.

As TIC has become more widely embraced, there are now a variety of options to learn about applying this concept to treatment. Several experts in the field provide conference and other continuing education options, and for the treatment of ISOs specifically Levenson and colleagues (2020) have provided an entire book on the subject. TIC has been shown to benefit in general treatment (Hales et al. 2019), and shows promise for the treatment of ISOs (Janssen 2018).

The Intersection of Personality and Trauma, and the Relevance to Addressing Sexually Offending Behavior

Among individuals who have sexually offended, there are four domains to consider in the identification of trauma: one's history of child sexual abuse, one's history of child non-sexual abuse and neglect, one's cultural factors contributing maladaptive behavior, and one's experience with incarceration and the criminal justice system. The manner in which these trauma factors manifest can be highly specific depending on the individual, and the manifestation of these trauma factors can either run parallel to or intersect with maladaptive personality factors.

Consider the impact of child sexual abuse. While there is not a guaranteed pathway from a history of child sexual abuse to engaging in child sexual abuse, one's history of abuse does create a greater risk of perpetuating sexual abuse against more children, either related or unrelated. Sexual trauma may result in having distorted beliefs about healthy sexuality (Ricci and Clayton 2016); children may not have the ability to fully comprehend the sexual abuse perpetrated upon them because of their ongoing psychological development. This may include conflicting feelings related to their sexual abuse due to reacting against the abusive

behavior and yet having a positive physiological response during the course of the abuse. Consider the case of Adam:

> Adam was convicted of sexually abusing multiple prepubescent and pubescent boys in the United States. His criminal history included a number of non-sexual juvenile offenses, such as shoplifting and underage drinking, as well as having issues with truancy and eventually dropping out of school. As an adult, he had difficulty maintaining employment, both because of his difficulty following direction from authority figures and because of a lack of opportunity for stable jobs due to his lack of a high school diploma. He considered himself charismatic and clever, though, and was able to make supportive friendships in the community fairly easily. This was generally accomplished by offering to do "odd jobs" for people in the community when between jobs. However, he was vulnerable to sexual attraction to children and becoming more familiar with the family both allowed him to gain the confidence of the family and build trust with the children. Adam's initial psychosexual evaluation focused on his history behavior problems as a child and parasitic tendencies as an adult as evidence of the presence of antisocial personality disorder, but due to the bias at the time of evaluation, the role of trauma was not significantly considered in the case conceptualization. While the core components of Adam's treatment program were generally effective in addressing the development of a basic risk management plan, he continued to express resistance to addressing offense-supportive attitudes. Through the process of participating in group therapy, his hold on these attitudes was reframed less as a reflection of antisocial traits and more a developmental consequence of his own abuse. This shift in perspective allowed for a different approach to Adam's treatment, and allowed him over time to more successfully work through his resistance.

In the case of Adam, the bias toward his history of manipulation failed to address the underlying etiological underpinning of his behavior. The targets in treatment assumed that his antisocial personality in of itself drove the behavior, and because of the immutable nature of personality disorders, the foci focused on how he could achieve his goals without risk of legal consequences. The conceptualization of his treatment failed to consider that his response to having been abused himself played a greater role that he was able to volitionally express. He was in treatment

as an adult, but never was provided an opportunity to process the experience of his abuse outside of his concrete operational perspective. While Adam was still vulnerable to some of the emotional and social instability associated with having developed antisocial beliefs, addressing the sexual trauma of his childhood allowed him to tackle his sexual-related risk issues more effectively. In this sense, one could consider his history of trauma as intersecting with his personality disorder.

Trauma in treatment can manifest in other ways, though. For Adam, it manifested as a treatment target concerning how his trauma reinforced his maladaptive beliefs about child sexual abuse while simultaneously supporting maladaptive coping strategies. In the context of personality disorders, Adam's case might be as close as possible to the definition of a "rational actor" with the desire to relieve one's suffering. Many people experiencing personality disorders do not function as rational recipients of treatment (Samar et al. 2013). They may have different priorities or goals than the treatment provider, regardless of their explicitly expressed interest. The case of Ben is presented to consider this issue.

