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Daring to Ask "What Happened to You?" - Why Correctional Systems Must Become Trauma-Responsive

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Abstract

Drawing on qualitative interview data collected during the author's ongoing PhD research, this paper argues that the findings of many mainstream criminological studies and the dominant Risk/Needs/Responsivity (RNR) model of offender rehabilitation might be reinterpreted in the light of the evidence from epidemiology studies and neuroscience evidence that exposure to an overdose of trauma or Adverse Childhood Experiences (ACEs) in infancy arrests normal brain development and leads to catastrophic health, relational and social impacts over the life-course. The focus of prison-based services, in particular, should be redirected towards trauma-responsive practice in order to assist unrecovered trauma survivors with offending behaviour to make better sense of themselves and their multiplicity of personal struggles. Criminality and the consequent loss of liberty may, for many prisoners, be a minor aspect of their personal adversity stories. Offenders tend to come from communities where ACEs are all around them; in their homes, on their streets, in their schools, doctor's surgeries and emergency rooms. Criminal justice agencies that are not trauma-informed and which omit to train specialized staff to ask offenders about childhood trauma are overlooking important information relevant to continued offending behaviour. If prisons and probation become trauma-responsive and help people to understand their childhood adversity and its enduring magnitude, they will be more likely to buy into participation in both personal development and offending behaviour interventions.

Offending: a 'minor' aspect of wider personal, social and psychological problems

Crime is a complex social phenomenon that generally occurs against a backdrop of poverty, social exclusion and personal adversity. Prisoners today, as in the past, could largely be described as belonging to the idle poor (Foucault, 1977; Melossi & Pavarini, 1981). Criminologists have found that people who become embroiled in criminality tend to come from deprived urban communities characterised by social disorganisation, low social capital and weak social networks. They are generally born into dysfunctional families where they experience ineffectual or destructive parenting. For example, Lukas summarising the Glueck's findings stated that delinquent boys "are products of homes of little understanding, affection, and stability, in which the parents are usually unfit to serve as examples for their children" (Lukas, 1952).

Low economic class, ethnic diversity and residential mobility have been shown to have a negative impact on community social organisation, with a knock-on effect on crime (Shaw & McKay, 1942). According to Sampson *et al*, communities that experience a high concentration of imprisonment are places where a range of social harms coalesce, such as

"crime, adolescent delinquency, social and physical disorder, low birth weight, infant mortality, school dropout, and child mistreatment" (Sampson *et al*, 2002).

O'Mahony's 1997 study of the social background of prisoners in Mountjoy prison in Dublin revealed that 56% of all prisoners came from 6 economically deprived areas of Dublin. Almost 80% of research participants had left school before they turned 16 and the majority came from households where there was low parental employment and personal employment, and high levels of personal heroin use (O'Mahony, 1998: p. 59).

The Pittsburgh Youth Study found that the higher the number of risk factors, the more likely it was that a person would commit crimes (Browning & Loeber, 1999). Risk factors included: structural (social/ecological) factors including parental unemployment and general deprivation, family dynamics such as inadequate parental supervision, and personal (psychological) characteristics relating to gender, hyperactivity and IQ.

Flood-Page *et al*. surveyed almost 5,000 boys and young men, aged between 12 and 30 and found that the absence of pro-social bonds, difficulties in school and drug use were the most significant risk factors for offending behaviour in males (Flood-Page *et al*, 2000). As with the Pittsburgh study, the more risk factors that a person had, the greater the risk of antisocial behaviour and criminality. Half of the survey respondents who experienced four or more risk factors were persistent or serious offenders.

More than half of the interviewees in Maruna's Liverpool Desistance Study came from single parent families, over a third had experienced severe childhood neglect or abuse and roughly a quarter were placed in care due to familial abuse or dysfunction. Of the 50 participants 80% came from an area considered "dangerous or bad", 75% reported that their parents had been unemployed, sporadically employed, or employed as unskilled labourers and two thirds left school without any qualifications. Liverpool had a male unemployment rate of 21% in 1991. Of Maruna's interviewees, 92% were raised in the city.

Farrington stated that offending behaviour is an element of "a larger syndrome of antisocial behaviour" starting in childhood and continuing throughout the person's adult life (Farrington, 1997: p. 362). The Cambridge study revealed that behavioural problems in childhood preceded antisocial behaviour and offending as adults. The children who were at the greatest risk of offending had lax parental supervision, impulsive personalities and low educational attainment, experienced deprivation and had a family member involved in criminality (Farrington *et al*, 2006).

