# <HEADER LEVEL ZERO> Trauma-informed care in secure settings: The whys, hows and challenges associated

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## <HEADER LEVEL ONE> The case of Paul

Paul[2] was having a difficult time moving forward in treatment. He had been civilly committed, meaning he was deemed by the courts to be at a high risk of re-offending sexually and to have diagnoses that predisposed him to further acts of sexual violence. Once civilly committed, it is notoriously difficult to be released; something that has been the subject of controversy and legal action (Brandt, Wilson, & Prescott, 2015; Prescott, 2015).

Paul had been in the earliest stages of treatment for a long time. He could not seem to refrain from physically assaulting the uniformed staff in the institution; each time he appeared better able to manage his behaviour, he would involve himself in a situation where he became aggressive. Curiously, Paul was a highly effective treatment participant, and may have been just as good at teaching cognitive skills courses as any of the clinicians in the institution's employ. There was almost no accounting for his aggressive behaviour, which some staff referred to as "self-sabotage".

As it turned out, Paul had a long history of being traumatised by people in authority. Further, where the staff members all saw a sedate living unit in a high-security setting, Paul lived with constant reminders about the potential threats to his safety – just as much from the uniformed

[1] The author is extremely grateful to have collaborated with others in this subject area, including Jill Levenson, Gwenda Willis, Dave Emerson, Karen Webster, and many others.
[2] All names used in this chapter are fictitious

staff as from the other clients. To others outside of the living unit, Paul appeared to be high-functioning and to possess good verbal skills. However, when left on his own in the living unit, he was locked in an ongoing pattern of viewing his surroundings as dangerous and living in a constant state of readiness to react to the slightest indication of a threat. To others, his assaults seemed to come without provocation. However, Paul was an astute observer of others; his historical survival had been built on his ability to scan his environment for threats. This posed a dilemma: on the one hand, he was extremely effective at protecting himself; on the other, he grossly over-estimated the risk that others posed to him, and because he was constantly looking out for his own survival, Paul was unaware of this dilemma.

Without knowledge of how his past experiences had shaped his present-day functioning, Paul appeared to the staff to be a high-risk, high-treatment need, and low-amenability client, who simply did not apply what he learned in treatment to his behaviour. It was easy to view him through the lens of the diagnostic criteria for Antisocial Personality Disorder and assume that he was willing to cause harm to the rights and welfare of others whenever it suited him. At the time, the thinking of many professionals was that if Paul had tried to address the role of trauma in his behaviour (including his offending), it would mean that he was attempting to make himself less culpable. In other words, not only was treatment focused exclusively on directly reducing risk, there was an ethic that complete acceptance of responsibility was more important than a holistic understanding of one's life and pathways to offending.

One thing was certain however, by all accounts, Paul's aggression did seem to come from nowhere. In the parlance of marksmanship education, which teaches the sequence of "ready, aim, fire", Paul seemed to be in a constant mode of "ready, fire, aim". Although various psychotherapeutic models describe the sequence of events ending in action differently, it became clear that Paul's in-the-moment experience involved elements well beyond cognitive-behavioural

explanations. Ultimately, given Paul's focus on external threats, it was untenable to ask Paul to change his cognitions and behaviours before he could actually become aware of and observe them. Paul's life had left him unable to focus internally. It was no wonder he could learn the words of cognitive-behavioural interventions, but not fully appreciate or integrate them into his efforts to build a better life. Ultimately, cognitive-behavioural and dialectical-behavioural approaches would have to wait.

With the use of Paul's case example, this chapter explores trauma-informed care (TIC) in secure settings, with a particular focus on the nuances involved in understanding clients, the challenges that play out in therapist-client relational dynamics, and implementing the most conducive possible environment for change under the conditions. It explores how the history of the field of treating people who sexually offend has evolved to this point and discusses how our diagnostic categories have not always served the field well. It goes on to describe how developmental trauma can influence the development of risk factors for offending and re-offending and act as barriers to leading a good life (as viewed through the lens of the Good Lives Model [GLM]) (Prescott, 2019; Yates, Prescott, & Ward, 2010).