> Ben was returned to a secure custody in the United States following a violation of his community supervision. A previous psychological assessment diagnosed Ben with Antisocial Personality Disorder, along with other substance-related, paraphilic, and mood-related disorders. During this period of detainment, he began to disclose a history of physical and sexual trauma through his life which has previously not been a treatment priority; previous treatment focused on addressing relapse preventionprevention-related targets. He was referred to specialized trauma treatment when available, but this required a considerable delay due to a waiting list for this treatment and limitations on facility resources. During this wait period, Ben became increasingly argumentative about facility rules. Of particular note, Ben would regularly attempt to propose that due to his history of abuse, he should be granted a single room. Space was at a premium and he did not meet the criteria for special accommodations based on his reports of post-traumatic reactions alone. Ben began to report that he was having thoughts of preemptively assaulting his current roommate. His treatment providers discussed augmenting his treatment plan with prazosin to address his nightmares and he was offered less-specialized narrative therapy as an alternative to

waiting for more specialized trauma services. Although he reported benefits from prazosin therapy, he ceased all participation in psychotherapy and began to refocus himself on legal action against the facility. He continued to assert thoughts of harming his roommate and he was reclassified for single-room status due to safety concerns. He continued to refuse participating in therapy despite the consequences against his ongoing assessments of progress.

Ben's story involves a number of other dynamics that are not relevant to the present discussion. However, his psychological assessment highlighted his experiences with the criminal justice system, difficulty with consistent adherence to rules and supervisory expectations, pervasive patterns of impulsivity, and concerns about his attempts to manipulate others to achieve personal gains. His history of trauma did not significantly factor into the diagnostic conceptualization during his previous assessment. When he finally did begin to discuss his history of abuse, unsuccessful attempts were made by treatment providers to validate his reports of abuse and assault while detained at other facilities to ensure the veracity of his self-report (N.B.: such records are not considered definitive as many institutional assaults go unreported or underreported; Saum et al. 1995).

In institutional settings, space is often at a premium (Edgemon and Clay-Warner 2019; Rosenfeld and Kempf 1991). Facilities must develop policies about assigning residents to space balancing the demands of the population (including safety and security) and the needs of the individual (such as medical issues). While it has long been argued that there are many benefits to not placing residents in shared rooms (e.g., Adwell 1991), the populations of inmates and psychiatric inpatients in their respective facilities do not always allow for this opportunity. Having a single room can be reasonably seen as a measure of relief in an otherwise stressful environment, and when facilities make exceptions to undesirable policies, some ISOs may request exceptions based more on personal preference than clinical need (Mallinger 1991; Worley 2016). One of the hallmarks of Antisocial Personality Disorder is the propensity to manipulate others, and the lack of empathy for those effected by that manipulation.

The concern in Ben's case is at what point accommodations should be made based on one's self-report of trauma. Attempts were made to reasonably accommodate his needs through psychiatric and psychotherapeutic means. While he took advantage of some options (prazosin treatment), he elected to pursue his legal efforts instead of utilizing available resources to address his trauma symptoms. This raises the question of secondary gain. While some of his assigned treatment providers made an argument that his warnings of aggression and impulsivity were a manifestation of trauma reaction there were multiple factors leading the majority of clinical staff to interpret this as a manifestation of his personality disorder. First, as noted above, there is the issue of secondary gain: it was known within the facility that making threats against one's roommate increased the probability of being placed on temporary single-room status (although not without long-term consequences). Second: reasonable interventions were available, but despite efforts to work through his resistance, emphasizing motivational interviewing strategies, he continued to refuse available treatment. This was primarily viewed through the perspective of his self-report that it would draw him away from his efforts to pursue legal action, but it was also considered that he may have had the insight that improving his psychiatric status would draw away from the justification for a single room. Finally, the impact of his recently reported history of sexual and physical abuse was weighed against his life history of antisocial behavior. Considering the potential for reinforcing this behavior, as well as providing a blueprint for manipulating the facility to other residents, it was decided to focus on the management of his antisocial tendencies given the earlier mentioned considerations.

Ultimately, Ben was able to make progress addressing his trauma history. He benefited from a change in his primary treatment providers, although it was not definitively determined if this reflected an issue on Ben's behalf (such as transference toward a member of, or his entire treatment team), a better therapeutic relationship fostered by his new therapist, or some other factor. Whatever the reason, Ben was able to begin specialized trauma therapy session after being on a waiting list for this, and shortly thereafter began again participating in core sexually abusive behavior groups. This portion of his history with treatment

describes a major contrast from the case of Adam in how individuals with both Cluster B personality disorders and trauma present. The line between these two needs is not clearly drawn. Both can manifest in abusive or aggressive tendencies. Addressing both can provide improvements in quality of life (Black et al. 2010; Morrill et al. 2008). However, the skilled clinician or assessor cannot consider these unilaterally. It is necessary to consider one's own biases when considering case conceptualization (Bottoms et al. 2015), and these include one's expectations regarding available information at the time of assessment (Falvey et al. 2005). At this time, there is no measure to discriminate between trauma and personality manifestations, but the key difference between Adam and Ben is that the advantage in expressing trauma for Adam was that it allowed him to move forward toward his prosocial objective, whereas for Ben it facilitated gaining an advantage that he was not otherwise entitled. If there was one question to begin the examination of this issue, then it could be, "Why is this manifesting (now)?".