Zara and Farrington discovered that people who grow up to be chronic offenders - those with in excess of 10 criminal convictions – were typically born into "family conditions, where parental affection and support are optional rather than a secure basis to lean on" (Zara & Farrington, 2016: pp. 46-47). Chronic involvement in criminality was only one minor aspect of a bigger picture characterised by "family disruption, parental negligence, abuse and neglect, emotional solitude, social deprivation, and psychological desperation".

The Risk/Need/Responsivity model

Coping with the slings and arrows of outrageous fortune: risk vs trauma and 'the contest of interpretations'

In A Theory of Human Motivation, Maslow articulated his philosophy of what drives human behaviour, suggesting that human needs exist in a hierarchy, at the base of which are physiological needs relating to the need for food, shelter, warmth and rest, followed by safety and security needs (Maslow, 1943). These are the most basic human needs without which people cannot hope to flourish. Once the basic needs are secured, people can turn their attention to the pursuit of needs of a higher, more psychological nature such as love and belongingness as well as esteem needs, where they strive to accomplish things that give them a sense of self-respect and esteem in the eyes of others, such as pursuing a purposeful career. Collyer and Lenton state that "to feel a sense of belonging, people need to feel safe, valued and a part of the community" (Collyer & Lenton, 2006: p. 1). Many people who end up in prison have grown up in households where they never knew or enjoyed a sense of personal safety, a feeling of belonging, or any affinity with mainstream society.

Correctional services make widespread use of expensive evidence-based actuarial risk assessment instruments pioneered by Canadian psychologists following the 'nothing works' anti-rehabilitation backlash (Martinson, 1974). These instruments determine how best to intervene, and with what degree of treatment intensity in relation to offenders with different statistical likelihoods of re-offending. Actuarial risk assessment tools probe individual items such as destructive peer influences and anti-social attitudes that the evidence has linked to a significant increase in the risk of reoffending and quantitative scores are assigned. The higher the final score, the higher the risk that the offender will reoffend.

In the *Psychology of Criminal Conduct*, Andrews and Bonta criticise sociological-based criminology for giving primacy to social and structural factors, to the exclusion of personal psychological factors (Andrews & Bonta, 2006). Under the Risk/Need/Responsivity (RNR) approach an individual offender's risks and needs, as assessed by a professional using the risk assessment tool, dictate the intensity of the intervention or supervision required (e.g., weekly or monthly) to target and treat the criminogenic needs. The RNR model contends that treatment is most effective when delivered in the community, i.e., not in the prison setting. Criminogenic needs are those dynamic needs (capable of change) that "are functionally related to criminal behaviour," i.e., the factors in, or surrounding the person that the empirical research studies have shown to be most closely related to reoffending (Andrews *et al*, 2001, p. 735).

On the basis of a meta-analysis of existing studies Andrews and Bonta identified the 'Big Four' risk factors as being a history of antisocial behaviour, which is a static risk factor (however, past behaviour is the best predictor of future behaviour), antisocial personality, antisocial attitudes, and antisocial peers. They found that four other risk factors were the next most likely predictors of future offending behaviour, namely family/marital difficulties, addiction (or mental health problems), issues relating to school/work and poor use of leisure time. These factors are known as the 'central eight' in the RNR literature. Factors such as personal and/or emotional distress, major mental disorder, low IQ and social class of origin are deemed to be "less promising intermediate targets for reduced recidivism" (Andrews *et al* 2006: p. 11).

In the remainder of the paper, I will argue that the various criminological studies identifying the types of communities, social problems and personal characteristics of offenders, and the

continued RNR focus on criminogenic risks/needs, should be re-interpreted in the light of research from neuroscience and epidemiology which has revealed the life-long damaging impact of childhood trauma.

The devastating impact of trauma

Childhood trauma expert, Dr Robert Anda, states that when people "tell you the truth about their lives, and you listen, you understand their life course" (Cork Simon, 2017: p.1). In 1953, Bowlby stated that a major development over the previous 25 years was "the steady growth in evidence that the quality of parental care which a child receives in its earliest years is of vital importance for his future mental health" (Bowlby, 1953).