## <HEADER LEVEL ONE> Trauma-informed care (TIC) in secure settings: Background and challenges

There is a saying that "You are sent to prison as punishment, not for punishment". In other words, imprisonment is itself the punishment, not a circumstance in which the staff members are expected to punish those who have broken the law. In the author's experience (and there is apparently no meaningful study in this area), there can be a lack of clarity in the professional boundaries of people who work in secure settings. For some, even though their work is intended

to be rehabilitative in nature, it is too easy for moral judgements to enter the tenor of conversations between those employed by the secure setting and those who reside in it. Even within forensic psychiatric hospital settings, role confusion can exist, with the result that staff can view people who have abused as "moral strangers" rather than "fellow travellers" in the same world (Purvis, Ward, & Willis, 2014, p. 209).

The early years of treating people for sexual aggression saw an understandable suspicion towards understanding their adverse life experiences. Bestsellers such as *The Abuse Excuse: And other cop outs, sob stories, and evasions of responsibility* (Dershowitz, 1995), emphasised that claiming victim status, as many famous criminal defendants had done, was in direct contradiction to the values of democracy. In an influential paper in 2001, Jan Hindman and James Peters wrote about the "sex offender as victim paradigm" stating that:

> "In the early years of sex offender research and treatment, clinicians typically asked offenders to report on their own early histories. In staggering numbers, they reported that they had been sexually abused as children… even the normally-sceptical mental health community readily accepted such claims, in part at least because they offered a comforting explanation for the otherwise inexplicable behaviour of child molesters… it was not until offenders' self-reports began to be compared with reports verified by polygraph that the sex-offender as-victim idea was challenged and discredited" (p. 9).

By 2007, however, these seemingly categorical beliefs (for example, that all people convicted of sexual crimes fabricate abuse histories for exculpatory purposes) had given way to a more nuanced understanding. In a review of the available literature, Dominique Simons noted that prevalence was indeed quite high, that interviewing people who had been through extensive

treatment appeared to yield more meaningful results, and that the most accurate means of understanding the prevalence of abuse in these men's backgrounds involved using behavioural descriptions and not emotionally laden terms such as "abuse".

Trauma and adversity can affect people in drastically different ways. Levenson, Willis, & Prescott (2016) found in a study of adult males convicted of sexual crimes that the rate of child sexual abuse was nearly 14 times that of the general population. Likewise, these individuals described nearly twice the odds of physical abuse, 13 times the odds of verbal abuse, and more than 4 times the odds of emotional neglect and coming from a broken home. Less than 16% of these men endorsed having no adverse childhood experiences. At the same time, nearly half endorsed four or more. Multiple maltreatments often co-occurred with other types of household dysfunction, suggesting that many individuals convicted of sexual crime were raised within a disordered social environment. Higher Adverse Childhood Experiences (ACE) scores were associated with higher risk scores.

There are many implications that follow this. Firstly, this study added to what had already been known for quite some time; namely, that our prisons house significant numbers of people with various forms of mental illness, and this includes Post-Traumatic Stress Disorder (PTSD). Second, it suggests that practitioners who engage in harsh or confrontational methods are not only practicing what studies have found is not an effective style (Marshall, 2005), but may actually risk replicating the very environments that clients grew up in. This is not insignificant; over time, many observers (e.g., Jenkins, 1990) have found that men who have been abusive and violent can appear to invite the therapist to adopt a confrontational style. Third, in the author's experience, when clients do engage with professionals whose approach is harsh and confrontational, it actually serves to prevent the hard work of examining and improving one's relational style.

Taken together, our field's history and broader western cultural values have often combined to lead professionals to a dim and un-nuanced view of the role of trauma and adversity in the lives of our clients. All too often, the problem at the front line of treatment is not that clients lie to avoid responsibility (although this certainly happens), it is that they have not always recognised the effects of trauma and adversity in shaping their lives (Levenson, Willis, & Prescott, 2017). This will be explored further in the sections that follow.

