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Implementing Trauma-Informed Care in Correctional Treatment and Supervision

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ABSTRACT

This article provides a rationale for trauma-informed care (TIC) in correctional services, and challenges readers to think about offending behavior through the lens of trauma. Based on interdisciplinary research and cross-theoretical literature, TIC can help in our quest to develop relevant and successful programs, practices, and policies, and the best methods for delivering them. Using Substance Abuse and Mental Health Services Administration (SAMHSA)'s core principles of TIC, this article will make suggestions for the implementation of trauma-informed service delivery and practices across correctional settings. The authors translate trauma-informed concepts into practice behaviors through the acronym SHARE (safety, hope, autonomy, respect, empathy), which honors the principles of TIC recommended by SAMHSA and the principles of effective correctional rehabilitation. TIC in corrections may help improve the desired outcomes of successful re-entry and reduced recidivism.

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Introduction

People convicted of crimes rouse little sympathy. Against a societal backdrop of crime policy emphasizing offense culpability and punishment, it is not surprising that correctional programming and community supervision practices have rarely addressed the role of trauma in offending behavior. The reality is that many people who commit crimes were victims of child maltreatment and family dysfunction as youngsters, and correctional clients have much higher rates of adverse childhood experiences (ACEs) than the general population (Baglivio et al., 2014; Harlow, 1999; Levenson & Grady, 2016; Maschi, Gibson, Zgoba, & Morgen, 2011). Early adversity changes the neurochemistry of the brain, sometimes compromising self-regulation and executive functioning into adulthood (Holley, Ewing, Stiver, & Bloch, 2017; van der Kolk, 2006). Viewing criminal behavior through the lens of early trauma does not excuse crime or victimization; rather, it enriches our understanding of how criminal behavior develops and informs intervention

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strategies. In this way, we can improve desired outcomes such as reduced recidivism and successful reintegration.

Traditionally, correctional treatment services – especially for males in the U.S. – have been highly risk-focused and confrontational, neglecting the principles of effective correctional rehabilitation and trauma-informed care (TIC) (Kubiak, Covington, & Hillier, 2017; Levenson, Willis, & Prescott, 2017; Miller & Najavits, 2012). While many practitioners, administrators, and policymakers know of TIC and are familiar with its basic principles, male correctional populations are among the last frontier for TIC implementation. There is a need to help treatment providers, correctional supervisors, and case managers translate TIC concepts into practice based on the guiding principles outlined by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Correctional settings pose unique challenges when applying trauma-informed skills that engage clients in a healing relationship to foster positive change (Donisch, Bray, & Gewirtz, 2016). This article aims to address some of these challenges and provides recommendations for implementing TIC in correctional services.

The over-arching goal of TIC is to incorporate knowledge about the neurobiological, social, and psychological effects of trauma into policies, procedures, and practices that guide a safe, compassionate, respectful service delivery environment (Bloom, 2013; Bloom & Farragher, 2013; Brown, Baker, & Wilcox, 2012; Fallot & Harris, 2009; Giller, Vermilyea, & Steele, 2006; Lang, Campbell, Shanley, Crusto, & Connell, 2016; Levenson et al., 2017; Miller & Najavits, 2012; Saakvitne, Gamble, Pearlman, & Lev, 2000; SAMHSA, 2014b). TIC is a framework that conceptualizes current problems as maladaptive coping strategies viewed in the context of collective past experiences, and proffers that a positive therapeutic alliance can be a powerful tool to address trauma's long-term effects (Giller et al., 2006; Knight, 2015; Levenson, 2017; Saakvitne et al., 2000). Correctional mandates and court-ordered services can be disempowering and oppressive, replicating traumagenic childhood conditions. Accordingly, a fundamental goal of TIC is to proactively avoid re-traumatization in the service delivery setting by creating safe spaces for vulnerability, accountability, honesty, and ultimately, change (Bloom, 2013; Levenson, 2017; SAMHSA, 2014a).

In this article, we will first focus on the essential components of TIC. Next, we will conceptualize criminal justice (CJ) involved cases through a perspective informed by trauma research. We will then offer ideas for implementing strategies that avoid repeating traumagenic dynamics in service provision. Finally, we apply SAMHSA's components of TIC to help transform CJ interventions into more collaborative, empowering, and client-centered practices that facilitate a corrective experience and successful reintegration.