In the early years of developing their RNR model, Andrews and Bonta and their associates did not have the benefit of the neuroscience evidence from the Center on the Developing Child[1] at Harvard University, or the impressive body of work on ACEs by Felitti, Anda and colleagues since 1998. ACEs quite literally attack the structures of a child's developing brain, leading to lasting "stress-induced changes in brain structure and function" (Bremmer, 2006: p. 446). This brain injury - acquired in infancy or adolescence - has individual and societal costs in terms of damage to the person's health over the life course, in addition to a variety of behavioural and social problems, including involvement in drug-taking and criminality (Felitti *et al*, 1998; Van der Kolk, 2014; Burke Harris, 2018, Mulcahy, 2018).

Basically, ACEs cause the production of toxic stress or cortisol in children, which activates the 'fight/flight/freeze' stress response system causing harmful 'neural pruning' in which the development of normal neural pathways is stunted (Jackson Nakazawa, 2015). Lyons *et al* state that traumatized children are:

> developmentally stuck in their primitive brain, and very little information can get passed up to the higher parts of their brain where rationalising happens. All their resources are 'used up' on staying alive physically and staying in the minds of their adults. This means there is little left over for the development of 'luxuries' such as processing and retaining new information; reasoning; sharing with siblings or peers; empathy or a sense of the intentions of adults as being positive or even neutral.[2]

Childhood trauma haunts people into adulthood. Over time the traumatized person's 'window of tolerance' (where they can comfortably metabolize the ups and downs of daily life) shrinks, causing them to either remain constantly on high alert for danger, responding with anger, violence, impulsivity or defensiveness (hyperarousal) or by shutting down/disconnecting (hypo arousal) when emotionally overwhelmed or triggered (Fisher, 2011: p. 6; Harkinson, 2014, Edwards *et al*, 2007). Van der Kolk, a psychiatrist and founder of the founder of the Trauma Center at the Justice Research Institute in Brookline Massachusetts, refers to the periaqueductal gray - the brain's fear hub - as the "cockroach center of the brain" that registers "get the hell out of here, this is dangerous"[3]. Even the

[1] See https://developingchild.harvard.edu/resources/experiences-build-brain-architecture/
[2] See http://beaconhouse.org.uk/wp-content/uploads/Developmental-Trauma-Close-Up.pdf
[3] See See Bessle Van der Kolk, Changing the Paradigm 2015 Developmental Trauma Panel, at 21 minutes available at https://www.youtube.com/watch?v=-pCbbOWKB2I

lovely presence of a psychologist or psychotherapist may be a "traumatic stimulus" to their distressed patient. The same may be true of a probation officer who displays kindly concern.

ACEs are divided into three groups: abuse, neglect, and household challenges. The ACE Score Calculator[4] asks people questions about whether they experience ten types of childhood experience known to cause trauma before they turned eighteen. The ten questions relate to:

- Persistent physical abuse
- Persistent emotional abuse
- Contact sexual abuse
- Physical neglect
- Emotional neglect
- Presence of an alcoholic/drug abuser in the home
- Imprisoned family member
- Depressed, mentally ill or suicidal family member
- Mother subjected to domestic violence
- Loss of/separation from parent(s).

It is important to acknowledge that ACEs in the general population are commonplace. Many of us will have experienced at least one ACE in childhood. In the two wave CDC-Kaiser Permanente study of over 17,000 mostly white, college educated Americans, almost two-thirds of people reported at least one ACE, and more than one in five reported three or more ACEs. One in sixteen research participants experienced four or more ACEs. Similar to the RNR evidence base which shows the higher the number of risk factors, the higher the likelihood of reoffending, the ACE study found **"the higher the ACE Score, the greater the risk of experiencing poor physical and mental health, and negative social consequences later in life**"[5](emphasis in the original).

According to the initial ACEs study, sexual abuse was the second most common ACE or trauma, reported in 22% of the first wave of 9,508 adult respondents. The core finding of the research relates to issue of 'dose response', i.e. the greater the dose ratio of childhood trauma, the more detrimental the impact on a person throughout their life (Felitti *et al*, 1998: p. 251). ACEs contribute to ischemic heart disease, liver disease, mental illness (chronic anxiety, chronic depression, OCD, bipolar and personality disorders), obesity, alcoholism, drug addiction[6] and early death.[7] Significantly, Felitti *et al*'s research does not "include higher risk populations such as patients attending psychiatric clinics and in psychiatric hospitals and institutions, prisons, the homeless, and others who have a very high rate of child abuse and neglect in their histories" (Whitfield, 1998: pp. 361-362).