<HEADER LEVEL ONE> Trauma-informed care (TIC) in secure settings: Challenges in implementation

Making secure settings, particularly large institutions, truly trauma-informed can be especially challenging. A 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, 2019). It is worthwhile pausing here, and considering some important questions that arise from attempting to implement a trauma-informed approach.

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<HEADER LEVEL TWO> Reflective questions for professionals and organisations when considering implementing a trauma-informed approach:

- When considering the widespread impact of trauma, has your secure setting taken this to include many (i.e. the vast majority) of the people in its care? As much as the lay public often perceives a divide between victims and victimisers, those who victimise have very often been victimised. If we are to be sympathetic to those who have been harmed by trauma and adversity, does not this include those who end up in secure settings? Does hurting others negate our concerns for their welfare as people who have been hurt?
- When considering the potential paths for recovery, has the setting considered the many ways that recognising the impact of past trauma can be helpful to people beyond simply providing high-quality therapeutic services? After all, becoming trauma-informed means transforming the treatment and the culture in which that treatment exists. It does not necessarily mean providing treatment for trauma.
- Reflecting on the recognition of the signs and symptoms of trauma in clients, to what extent are professionals in secure settings recognising the many ways that trauma has manifested in clients' lives? This might include many of the items in our risk assessment scales (e.g., relationship instability, emotional dysregulation, etc.). It might also be that the results of trauma and adversity have left their mark in the life events that have culminated in various diagnoses, such as Antisocial and Borderline Personality Disorders, substance abuse disorders, and many others.
- Reflecting on recognition of the signs and symptoms of trauma in staff may actually be among the most difficult tasks in any consideration of implementing TIC. There are few, if any, applicable studies on the topic. However, those who have worked in secure settings and are sensitive to the signs and symptoms of trauma can easily recognise that staff members in these settings often display serious signs of the cumulative effects of trauma. Some agencies have set up an assistance programme for staff who become

concerned about how the work they do affects them or opens up old wounds, or hired a licensed therapist for the staff to see at no cost. Although vicarious (also known as secondary) traumatisation is the topic of a number of research studies, the simple fact that staff members often have trauma histories of their own has received insufficient attention in the field and needs to be considered in any implementation. For a detailed exploration of 'the cost of caring', see chapter 7 of this volume.

- Finally, there is the issue of re-traumatisation and the question of how best to prevent it in a secure setting. Re-traumatisation is not the same as traumatising someone. Rather, the term refers to re-experiencing elements of traumatic events in one's present-day environment. Sometimes, this can spark memories of adverse incidents, or it can be a response beyond someone's awareness. For example, in the case of Paul (as described in the beginning of this chapter), seeing uniformed guards activated a rapid response and move towards aggression that was difficult for Paul to understand. Further examples are discussed in later sections of this chapter.

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Implementing changes such as TIC to practice at the individual and institutional level is hard enough without considering the personal nature of implementing TIC (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). One need only look at the medical world's attempts to implement handwashing as disease prevention to see that not every implementation of an evidence-based practice goes according to plan or as quickly as hoped. In this way, becoming truly trauma-informed requires self-compassion as well as diligence at an individual and institutional level.

Professionals and administrators in secure settings will naturally have concerns that many clients in secure settings are considered responsible for their actions, while others are considered not competent to live responsibly in the community. Setting aside questions about the definitions and connotations of terms such as “competence” and “responsibility”, TIC is not meant to absolve people of their behaviours, but rather provides a lens through which professionals and the secure settings in which they work can develop a deeper understanding and ability to provide treatment to these individuals.

<HEADER LEVEL TWO> Initial application: Reconsidering Paul

Let us return to the case of Paul from the beginning of this chapter. After his first conviction, as an adolescent, he had been placed in a juvenile detention centre. At that time in the US, there was a moral panic about young people who violated the law as being at risk of becoming part of a rising tide of so-called “super-predators” (Larsen & Carvente, 2017). The staff members in Paul’s program used harsh, confrontational methods in order to ensure that he disclosed the full extent of his actions, and labelled many of his thoughts as cognitive distortions. The rationale at the time was that a willingness to acknowledge and become accountable for all behaviours at the outset of treatment was far more important than whether or not a client in treatment had endured trauma or adversity. Unfortunately, Paul’s upbringing, in a home marked by domestic violence and drug abuse, left him in greater need of learning about accountability before he could actually become accountable.