Conceptual and empirical framework of TIC

Trauma is defined as an experienced or observed event that threatens the physical or psychological wellbeing of oneself or others, and produces feelings of fear, helplessness, or shock (American Psychiatric Association, 2013; Bloom, 2013). Trauma can be triggered by any unexpected event outside of a person's control, including a natural disaster, illness, accident, violence, war, or loss of a loved one. Further, relevant and frequently overlooked are the intergenerational effects of historical trauma – such as systemic oppression, poverty, and discrimination – which are common among indigenous persons, ethnic minorities, and other marginalized groups.

Common physical and psychological responses to trauma include hyperarousal, intrusive or preoccupying thoughts and images, mood dysregulation, and avoidance of cues related to the trauma. Posttraumatic stress disorder (PTSD) is characterized by the continuation of symptoms over time, causing clinically significant distress or functional impairment (American Psychiatric Association, 2013). Importantly, the experience of trauma is not always confined to a discrete event and its immediate aftermath. Chronic toxic stress impedes the integration of overwhelming emotions and responses to danger into a cohesive cognitive narrative (Bloom, 2013).

ACEs represent a specific set of traumatic events with profound impacts across the lifespan. When exposed to threatening conditions, the body releases hormones associated with fight-or-flight responses. When toxic stress is chronic or prolonged, the body needs to remain prepared to scan for danger in the environment and respond to it quickly, which alters the basic architecture of the brain (Beech & Mitchell, 2005; Bloom, 2013; Creeden, 2009; Halldorsdottir, 2007; National Scientific Council on the Developing Child, 2012; van der Kolk, 2006). This means that, for children exposed to ongoing abuse, neglect, and household dysfunction, survival mechanisms become well-rehearsed while other areas of the brain, particularly executive functioning (decision-making and self-regulation), remain under-developed. ACEs contribute to a cascade of psychosocial impacts, including the development of health and behavioral disorders, addictions, maladaptive coping, and disordered personality styles (Anda et al., 2006; Grady, Levenson, & Bolder, 2016; Masten & Cicchetti, 2010; Najavits, 2009; Najavits et al., 2009). Obviously not all abused children grow up to engage in criminal behavior, but the biological, social, and psychological consequences of early mistreatment significantly raise the risk for involvement in crime (Baglivio & Epps, 2016; Topitzes, Mersky, & Reynolds, 2012).

Conceptual models of trauma and offending emphasize the role of early adversity in the development of criminal behavior (Ardino, 2012; Miller & Najavits, 2012; Patterson, DeBaryshe, & Ramsey, 1990). Attachment theories (Bowlby, 1977) postulate that relationships with primary caregivers can be

determinative, and when a small child lacks a responsive and nurturing adult, subsequent relationships may be fraught with anxiety or resentment. Applied to criminal behavior, Ansbro (2008) described how attachment disruptions can contribute to a lack of empathy and suggested that distorted cognitive schemas are "deeply rooted rather than mere gaps in learning" (p. 15). From a social learning perspective, a lack of role modeling for responsible behavior and healthy relationships can reinforce negative expectations of others. Personality pathology develops in the context of chaotic and dysfunctional early social environments, and the impulsivity, aggression, or emotional dysregulation seen in people who have offended often go unrecognized as symptomatic of PTSD (Goff, Rose, Rose, & Purves, 2007; Jovev & Jackson, 2004; Kubiak et al., 2017; Loper, Mahmoodzadegan, & Warren, 2008; Najavits et al., 2009).

TIC differs from trauma-specific interventions. Many evidence-based, cognitive-behavioral treatments exist to help clients resolve trauma, reduce PTSD symptoms, and improve functioning (e.g., Cohen, Mannarino, Kliethermes, & Murray, 2012; Najavits, 2002). Trauma-informed practices incorporate relational elements that provide a sense of safety, empowerment, trust, and respect in service settings across an array of problems, populations, and theoretical models (Covington, 2007; Saakvitne et al., 2000; SAMHSA, 2014a). TIC is based on a foundation of research documenting the pervasive and enduring impacts of chronic childhood adversity in the absence of resilience factors (Anda et al., 2006; Felitti et al., 1998). It is not a structured treatment program, but rather it allows an intervention to be flexibly adjusted within the context of the helping relationship and relevance to a client's history, current needs, and treatment goals (Bloom, 2013; Levenson et al., 2017; Najavits, 2002).