Whitfield notes that 50-70% of people who require psychiatric inpatient treatment as well as those who avail of psychiatric or psychological out-patient services are trauma survivors (Whitfield, 1998: p. 362). When people engage in high-risk behaviours such as drug-taking,

[4] See http://www.acestudy.org/uploads/3/4/9/6/34961588/10-qacecalc.pdf.
[5] See http://www.acestudy.org/the-ace-score.html.
[6] See Dr Gabor Maté, "The Power of Addiction and The Addiction of Power", available at https://youtu.be/66cYcSak6nE
[7] See Dr Nadine Burke Harris "How childhood trauma affects health across a lifetime" available at https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime

excessive drinking or feckless promiscuity that are often interpreted by others as 'antisocial' or 'crazy', they are, in fact, according to Whitfield "unconsciously re-enacting aspects of their original trauma in order to master it in hopes of eventually healing from it" (Whitfield, 1998: p. 362; Herman, 2015: p.42).

Van der Kolk claims that trauma is the most urgent public health issue of our time, arguably the greatest threat to our wellbeing (Van der Kolk, 2014: p. 350). He states that the ACE study has shown that "child abuse and neglect is the single most preventable cause" of mental illness and drug/alcohol addiction (p. 353). Nonetheless, mainstream society is completely blinkered to the huge costs of ACEs, "too embarrassed or discouraged to mount a massive effort to help children and adults to deal with the fear, rage, and collapse, the predictable consequences of having been traumatized (p. 350).

Dr. Daniel Sumrok, Director of the Center for Addiction Sciences at the University of Tennessee Health Science Center's College of Medicine, advocates for the renaming of addiction as 'ritualized compulsive comfort-seeking'. According to Sumrok, ritualized compulsive comfort-seeking is a '*normal* response' to ACEs, 'just like bleeding is a normal response to being stabbed'. In his individual and group-work with patients seeking to overcome harmful substance dependencies he aims to help them find a healthier replacement ritualized compulsive comfort-seeking behavior 'that won't kill them or put them in jail' (Stevens, 2017).

In the recently published Welsh ACEs study, 2,028 Welsh adults were questioned about their current health behaviours and exposure to ACEs. In the Welsh study 47% of respondents reported having experienced at least one ACE and 14% experienced four or more ACEs (Bellis *et al*, 2015: p. 3).

Compared with interviewees with no experience of ACEs, those who experienced four+ ACEs were:

- 4 times more likely to be a high-risk drinker
- 6 times more likely to have had or caused unintended teenage pregnancy
- 6 times more likely to smoke e-cigarettes or tobacco
- 6 times more likely to have had sex under the age of 16 years
- 11 times more likely to have smoked cannabis
- 14 times more likely to have been a victim of violence over the last 12 months
- 15 times more likely to have committed violence against another person in the last 12 months
- 16 times more likely to have used crack cocaine or heroin times
- 20 more likely to have been incarcerated at any point in their lifetime (Bellis *et* al, 2015: p.5).

In the health context, Launer has suggested that 'medically unexplained symptoms' could more usefully be understood and renamed as 'medically unexplored stories' (Launer, 2009). In relation to medically unexplained symptoms, Kirmayer refers to the 'contest for interpretations', arguing that medical practitioners generally lack the skills to deal positively with patients' psychosocial problems, actively avoid emotional distress (Kirmayer, 2004) and

are concerned with preserving their professional power.[8] In his view, patients might well experience better health outcomes if their doctors received training in the psychosocial aspects of health and wellbeing and to help them manage their own sense of incompetence regarding trauma and its impact. In advocating for a better national health system in the UK, Tomlinson writes that:

> [m]ost GPs, especially those who work in deprived areas, bare witness every day to their patients' accounts of trauma; including physical abuse and neglect; parents who were, because of alcoholism, drug abuse or mental illness unable to care for their own children in their earliest years; stories of material and emotional deprivation, abandonment and loss, domestic violence, crime and imprisonment and with shocking frequency, child abuse. Trauma begets trauma so that people rendered vulnerable by trauma in childhood are very frequently victims of violence and abuse in later life. Survivors of trauma use drugs and alcohol to cope with the aftermath, then find themselves involved with crime which leads to imprisonment and homelessness and further cycles of alienation and despair" (Tomlinson, 2017).