These examples presume individuals have the ability to effectively express themselves. Unfortunately, it is not always so easy for individuals to express their history of trauma. This brings us to one final case to discuss the challenges in conceptualizing trauma reactions and personality disorders, with an emphasis on cultural trauma.

> Charlie, a man of African origin in the United States, was under detention following his conviction for sexually abusing an adolescent female. His long history of criminal convictions influenced his receiving a considerably longer sentence than others with comparable offenses. His institutional record included a variety of rule infractions, including assaultive behavior and possessing or manufacturing intoxicants. The results of his ongoing rule-breaking behavior is that limited his opportunities to participate in specialized treatment programs and he delayed his opportunity to gain supervised community re-entry. Charlie was referred to a treatment program specifically designed to address ineffective decision-making and resistanceresistance to adhering to institutional and supervisory rules. When he began working with his therapist, it was noted that Charlie had adorned his property and clothing with the initials B.L.M. (Black Lives Matter). Charlie's intervention focused heavily on employing motivational interviewing strategies to identify pathways toward greater rule

adherence of treatment amenability. To exemplify this, Charlie was asked to identify what was important to him and what personally relevant goals he had. To summarize the theme of his response, Charlie continually expressed concern for supporting and helping his family and community, and to teach the "younger generation" how to live their lives in a way that both empowers them and reduces the chances of making decisions that result in legal consequences. Charlie was never diagnosed with PTSD or other trauma-related disorders, but his presentation and statement of values encouraged his therapist to view Charlie's presentation through the lens of cultural traumacultural trauma. Charlie was encouraged to consider what was needed for other detainees to improve their chances of community re-entry, rather than focus on what was (perceived as) dictated from administration. It appeared that Charlie was developing more openness to how he could use his experience to benefit himself and his fellow detainees; however, he continued to be cited for rule-breaking behaviors which appeared to reinforce his antagonistic view of the facility. While he was not diagnosed with a trauma-related disorder, he was assigned the diagnosis of Antisocial Personality Disorder. Despite the apparent gains in appealing to his desire to improve the quality of his community's identity and support others in the facility, his behaviors reflected a primary interest in meeting one's own self-interests, whether that be in opposition to the facility or at the expense of other detainees.

The story of Charlie highlights the complicated nature of trauma. In contrast to the stories of Adam (whose trauma history appeared to have a direct impact on his offending history and his ability to successfully return to the community) and Ben (whose trauma did not appear to directly influence his offending behavior but prevented him from fully engaging in treatment), Charlie's story highlights how TIC can provide an avenue toward improved engagement in treatment and improving one's opportunity to demonstrating prosocial personality traits. In addition to their specific and unique trauma histories, each of the men here had behavioral histories which warranted assigning a personality disorder diagnosis as well. Each demonstrated a unique manner in which the manifestation of their trauma history intersected with their unhealthy personality traits. This suggests that case conceptualization goes beyond

just diagnosis and theoretical orientation, but can also benefit from having a trauma-informed perspective.

Practical Suggestions for Case Conceptualization

Under the RNR model (Bonta and Andrews 2016), issues of personality disorders most often fall in the realm of needs. For example, when considering individuals with Antisocial Personality Disorder, a major treatment target could be addressing the offense-supportive attitudes and beliefs of the individual. Issues of trauma are not so clearly defined.

One's history of trauma could be related to treatment needs. This is illustrated above in the case of Adam, if in a somewhat simple manner. Adam's history of trauma directly influenced his offense-supportive attitudes, specifically when it came to his beliefs about sexual behavior with children. His history of trauma also blunted his ability to develop healthy coping strategies; another treatment target included building a healthy repertoire of coping strategies to reduce the likelihood of exhibiting with illicit behaviors. Trauma could also be conceptualized as a responsivity factor, though. While responsivity factors are often myopically limited to intellectual ability and learning disabilities, they can also include factors such as gender, age, ethnicity, and mental health concerns (Bogue et al. 2004). For Ben, his trauma history was a factor in treating his general mental health needs, but did not seem to meaningfully influence his history of sexual offending behavior. Not addressing his trauma did become a factor in his ability to benefit in therapeutic options which would target his specific offense-related treatment needs. In this case, unaddressed trauma was a therapy-interfering factor. Not accounting for Ben's trauma history interfered with his ability to self-regulate and, in turn, benefit from the interpersonal dynamics necessary in effective psychotherapy. In a metaphorical sense, Ben could not "hear" what his treatment provider was saying, much as a patient cannot interpret what a treatment provider is saying if the treatment provider is not communicating in a language that the patient understands or utilizing concepts beyond the patient's capacity for comprehension.