Making the case for TIC: Interdisciplinary evidence

The application of TIC requires an individualized and flexible approach that does not lend itself to the rigidly prescribed conditions required for research replicability. The role that research plays in designing empirically-informed interventions is not limited, however, to experimental testing or outcome studies. Evidence-based practice (EBP) must first be built upon a consolidation of interdisciplinary evidence and theoretical knowledge. For instance, literature about childhood adversity, neurobiology and traumatic stress reactions, therapeutic alliance and client-centered principles, common factors of psychotherapy, attachment, cognitive schema, and self-regulation all provide a strong evidence base informing the use of TIC in forensic settings (Grady, Levenson, & Prescott, 2017). EBP is defined as a process by which clinicians combine research evidence with professional expertise and apply them in a way that is relevant to client characteristics and circumstances (Drisko & Grady, 2015). TIC is a good

example of an EBP requiring a *process* of critical thinking specific to each case, not a *product* that is packaged, tested, and delivered in a standardized fashion (Drisko & Grady, 2015; Levenson, 2017).

Interdisciplinary evidence supports the idea of trauma-informed practices. It is clear ACEs are more prevalent in criminal justice samples, and that the social and neurobiological impacts of trauma can undermine cognitive and psychological functioning over the course of life (Anda et al., 2006; Maschi, Baer, Morrissey, & Moreno, 2013; National Scientific Council on the Developing Child, 2012; van der Kolk, 2014). Psychotherapy research indicates that a client-centered, empathic, and collaborative alliance explains a large part of the variance in successful counseling outcomes (Duncan, Miller, Wampold, & Hubble, 2010; Rogers, 1961; Wampold, 2010; Yalom, 1995). When professional helpers respond in harsh or rejecting ways to clients, it can create a negative process that interferes with engagement and contributes to treatment failure and client dropout (Binder & Strupp, 1997; Teyber & McClure, 2011). A recent study found that when mandated clients in treatment for offending experienced a rupture in the therapeutic alliance, participation and progress were reduced, and they scored higher in interpersonal hostility and dominance characteristics (Watson, Thomas, & Daffern, 2015). Clients who seem combative, hostile, or resistant are often those most in need of trauma-informed responses (Levenson, 2017).

Finally, TIC is highly compatible with the risk, need, and responsivity (RNR) principles of effective correctional rehabilitation (Andrews & Bonta, 2010). Correctional programs for criminality work best when they target specific risk factors and individual needs for each client, tailored in a way that best engages the client to benefit from the intervention (Andrews & Bonta, 2010, 2017; Miller, 2011). TIC is central to the responsivity component, which may be the most important yet most overlooked of the three RNR principles (Miller, 2011). Research with females has demonstrated that trauma-informed programming improves participation in treatment and reduces disciplinary infractions and conflict between inmates (Benedict, 2014). Thus, TIC has much to offer in the design and delivery of correctional counseling and supervision services.

Prison, parole, and probation are traumagenic

In 1974 a publication typically referred to as the "nothing works" doctrine (Martinson, 1974) reviewed the success of programs designed to reduce recidivism and ultimately questioned whether rehabilitation of offenders was possible. This led to an abandonment of the therapeutic ideal and inspired mandatory minimum sentences and removal of judicial discretion. From a position of hindsight, many scholars speculate that the failings of rehabilitative criminal justice have roots in the oppression, discrimination,

and marginalization of poor and minority groups, and that social injustice can create a vicious cycle of crime, hopelessness, and lost potential (Pettus-Davis & Epperson, 2015). Early adversity is inextricably linked to social problems, and therefore societies need to proactively invest in human capital in the interest of public good (Larkin, Felitti, & Anda, 2014). There has been a renewal of interest in understanding narratives of criminal careers that lend insight into the patterns of desistance and recidivism (Ansbro, 2008; Harris, Pedneault, & Willis, 2017).

Penal institutions are built for perpetrators, not victims, and therefore it is difficult to alter correctional culture to become trauma-informed (Kubiak et al., 2017; Miller & Najavits, 2012). Ironically, because correctional systems serve individuals who bring their troubled and traumatized histories into the prison with them, the characteristics of confinement can trigger PTSD reactions and increase risk for aggression and impulsivity (Kubiak et al., 2017). These dynamics create a complex interaction between inmates and staff by which a reciprocal parallel process of threat and hostility can evolve (Bloom, 2010; Kubiak et al., 2017). Hearing about crimes committed or early adversity can also create vicarious trauma for workers and officers (Lee, 2017).