As Paul grew older, he re-offended sexually and went to prison for several years before ultimately becoming civilly committed. It was in the civil commitment centre that he became noticed as highly skilled in teaching the very cognitive skills that he was unable to master

himself. Despite the best efforts of the institution's administration, secure settings are all too often re-traumatising. People are typically housed in very small rooms or cells, locked into their rooms at night, share space with a potentially threatening roommate, and are observed by staff who remind them of past authorities they viewed as abusive. It is important to understand that the events inside a secure setting can be re-traumatising, regardless of the best intentions of all involved. Implementing TIC does not mean removing all potentially re-traumatising circumstances - that would likely be impossible; rather, TIC implementation involves minimising these circumstances as much as possible, without compromising the security or integrity of the programme.

<HEADER LEVEL THREE> A case example of TIC implementation

Paul's institution was at a crossroads. They had tried to change the client unsuccessfully and thus came to conclude that the situation required programme- and institution-level change. However, new questions quickly followed these decisions. The administration pursued steps along the lines of:

- Consultation with an external expert to ensure that moving to a trauma-informed approach was the correct course of action for the organisation.
- Staff training delivered by an external expert to raise the staff's awareness of the prevalence of trauma and how otherwise well-intended behaviours can cause re-traumatisation (as described above, this means that sometimes seemingly innocuous events can cause clients to re-experience elements of past traumatic events).

- The staff received further training in communication methods that would reduce the risk of re-traumatisation. This included training in motivational interviewing and other approaches grounded in demonstrating respect, safety and empathic understanding.
- The administration wrote policies regarding TIC and its place in the institution, including both in treatment programming itself and on the living units, medical facilities, and areas where the clients worked. For example, the policy document describing the institution's approach to treatment specifically stated that treatment was to be trauma-informed. Likewise, the policy regarding protocols for medical staff stated explicitly that all staff should keep in mind that they were dealing with people who had been traumatised in addition to having caused harm to others. Finally, the director of the facility placed a sign above the entrance reminding the staff that "kindness matters".
- The treatment programme staff members learned key skills in therapeutic engagement in order to approach their clients in a spirit of collaboration rather than as adversaries.
- The treatment programme added adjunctive programming such as meditation and trauma-sensitive yoga (Emerson, 2015). The treatment rationale is that these activities specifically focus on observing thoughts, sensations, and behaviours. Self-observation of these experiences is critical to changing one's thoughts and behaviours. These methods are different from other forms of yoga and meditation in that the focus is entirely on self-observation (as opposed to competitive stretching) and they are delivered in a manner that is cognisant of re-traumatisation. As one example, trauma-sensitive meditation avoids holding one's breath, as doing so can be highly activating for people who have been abused (e.g. choking). Likewise, the wrong yoga positions can leave the practitioner feeling vulnerable or frightened based on past experiences.

- Importantly, the treatment programme also implemented treatment approaches specifically focusing on trauma, but did not automatically assign them to everyone. Rather, all treatment delivery was provided in a fashion sensitive to the widespread effects of trauma, even when the interventions were not trauma-specific.

Ultimately, Paul would not have an easy time of interacting with uniformed staff for a long while. However, his response to the adjunctive treatments, especially meditation, helped him to notice thoughts, sensations and emotions as they started to arise in challenging situations, with the end result being that he was finally able to begin adopting the many skills that he had only cognitively learned up to that point, although he could only practice when he was calm. A major teaching point for Paul's caretakers was that client experience does not always match the theories underlying our treatment models. For example, many professionals might assume that cognition precedes emotion, which in turn precedes behaviour. In Paul's case, this elegant theory had no practical value; fighting back against a perceived threat was so ingrained in his functioning that only developing self-observation skills outside of other interventions could prepare him for more traditional, evidence-based treatments. Neuroscience has found that dysregulated arousal is often attributable to compromised nervous systems in the wake of trauma and adversity (Ogden, Goldstein, & Fisher, 2012)

