Chapter 24
Trauma-Informed Treatment Practices in Criminal Justice Settings

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

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

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

J. S. Levenson (✉)
Barry University, Miami Shores, FL, USA
e-mail: jlevenson@barry.edu

D. S. Prescott
Private Consultant, Director of Acquisitions and Training, Safer Society Press, Brandon, VT, USA
e-mail: davidprescott@safersociety.org

G. M. Willis
The University of Auckland, Auckland, New Zealand
e-mail: g.willis@auckland.ac.nz

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

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

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

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

Trauma and Crime

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

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

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

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

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

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

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

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

The Traumatic Childhood

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

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

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

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

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

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

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

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

Diagnostic Considerations

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

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

What Exactly is Trauma-Informed Care?

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

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

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

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

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

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

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

Trauma-Informed Care and Criminal Justice

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

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

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

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

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

The Anatomy of Trauma-Informed Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What It All Means for Practitioners

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

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

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

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

Useful Questions for Professionals and Organizations Interested in Implementing TIC

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

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

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

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

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

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

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