A growing body of research is informing the development of therapeutic prison models, sometimes called psychologically-informed planned environments (PIPEs), which emphasize rehabilitation and pay attention to the interpersonal styles of residents. Such facilities create a climate of safety, purpose, and positive relationships, facilitating readiness to change and hope for the future (Bainbridge, 2016; Blagden, Winder, & Hames, 2016). Trauma-informed correctional services can generate the self-efficacy that leads to cognitive transformation, making it less likely that offenders will resume a life of crime (Maruna, LeBel, Mitchell, & Naples, 2004; Miller & Najavits, 2012; Willis, 2017). Unfortunately, therapeutic prisons are rare, especially in the U.S., and especially in male corrections.

Time spent in correctional facilities produces a set of traumagenic experiences for most people. Because childhood adversity can lead to maladaptive behavior that increases the likelihood of imprisonment later in life (Wallace, Conner, & Dass-Brailsford, 2011), incarceration intersects with posttraumatic stress among this population (Maschi & Gibson, 2012; Maschi et al., 2011). Prisons are, by design, disempowering places where rules are rigidly and unilaterally applied by authority figures with little concern for the impact of confinement on inmates (Kubiak et al., 2017; Levenson et al., 2017). Power disparities and exploitation of power by both staff and inmates exist. Incarceration plays a role in promoting deterrence and maintaining social order by enforcing consequences of crime, yet the prison environment itself can reinforce criminogenic thinking and manipulative behavior instigated by early maltreatment. On the other hand, for some women, prison provides a sense of safety and relief from abusive conditions at home (Miller & Najavits,

2012). It is also important to recognize the importance of gender-responsive services, as men and women have different needs in terms of their experience and manifestation of trauma, and they require different reintegration services upon return to the community (Covington & Bloom, 2007; Najavits et al., 2009).

Challenges

Implementation of TIC in custodial settings requires buy-in from security and program staff, who encounter aggressive and hostile clients that generate a sense of threat to one's safety in the workplace. In the face of authoritarian policies, limited resources, fear, and stressful duties, correctional employees may become controlling, punitive, and passive-aggressive, creating a parallel process of learned helplessness that mirrors and re-enacts that of the correctional client (Bloom, 2010). In other words, authoritarian responses can replicate oppressive family or community dynamics that cultivated the development of antisocial characteristics or problematic behavior in the first place (Bloom, 2010; Miller & Najavits, 2012). 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 challenging conditions can inhibit service innovation and prevent opportunities for role modeling healthy interpersonal boundaries and interactions. Corrections practitioners are at risk for vicarious traumatization and it is recommended that organizations recognize the need for self-care practices, effective practitioner–supervisor support systems, and trauma-focused training (Lee, 2017; Miller & Najavits, 2012).

The experience of arrest, jail, court processes, and prison can all create trauma in the lives of correctional clients. For most individuals, having the police show up at one's home or business to serve a warrant is consistent with the definition of trauma: an unexpected event one has no control over, threatens one's sense of physical and/or psychological safety, and leads to reactions of fear and helplessness. The uncertainty of being in jail while waiting for an unknown legal outcome can be traumatic. The deprivational conditions of jail and prison are traumatic. Other prisoners or correctional officers who prey on the vulnerability of new inmates can feel terrorizing. Use of restraints or seclusion can feel like re-victimization or reenactment of childhood maltreatment for some individuals. These experiences in an environment where it is unsafe to express fear or distress can leave few outlets for coping in healthy, adaptive ways.

When individuals return to the community from incarceration, PTSD symptoms may further complicate the reintegration process. After a conviction, correctional clients face many social and practical re-entry barriers. The stigma

of a felony label hinders employment, housing stability, and social support, and can foster profound disempowerment, social isolation, hopelessness, and shame (Braithwaite, 1989; Laub & Sampson, 2001; Maruna et al., 2004; Uggen, Manza, & Behrens, 2004). Labeling theory suggests that disparaging words shape the identity of individuals who internalize the shaming language of society (Goffman, 1963; Maruna et al., 2004). Self-fulfilling prophecies occur when an individual incorporates stereotypical assumptions into his or her self-concept, and then adopts behavior that conforms to those ideas (Paternoster & Iovanni, 1989; Willis, 2017). Exclusionary practices and shaming labels often separate returning prisoners from mainstream social life, ironically reinforcing deviant identity and criminal behavior (Bernburg, Krohn, & Rivera, 2006; Paternoster & Iovanni, 1989). In 1902, sociologist Charles Cooley wrote about the "Looking-glass self," a process by which we see ourselves reflected in the ways others treat us, shaping constructions of social identity that are maintained over time. In the ethical codes of the helping professions, there is a strong emphasis on respect and dignity of persons, and the duty to avoid disempowering practices such as shaming or labelling (Willis, 2017).