Ben's case shows how one's trauma being explicit and definitive is actually an advantage: he could verbalize the etiology of his trauma-related issues even if appropriate accommodations were debated. Charlie's situation demonstrates that while a trauma-informed perspective can provide different insights into responsivity factors, cultural trauma issues do not provide clear intervention targets. While in ideal psychotherapeutic episodes the trauma event is discreet, the impact of cultural trauma on Charlie is potentially ongoing as cultural disadvantages for individuals of minority sociocultural groups continue at this time. As described in the PTSS theory, anger plays a dominant role in a person's coping response. Consider the difference between destructive and constructive anger, though (Tangney et al. 1996). If left to manifest destructively, then it is strongly possible that this anger can result in a treatment-interfering or impeding factor. However, constructive anger can be thought of as a means to bring about change; in the case of Charlie, tapping into his socioculturally driven anger helped focus him on a pathway toward participating in risk-reducing therapy (Table 12.1).

Considering the potential for trauma's impact in the treatment of sexually abusive behavior among individuals with personality disorders, SAMHSA's (2014) key principles remain relevant. Considering the environment in which this treatment occurs, there are some additional considerations to contextualize TIC.

1. On an organizational level, develop (or amend) policies to allow for accommodating trauma-related issues where possible, but first employ policies consistently and with compassion. Policies should balance the implementation of TIC with the practical demands of an environment to promote personal growth and population safety.
2. When working with individuals who have experienced trauma but also manifest personality disorders, objectively consider the motivation for their behaviors. While there are a variety of different models to examine the etiology of behavior, an example of this is to consider the motivation for a behavior, the willingness to engage in a behavior (particularly in cases of rule-breaking or boundary violations), and how much effort is expended in creating the opportunity for the

Table 12.1 Six key principles for trauma-informed care

Key principle	Description
Safety	Ensure that both individuals being served and those providing services feel physically and psychologically safe
Trustworthiness and Transparency	Decisions should be made with transparency with the goal of building and maintaining trust
Peer Support	Peer support can provide a culture and environment of safety, hope, trust, collaboration, and recovery
Collaboration and Mutualit:	Understanding that both the treatment provider and recipient have a role to play in treatment success, and that all aspects of the treatment environment can contribute to therapeutic progress
Empowerment, Voice, and Choice	Organizations should strive to empower those who receive services, as well as support those who directly provide services
Cultural, Historical, and Gender Issues	Systems should be aware of, and responsive to racial, ethnic, cultural, and gender needs of those receiving services, including historical and cultural trauma

Note Adapted from SAMHSA (2014)

behavior. All of these factors can be examined objectively in the context of either personality disorders or trauma.

3. Consider the cultural context of the individual when developing one's conceptualization of their behavior. In this sense, cultural competence and TIC go hand in hand.
4. Do not mandate trauma-specific interventions (such as EMDR). An individual must be ready to address his/her trauma, but engaging in strategies such as those consistent with motivational interviewing may improve openness to addressing trauma-related issues. This is addressed in the context of justice or corrections-motivated treatment; while addressing trauma may be a risk-related need, it should not be

externally motivated through privilege or opportunity. Motivational interview strategies are highly encouraged, though.

In summary, the manifestations of personality disorders and trauma reactions present with a variety of similarities. Trauma and personality may intersect (having an influence on one another), or run parallel (impact the individual virtually independent of each other). This makes the process of case conceptualization as much of an art as it is a science. It may be tempting to view behavior through the lens of a diagnosis such as a personality disorder, but effective case conceptualization requires repeated, objective reassessment as new information comes to light. This requires an individualized approach to each patient. We must not define ISOs solely on their experience committing sexual offenses, but also how their history of being justice-involved intersects with their experience as a person with a gender identity, a racial and/or ethnic identity, and any other relevant social dynamics to create a lived experience. This includes considering the setting that an individual learned to live in as well as the setting they exist in today. While examples and issues are discussed here from an American point of view, understanding the individualized intersectionality of an individual transcends boundaries.

Skilled treatment providers are also aware of their own countertransference as a result of both individual experiences and societal dynamics—in a therapeutic relationship, intersectionality is relevant for both the treatment provider and the treatment recipient. Thus, whether it is a discrete event, repeated occurrences, or a cultural context, a skilled treatment provider working either with the victims of sexual abuse, those who have sexually abused others, or in many cases both, the consideration of trauma is an ongoing process. This makes the employment of a trauma-informed perspective ever necessary, and with the extant opportunities for training and continuing education today, there is little reason to avoid this.

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