<HEADER LEVEL TWO> Going deeper: PTSD and developmental trauma

Perhaps one reason why TIC has been so difficult for professionals to understand and implement is that trauma has been so poorly defined in the literature. The American Psychological Association's (APA) definition describes it as an "emotional response" and implies that psychologists are best suited to help people recover from it:

> "Trauma is an emotional response to a terrible event like an accident, rape, or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives. Psychologists can help these individuals find constructive ways of managing their emotions." (American Psychological Association, no date given)

A brief definition of trauma provided by the British Psychological Society is similar, noting emotional and physical responses (British Psychological Association, no date given). However, neither definitions sufficiently acknowledge the myriad of cognitive, relational and physical consequences that often take place as well.

Findings from the ACE studies described elsewhere in this book appear to belie these definitions (for example see chapters ??). The sequelae of trauma appear to include many unfortunate physical outcomes such as heart pulmonary disease. Further, many people who have been abused describe somatic challenges such as hating their bodies (Emerson, 2015). Of note, these studies have largely taken place outside of secure settings. Once incarcerated, it is difficult to describe the myriad implications of physical functioning. In a visceral account, Rivas (2019) described imprisonment as "like being a ghost" and stated, "To put it in vulgar terms: From that point on my ass belonged to the (Bureau of Prisons)". Although there are few, if any writings on the topic, being sensitive to the changing relationship that clients in secure settings have with their own bodies, particularly in the wake of trauma, is crucial to understanding the full spectrum of their experience.

Likewise, the APA's definition of trauma focuses on emotional responses to the exclusion of relational sequelae. Risk assessment instruments for people convicted of sexual crimes are replete with proxies for relational challenges (e.g. whether or not the person victimised was a relative or a stranger, as well as the length and quality of intimate relationships and peer associations). One need only work for a short time in the field of treating people who have abused before discovering that those who have abused and those who have been victimised commonly have long histories of relational challenges. All too often, these are viewed as risk factors rather than part of a broader narrative of events that the client has had to grapple with, often at a very young age. Rather than viewing relational challenges as risk factors, it may make more sense from a treatment perspective to consider these as the barriers to developing a balanced and self-determined lifestyle.

Tying the above threads of trauma sequelae together, it is clear that there is more to the effects of adverse experiences than simple emotional responses. This seems important to consider, given that the criteria for PTSD have been the primary means by which clinicians consider trauma diagnoses. In other words, many professionals' over-arching view of trauma and adversity have been shaped by definitions and diagnostic criteria that do not necessarily reflect the experience of those who have been traumatised. As helpful as these definitions and diagnostic criteria can be, the author has come to believe that they lack explanatory depth. Further, in order to truly understand and work with clients who have experienced trauma and adversity, it may be important to look further into each client's experience. In considering the limitations of definitions and diagnostic criteria, two things become clear.

1) PTSD was developed to explain primarily the experiences of adults who experience horrific events. The diagnostic criteria do not recognise or account for the very different experiences of young people who experience traumatic and other adverse childhood

experiences. A central consideration (alluded to earlier) is whether the client in treatment even recognises their experiences as traumagenic. Likewise, early childhood trauma can create long-term aftereffects (described below) that are well outside the scope of PTSD criteria and go unnoticed (as can be seen in the case of Paul). This is precisely why many professionals prefer to describe the experiences of their clients in terms of "developmental trauma" (van der Kolk, 2015).

2) The ICD-10 criteria for PTSD do not seem to have been particularly influential in historical attempts to understand clients. It can be easy to make a list of symptoms, but harder to see how the diagnostic criteria and the client's life experiences have interacted with each other to provide an understanding of how the sequelae of trauma have affected the client over time. Beyond thinking about definitions and diagnosis, professionals may want to see if they can re-cast the effects of trauma into a narrative to explain the client's life and functioning.