Thus, by calling people by the very label we *don't* want them to be (e.g., "sex offender" or "addict"), they internalize a self-narrative that prevents the cognitive transformation associated with reduced recidivism risk (Maruna et al., 2004; Willis, 2017). This is particularly true in the ways that U.S. crime policy obstructs successful reintegration through labeling and restrictions on community engagement. Facing barriers to re-entry, many correctional clients describe deep desperation and despair, challenging coping skills that are already compromised. They report PTSD symptoms such as intrusive thoughts, hyperarousal, disrupted sleep, nightmares, or irritability. The following excerpts are modified from Levenson, Willis (2017, p. 155–156).

> *Michael described the trauma of being on probation. "I live in fear that I will violate a condition of my release without even knowing it. Every time I have to go check in, or my parole officer calls me, I panic. One time I went to a dental clinic at the university. Afterward, I wondered if there are laws about felons being on college campuses. I lived in fear that if my officer found out I'd had my teeth cleaned, he'd arrest me. It's like my whole life is under this cloud of doubt about my own ability to follow my rules. It's exhausting."*

> *Another described this experience: "They came to search my house as part of a routine address verification. Believe me, I follow my rules exactly. I thought I had nothing to worry about. Then they found this old decorative sword stored away in my garage – I had taken it down from the wall years ago – and arrested me for having a weapon. I spent 3 weeks in jail waiting for a hearing, and then the judge dropped the case. But it was too late – I lost my job when I didn't show up. Since then, I can't sleep, I've lost weight, I can't concentrate, I'm constantly obsessing if there is anything I'm doing that's wrong."*

Said another parolee: "I've got it all planned out, even though I always do what my conditions say. But my brother has my key to my house so he can take my cat if they arrest me for some violation. My mother has my car key so she can go get the car if it's parked at the justice center and I'm arrested at my monthly check-in, so it won't get towed. She has my bank account so she can pay my bills if I end up in jail. I'm not doing anything wrong, but there are so many rules and it is so confusing. Sometimes in my counseling group I hear guys talk about restrictions I never even knew about, so I'm expecting at some time I'll be revoked for breaking a rule by accident."

In summary, the correctional system is traumagenic from its point of entry. Counselors and supervision officers can help clients by recognizing the environmental triggers that activate trauma-based responses. Frontline workers in the justice system have an opportunity to engage with correctional clients in ways that reduce barriers, encourage accountability, and support reintegration and rehabilitation (Sachs & Miller, 2018). In the next sections, we expand on the application of each of SAMHSA's principles of TIC to correctional treatment and supervision.

From traumagenic to trauma-informed

SAMHSA (2014a) emphasizes that service delivery must seek to facilitate safety and trust, choice and voice, and be collaborative and culturally responsive to race, ethnicity, gender, and social differences. Viewing criminal behavior through the lens of trauma creates possibilities for more effective interventions that contribute to public safety. Correctional clients are predisposed to lack of trust, self-destructiveness, and wariness of authority figures. Combativeness and aggression may be displayed to overcompensate for feelings of vulnerability. There are many well-researched cognitive-behavioral interventions that correctional systems offer, but when neurobiological stress responses are activated, clients will have trouble processing that information. By utilizing some core principles of TIC, we can evoke client strengths in unique ways to build resilience.

SAMHSA TIC principle 1: Realize the prevalence and impact of trauma

People involved in the justice system have experienced traumatic events in their childhood homes and communities at higher rates than the general population (Harlow, 1999; Maschi et al., 2011; Patterson et al., 1990). Early adversity is linked to adult mental health syndromes, chemical dependency, and violent behavior (Harlow, 1999; Levenson & Grady, 2016; Messina, Grella, Burdon, & Prendergast, 2007). Dozens of studies confirm that ACEs are associated with increased risk for medical, behavioral, and psychosocial disorders in adulthood (Anda, Butchart, Felitti, & Brown, 2010; Anda et al.,

2006). ACEs are more prevalent in poor, marginalized, and oppressed communities where they are often aggravated by the stress of poverty, discrimination, and historical trauma; self-preservation survival skills can emerge as a response to traumagenic conditions (Eckenrode, Smith, McCarthy, & Dineen, 2014; Hill, Lui, & Hawkins, 2001; Larkin et al., 2014).

Etiological theories of antisocial behavior propose that chaotic early environments, severe or inconsistent discipline, and lack of positive parenting can all pave the way for conduct disorders and delinquent behavior (Cicchetti & Banny, 2014; Kohlberg, Lacrosse, Ricks, & Wolman, 1972; Lahey, Gordon, Loeber, Stouthamer-Loeber, & Farrington, 1999; Patterson et al., 1990; Rutter, Kim-Cohen, & Maughan, 2006). Chronic toxic stress in childhood may alter neurobiology, compromising cognitive processing and self-regulation into adulthood (Alink, Cicchetti, Kim, & Rogosch, 2012; Creeden, 2009; Finkelhor & Kendall-Tackett, 1997; SAMHSA, 2014a; Streeck-Fischer & van der Kolk, 2000; van der Kolk, 2006). Thus, an understanding of these conditions and their contribution to criminality is essential, and a strengths-based approach to mastery of new interpersonal skills can be fortified through helping relationships that foster affirmation and acceptance.

SAMHSA TIC principle 2: Recognize the signs and symptoms of trauma

Trauma symptoms often manifest as problems that bring people into the criminal justice system such as addiction, aggression, impulsivity, or lack of empathy. Early adversity shapes distorted thinking about self and others and can incite maladaptive coping mechanisms (e.g., violence or self-medication). ACEs can also interfere with attachment and bonding, relational patterns, empathy, and self-regulation capacities (Bloom, 2013; Cicchetti & Banny, 2014). An exclusive focus on laws and consequences without integrating an understanding of trauma can prevent innovative and effective solutions in crime prevention. Moreover, correctional settings may not recognize self-regulation and interpersonal deficits as symptoms of early trauma, but solely as risk factors for reoffending. Seen only in this way, the message communicated to the client is not one of "I can understand why… (e.g., you struggle managing anger)," but "there is something wrong with you that must be fixed."

Maslow's hierarchy of needs (Maslow, 1943) proposed that all humans require survival necessities, safety, social acceptance, and self-efficacy. When these conditions are absent, people seek to meet their needs in any way possible. For instance, youngsters exposed to maltreatment and social problems are vulnerable to criminal and gang activity that promise a sense of belonging and empowerment (Hill et al., 2001; Lahey et al., 1999). Individuals struggling with lack of resources may rely on unlawful activities to obtain material goods.

Chemical dependency may represent efforts to numb painful feelings through self-medication (Najavits, 2002). Though individuals are certainly responsible for their choices, these maladaptive behaviors often reflect strategies to cope with traumatic conditions. We must acknowledge that limited opportunities along with learned helplessness and lack of skills create the perfect storm for addiction or crime, but empowerment and human connection is an antidote.

SAMHSA TIC principle 3. Integrate knowledge about trauma into policies, procedures, and practices

By viewing criminal behavior as symptomatic of well-rehearsed survival responses to traumagenic experiences, we can shift the paradigm from "what's wrong with you?" to "what happened to you?" (SAMHSA, 2014a). In some cases, violence is reactive rather than predatory, and can be reframed as adaptations to the demands of a hostile environment that interfere with goal attainment and connections with others. When safe, collaborative, respectful, and empathic interactions are implemented, workers begin to model the type of shared power, appropriate boundaries, and behavioral change they hope to see in correctional clients.

Consistent with trauma as a responsivity factor (Miller, 2011), TIC helps maximize the likelihood that correctional clients can learn, comprehend, apply, and utilize evidence-based treatment concepts in their lives – ultimately mitigating risk to reoffend. Rather than focusing exclusively on consequences and punishments to shape behavior, correctional programs should seek to help clients bond and attach with others, establish an internal locus of control, and engage in meaningful pursuit of life goals to achieve self-efficacy and self-sufficiency (Bandura, 1977; Levenson et al., 2017; Willis & Ward, 2013).