To extend these ideas, as a thought exercise, the reader may wish to review the criteria and determine how many of them apply to their clients who do not carry a PTSD diagnosis. For example, is the inability to recall specific events from the time of exposure a trauma symptom, an unwillingness to disclose information to a therapist, reluctance to change, or some combination of each? What if the person experienced his own actions as traumatic? Is the inability to recall or unwillingness to disclose an act of self-protection to be honoured and discussed rather than evidence of non-engagement? At what point do professionals view reticence as a PTSD symptom rather than the actions of a difficult client? Ultimately, understanding the nuances of how events have shaped a client's life can be crucial for helping them. All too often what looks like opposition or defiance can actually be evidence of survival skills.

<HEADER LEVEL THREE> Cascade effects of trauma

Seen through a different lens, it may make sense to examine trauma in terms of its long-term, or cascade effects. Summarising decades of research (e.g., van der Kolk, 2015), trauma and other adverse childhood experiences appear to result in long-term challenges in the following areas:

**Attachment:** Put simply, trauma impacts the relationship between caregiver and child. It impairs the capacity to trust and form secure relationships. Many challenges flow across the life span from this single fact alone. For example, while other young people will grow up and gradually take constructive risks in establishing friendships and intimate relationships, young people who have experienced adversity often view relationships with others as potentially threatening.

**Cognition:** Surviving adversity often involves thinking about the world very differently from people who do not have to cope with such stressors. The young person's thought patterns naturally focus on keeping one's self safe. He or she comes to expect very different things when encountering and interpreting the outside world. Very often, staying safe involves scanning one's environment, constantly on guard for evidence of threats and potential harm by others.

**Self-regulation:** Research has established that early adversity can result in significant challenges in regulating one's emotions, behaviour, and sometimes attention. This can take the form of impulsivity, challenges in coping with stress, and problems focusing and maintaining attention.

**Cascade Effects:** As young people grow up, challenges in one of these areas can create difficulties in one or more of the rest. For example, the student who is constantly scanning his environment for threats will likely appear to others to have problems with attention (even though the student is, arguably, staying focused on surviving). The same student will face difficulty

forming a close bond with their teachers, and likely view them as a potential threat. Not surprisingly, the student will then have significant difficulties with behaviour management in the classroom. When problems occur, this might contribute to attitudes that teachers are unsafe, that other school resources are unhelpful, with the result that the student comes to believe that he or she is different from other students, cannot fit in, and so on. It is therefore no surprise that the young person has difficulties forming the relationships with others that will lay the foundation for more intimate partnerships later in life.

<HEADER LEVEL THREE> Cascade effects of trauma and sexual crime

While the previous section describes the interactive effects of childhood adversity generally, the question remains: How do the above factors translate to risk for sexually abusing others?

**Attachment:** Early problems in attachment, when combined with the other aftereffects of trauma, may result in any number of risk factors. The following are taken from a review by Mann, Hanson, & Thornton (2010):

- Loneliness;
- Negative social influences;
- Sexual preoccupation;
- Sexual preference for children;
- Emotional congruence with children;
- Lack of emotionally intimate relationships with adults;
- Grievance/hostility;
- Hostility towards women;

- Machiavellianism;
- Callousness/lack of concern for others.

In other words, studies of adults and adolescents who sexually abuse often find abuse experiences in their background, as well as sequelae such as those mentioned above (Grabell & Knight, 2009; Seto & Lalumière, 2010). As one scenario, the young boy who is exposed to his father's violence by his mother may be more likely to adopt hostile attitudes towards women. As another scenario, a boy molested by an adult may develop abuse-related sexual fantasies, interests, and behaviours that result from the memories and feelings of these early experiences. Further, there is some evidence that boys experiencing sexual abuse in childhood have elevated levels of sexual abuse later in life (Grabell & Knight, 2009).

**Cognition:** Early experiences of adversity can result in risk factors related to cognitions, attitudes, and beliefs, such as the following (extracted from Mann et al., 2010):

- Poor cognitive problem-solving;
- Offence-supportive attitudes (although not specifically referenced, these may include not just attitudes, but implicit theories about the world that can contribute to sexual offending, such as the belief that the world is a dangerous place, that children are able to consent to sex, or that women are deserving of sexual violence).