Concern that TIC might compromise immediate safety of staff and other clients is a factor that discourages its implementation in custodial settings (Kubiak et al., 2017; Miller & Najavits, 2012). Safety can be secured, however, through clear and consistent behavioral and relational boundaries that are flexible enough to respond to unique situations. There are indeed times in correctional settings where aggressive behavior can put the safety and security of residents and staff at risk. However, the use of restraints and seclusion should be used only when necessary as these methods can re-traumatize people who were physically or sexually abused or neglected (Frueh et al., 2005). De-escalation strategies that validate feelings, do not invade personal space, and give people a chance to choose from a range of behavioral choices can encourage self-regulation and self-correction skills while promoting the safety of others (Frueh et al., 2005).

SAMHSA TIC principle 4: Actively avoid re-traumatization in the service delivery setting

Human service systems can inadvertently re-victimize clients (Levenson, 2017; SAMHSA, 2014b). Correctional programs may replicate disempowering dynamics similar to those in abusive families, reinforcing a client's dysfunctional responses and coping styles (Levenson et al., 2017). With mandated clients, correctional counselors often resort to confrontational approaches, rigid limit-setting, and punitive consequences, hoping to teach a lesson and provide deterrence for others. Paternalistic practices (Glaser, 2011) that label, pathologize, diagnose, and prescribe one-size-fits-all methods may reinforce clients' feelings of mistrust, vulnerability, and hostility. Traumatic reenactment occurs when negative expectations are confirmed, which reinforces anger, depression, and inflexible coping.

Many consumers of services are ashamed of their criminal records and perceived personal failures. Moreover, their attempts at help-seeking in the past may have been futile or fraught with danger, leading to beliefs that authority figures are unlikely to be constructive or helpful. For example, a child who was ridiculed for crying when he was hurt, or who was beaten for expressing a need, will naturally become reluctant to seek help, believing there is little likelihood of a positive result. By creating an environment where help-seeking is rewarded, clients can obtain skills that facilitate lasting change (Ansbro, 2008; Najavits, 2009). Trauma-informed responding tries to understand "why does the client need to do this?" By de-escalating triggered reactions and creating a respectful encounter that offers a corrective experience, we alter the client's expectation that others are undependable and add to their repertoire of coping skills.

Implications for correctional practice

Treatment failure and recidivism are often viewed as individual shortcomings related to resistance, lack of motivation, or defiance. However, perceived lack of choice, control, and support from staff (factors that can be corrected through TIC) diminish client engagement and increase the likelihood of noncompletion of correctional treatment (Sturgess, Woodhams, & Tonkin, 2016). When trauma-informed principles are integrated throughout a service system, the culture shifts to one of collective responsibility for successful re-entry.

The Risking Connection program uses the acronym RICH to describe a relational framework emphasizing respect, information sharing, connection, and hope (Giller et al., 2006; Saakvitne et al., 2000). We proposed the acronym SHARE (safety, hope, autonomy, respect, empathy) to help practitioners translate trauma-informed concepts into service delivery honoring the principles recommended by SAMHSA (Levenson et al., 2017). Above all,

rehabilitative services should feel *safe*. Correctional counseling should foster physical and emotional wellbeing and trust in others. *Hope* is instilled through encouraging belief that change is possible, reducing despondence and learned helplessness. *Autonomy* and empowerment honor a client's right to self-determination by encouraging the client to choose and prioritize life goals that are most meaningful to him/her. *Respect* for humanity and dignity can help restore a sense of value and worth, modeling the type of interactions we want our clients to imitate. *Empathy* helps clients to appreciate the perspectives of others. When we listen with curiosity and compassion and demonstrate kindness we help correctional clients to experience human connections – a deterrent to harming others.

Client-centered engagement strategies help to enhance trust and promote personal responsibility (Ansbro, 2008; Blagden et al., 2016; Levenson, Prescott, & D'Amora, 2010; Marshall, 2005; Prescott, 2009). Confrontational approaches create resistance and cause clients to become further entrenched in defensive patterns of thinking and behaving (Jenkins, 1990; Stinson & Clark, 2017). Motivational interviewing has gained popularity with nonvoluntary consumers of social services, including those in the criminal justice system (Prescott, 2009; Prescott & Wilson, 2013; Stinson & Clark, 2017). By combining cognitive-behavioral techniques with humanistic principles, motivational interventions use open-ended questions, affirmation, reflective listening, and summarizing of themes (OARS) to help clients identify barriers to change and commit to small goals they can successfully accomplish without feeling overwhelmed (Miller & Rollnick, 2002; Prescott, 2009). Gradual successes begin to transform identity in a positive direction.

Cognitive interventions with offenders typically emphasize reframing distorted thinking about criminal activity, anger, social cues, and substance use (Landenberger & Lipsey, 2005). Yet, treatments should also identify maladaptive schemas about self and others that developed early in life (often as a result of ACEs) (Young, Klosko, & Weishaar, 2003). Empathy for others is a skill that may be unfamiliar to correctional clients as it may not be conducive to survival in a threatening environment. Empathy can be cultivated not just by telling clients how their behavior has harmed others, but by modeling compassion for the ways in which offenders have been abused or neglected themselves.

Communication and conflict resolution skills are important components of treatment to prevent future offending. An effective way to reinforce those strategies is through experiential learning in the correctional or rehabilitative setting. For instance, coaching clients to engage in problem solving with one another can reduce tension and decrease danger to staff and other clients. De-escalation tactics can help clients tolerate distress and self-correct when interacting with others. Innovative methods can be used to help clients recognize disinhibition and impulsivity, and to teach negotiation

and compromise, which are important life skills. For instance, in the Cook County (Chicago) jail, inmates can join a chess club, which introduces critical thinking and problem-solving skills. The chess board becomes a metaphorical lesson about cost–benefit analyses, cause-and-effect, patience, and strategic decision making (Koeske, 2016).

Finally, relapse prevention is ultimately not just about avoidance of risky situations, but requires movement toward meeting emotional needs in healthy ways so that tendencies to act out are diminished (Levenson et al., 2017). Improved self-efficacy, stability, and social support can help minimize risk to seek validation through victimizing, self-destructive, or aggressive means. In short, correctional rehabilitation counselors and staff can model relational and self-regulation skills that offer innovative opportunities for experiential learning and posttraumatic growth.

Case example

Pablo is on parole and in a mandated program for drug involvement. When asked for his homework assignment, he took a bullying stance with his therapist, insisting that she only cared about collecting papers and not about helping parolees. She could have responded by refusing to grant him credit for the session because he did not do his work. She might have replied with authoritarian or limit-setting warnings about his "inappropriate tone of voice." She could have debated with him about her intentions. However, instead of giving in to the feelings of vulnerability Pablo was trying to impose on her, she said "I can see you are upset with me and I'd like to understand why" and invited him to sit down. She went on: "I wonder if my asking for your homework today made you angry because you don't have it and you thought I might criticize or sanction you for that. Under the anger I think you feel scared. Let's talk about that, and about your tendency to "come out fighting" when you feel threatened." Pablo sat down and said under his breath: "You think you know everything." The therapist gently responded: "You tend to use intimidation to get your way, but if you talk to me about why the assignment was hard to do, maybe we can work on it together."

In this scenario, even though the client adopted a somewhat menacing demeanor, the therapist responded by modeling shared power and assertive adult dialogue, rather than using her position of authority in a threatening manner. Obviously in each situation the practitioner must assess any risk for immediate danger to self, the client, or others who are present. By avoiding disempowering or shaming dynamics, the counselor alters the encounter from one that might have reinforced the client's dysfunctional way of being to one that empowers self-correction. Through consistent displays of empathy, warmth, respect for client autonomy, and instilling hope, the therapist or supervision officer can provide a corrective relational experience and play a role in re-wiring their template for interacting with others.

Summary

TIC requires a trusting, collaborative, safe, empowering environment that avoids dynamics that can re-activate trauma responses (Bloom, 2010; Bloom & Farragher, 2013; Miller & Najavits, 2012; Saakvitne et al., 2000; SAMHSA, 2014b). Trauma-informed practices utilize relational modeling to reinforce healthy boundaries and interactions, cultivating the therapeutic alliance as a tool for change. Above all, TIC provides hope that a better life is possible through human connection and posttraumatic growth. Trauma-informed is different from trauma-specific or trauma-focused; the goal is not resolution or relief of PTSD symptoms per se (though that may be helpful for many clients) but rather to use the knowledge of trauma to inform case conceptualization and trauma-informed responding (Levenson et al., 2017).

Helping relationships must feel safe. Safe relationships are consistent, predictable, and nonshaming, and they model respectful boundaries and shared power. The acronym SHARE (safety, hope, autonomy, respect, empathy) will help practitioners translate trauma-informed concepts into service delivery. TIC is a way of viewing and responding to criminal 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.

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