To summarise, the experience of adversity can easily, almost necessarily, lead to perceiving the world differently. The person who is abused, neglected, or otherwise traumatised may become more suspicious of the intentions of others on one hand, or may develop the belief, based on his experience, that children are able to consent to sexual experiences. The simple fact is that people who have experienced higher levels of adversity end up thinking more about adversity than others would who have not had such experiences. Likewise, in the wake of adverse experiences,

the person naturally develops different skills for solving problems than their non-traumatised counterparts. For example, their perceptions of possible threats to their wellbeing may be more focused on immediate circumstances (such as assessing possible hostile intentions by others), than on circumstances that are further off into the future (e.g. deciding not to vacation in an area known to have a high crime rate or emerging political instability).

**Emotional regulation:** Early adverse experiences can also result in other risk factors related to emotional regulation. Taken from Mann and her colleagues (2010):

- Sexualised violence;
- Lifestyle impulsivity;
- General self-regulation problems (impulsivity, recklessness / employment instability);
- Resistance to rules and supervision (childhood behaviour problems / noncompliance with supervision / violation of conditional release);
- Dysfunctional coping (sexualised coping / externalising).

These risk factors make sense as trauma sequelae when one views the individual's daily behaviours as focused on trying to survive circumstances that have a high perceived likelihood of dangerousness, rather than the circumstances that their non-traumatised counterparts might perceive. For example, being quick to anger or impulsivity is actually an important attribute to someone who may need to protect themselves on a moment's notice. Further, given that reproductive urges are a natural part of human experiences, it may be that the individual views sexual violence as an acceptable short-term mating-effort strategy in the perception of someone who witnessed women being abused from an early age (Lalumiere, Harris, Quinsey, & Rice, 2005). Finally, it makes sense that individuals who live their lives protecting themselves from

perceived immediate threats will develop a different repertoire of coping skills than those without such a history.

**Cascade effects:** Early challenges in any one of these domains can impede further development in other areas. For example, problems in coping with life's stressors can lead to impulsive and reckless behaviours, which can in turn lead to resistance to rules and supervision. This is detrimental to building healthy and satisfying relationships, and can sustain pro-offending attitudes and beliefs. Understanding the cascade effects in terms of both trauma sequelae and risk factors can be particularly important in secure settings, where clients often present with more complicated risk profiles. Where many risk assessment protocols essentially create a list of factors, a trauma-informed approach can help to explain their aetiology and interaction.

Of course, the story of trauma and adversity does not end with risk. Although the above are important to understand in order to protect the public from harm, and clients in treatment from the consequences of their own behaviour, risk factors may best be seen as barriers to achieving a life worth living (Prescott, 2019; Purvis et al., 2014; Yates & Prescott, 2011). In order to explore this further, it can be useful to view trauma, adversity, and risk from the perspective of the Good Lives Model (GLM).

### <HEADER LEVEL THREE> The Good Lives Model (GLM)

The GLM is a strengths-based, comprehensive, and over-arching framework for rehabilitation. It builds on the assumption that all human beings are motivated to attain certain goals, experiences, or states of being referred to as primary human goods (Purvis et al., 2014) or common life goals (Yates & Prescott, 2011). The GLM also proposes that sexual offending results from challenges

in attaining these common life goals (Prescott, 2019; Purvis et al., 2014). Understanding how trauma interferes with adaptive ways of seeking these goals can be fundamental to establishing therapy goals at the individual level. It is also fundamental to developing treatment programmes for the institution. For example:

**Attachment:** Life goals that can be challenging in the context of attachment difficulties include friendships and relationships, being part of a community, and having a sense of meaning and purpose in one's life. Attachments might also be related to one's capacity for inner peace, happiness, and creative endeavours. The pursuit of each of these goals becomes far more complicated when one lacks the capacity or means to achieve them in a pro-social way.

**Cognition:** Life goals that can be challenging in the context of trauma-related cognitions include having meaning and purpose in life, acquiring knowledge, and having novel and creative experiences. GLM-related attitudes and beliefs may also include the belief that these goals are attainable in one way or another without causing harm to others.

**Self-regulation:** Life goals related to this important area of functioning include remaining autonomous and independent, being able to have new and creative experiences, having states of happiness and pleasure, being good at work and leisure interests, and healthy life skills and functioning.

**Cascade effects:** Problems in achieving one area of a good life can often affect another. Most professionals have experienced difficulty maintaining a healthy balance of work and rest, as well as balancing time with others and time to one's self. Certainly, clients in treatment can have similar experiences in achieving a balanced pursuit of life goals. Ultimately, however, the cascade effects of trauma are clear: adverse experiences create challenges in development, which create barriers to achieving a balanced, self-determined, and fulfilling life. Ultimately, this

results in risk factors for causing sexual harm, which in turn leads to further barriers in creating a healthy and satisfying future.

## <HEADER LEVEL ONE> Returning to Paul

Let's return to the case example of Paul. After he became able to stabilise his behaviour, he was able to work in treatment to fully explore his early life experiences. Rather than view these as exculpatory excuses for offending, he came to realise the many ways that growing up in adverse circumstances involving periodic victimisation had harmed his capacity for close relationships. Further, these experiences had left him constantly scanning his environment, seeking out evidence of threats and/or wrongdoing by others.

This constant environmental scanning was not just a symptom, it was a way to survive in a world that often appeared remarkably dangerous. Paul came to realise that his early life experiences with authority had left him with a profound distrust of all authority figures: the police and child welfare workers constantly seemed out to get him, while teachers seemed unable to help him learn, and mental health professionals were merely people who could not help him despite their saying that they could. He was so focused on surviving that he was never able to pay attention in school, which certainly did not assist him in getting along with his teachers. As he grew older and his classmates started dating and entering into relationships, Paul had already come to believe that he could not trust young women of his same age. In fact, it seemed that no one accepted him except for children who were much younger than he was, and occasionally other peers who did not fit in but who could supply him with recreational drugs.

Impulsive and lacking effective problem-solving skills, but interested in sex nonetheless (he would recall later that the incidents of sexual victimisation he experienced were the closest he had ever come to feeling loved), Paul sought out considerably younger children as sexual partners. This brought him into the legal system, which further limited any access he might have had to building healthy attachments, healthy emotional-regulation skills, or the attitudes and beliefs necessary to succeed. Further, all of Paul's experiences and actions had served to create barriers to the safe, healthy, and satisfying pursuit of his life's goals. This ongoing pattern of challenges and fighting back against perceived threats left Paul in a state of constant hypervigilance, to such an extent that traditional cognitive-behavioural treatments could not work until the institution was able to modify its approach to him and the many other clients whose trauma had gone unrecognised.

## <HEADER LEVEL ONE> Conclusion

There have been too many cases like Paul's in secure settings around the world. In erstwhile times, when professionals eyed much of what their clients told them with deep suspicion, understanding and coming to terms with clients' histories of trauma and adversity did not receive the prioritisation it deserved. All too often in the perceptions of the clients, treatment and the institutions in which it took place came to resemble the very environments in which the clients' initial trauma history took place. Although it is easy to dismiss past efforts at providing treatment, the field's historically risk-focused approach was certainly understandable given that studies were not able to find positive effects of treatment to a satisfying degree. The author advocates an approach towards TIC that does not negate risk, but rather places it into a deeper context for change.

As noted throughout this chapter, proper implementation of TIC in secure settings means not just modifying treatment regimes, but raising awareness of the prevalence of trauma among the staff and administration, and providing training in TIC-adherent interactional skills for all staff. Institutions will be most trauma-informed when they are actively seeking to minimise re-traumatisation and when they are cognisant of and attending to the role of trauma and adversity in the lives of the staff, including burnout and the activation of trauma sequelae in the work environment. Becoming trauma-informed is certainly hard work. However, the programmes and professionals that have done so report that experiences in treatment and the institution improves for all concerned.

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