In Ireland, Lambert and Gill-Emerson's recent investigation into the prevalence of ACEs among Cork Simon Community homeless service-users yielded fascinating results. Of the 50 service-users surveyed, ***77%*** had four or more ACEs, while 8% had *10 ACEs* (Lambert & Gill-Emerson, 2017: p.12). More than one in three were sexually abused as children, a quarter were subject to physical neglect and two thirds experienced emotional neglect. Over 70% lived with someone with an alcohol or drug addiction, more than 50% lived with a mentally ill person, 50% were raised in a single parent household and almost one third grew up in home where a was family member incarcerated. Almost half witnessed their mother being subjected to domestic violence. Moreover, 71.4% had a history of suicidal thoughts and 44.8% had self-harmed in the past. Other findings regarding physical and mental health were that:

- the average number of visits to Accident and Emergency departments was 17 and the mean number of Intensive Care stays was 1.89;
- 47% reported suffering a serious head injury;
- 39% admitted to having shared a needle for intravenous drug use;
- 62% reported they had overdosed in the past;
- 90% had been seen by a psychiatrist or psychologist;
- 90% stated they believed they had psychological problems but only 23.5% could name an exact diagnosis (e.g., depression, anxiety, psychosis, Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Borderline Personality Disorder, Bipolar and schizophrenia);
- Thirty five of the 50 participants were currently using prescription medication, including antipsychotics, benzodiazepines, methadone and sleeping tablets.

While most of the ACEs research to date has focused primarily on health outcomes, the ACEs Connection Network has realised the significances of ACEs in offender populations established a sub-group on 'ACEs in the Criminal Justice System' (Kochly, 2016). There

[8] See Law and Justice interview with Dr Jonathan Tomlinson on health inequalities, mainstream medicine and trauma, available at https://soundcloud.com/jane-mulcahy/dr-jonathan-tomlinson-law-and-justice-interview

have also been a number of recent ACEs studies exploring the impact on offender cohorts. Reavis *et al* found that their sample of 151 offenders in San Diego who were court-ordered to undergo psychological treatment were exposed to high levels of ACEs. Four times as many offenders surveyed "endorsed four or more adverse experiences in their early lives" as compared with the adult male normative sample. Apart from a history of neglect, the authors found that every negative experience probed by the ACE Questionnaire was experienced by research subjects at "significantly higher rates" (Reavis *et al*, 2013: p. 47). It is therefore no great surprise, Reavis *et al* note "that purely 'offense-specific' models of treatment, which pay little heed to the early lives of offenders, have shown scant effects in decreasing recidivism."

In Norway, Friestad *et al* explored the relationship between ACEs and suicide attempts and drug use among imprisoned females. They found that 34% of the 141 women surveyed reported experiencing more than five ACEs. After controlling for age, immigrant background and marital status, the ACE score "significantly increased the risk of attempted suicide and current drug abuse (Friestad *et al*, 2014: p. 40).

In 2016 Moore and Tatman conducted a study to determine whether there was a link between the dose of ACEs in an offender's life and their risk of reoffending as identified in the LSI/R. In a survey of 141 offenders on probation and parole in a community project, the authors controlled for race, age and gender and discovered that "early negative experience can predict future risk". In other words, increases in the ACE score were linked to increases in the LSI-R score; the more ACEs that an offender had, the higher their risk level. While the authors did not advocate for, nor foresaw that the ACE questionnaire would replace formal risk assessment instruments, they made the case for using the ACE questionnaire "as an initial screening tool prior to implementing a more time intensive comprehensive risk evaluation process".

> This finding is significant for correctional workers and mental health providers because once an offender is identified as having a high ACE score then various therapeutic resources and services could be implemented to address this past trauma, potentially reducing that individuals risk for future recidivism. (Moore & Tatman, 2016: p. 155)

Harnessing the ACEs evidence to improve outcomes for offenders

In addressing the thorny issue of whether it is ethical to ask questions about ACEs, Edwards *et al*, argue that "researchers studying health outcomes who do not ask study subjects about traumatic childhood experiences are overlooking an important risk factor for many of the major health issues of our day" (Edwards *et al*, 2007).

Criminal justice agencies that are not trauma-informed and which do not train specialised staff to ask offenders about ACEs including sexual abuse, neglect, domestic violence, intergenerational imprisonment, family addictions and mental illness among offenders, are similarly overlooking important information relevant to continued offending behaviour. They are missing out on opportunities to build an evidence base about the prevalence of ACEs in prisons and probation caseloads so as to better understand and interact more meaningfully with the 'unrecovered trauma survivors' (Whitfield, 1998) in their care, and to bolster calls for increased investment in early intervention and prevention services for families and

communities most riven by ACEs (Mulcahy, 2017c; IPRT, 2012, IPRT, Barnardos & IAYPIC, 2010).

Moreover, professionals whose raison d'etre it is to reduce crime and recidivism and to enhance community safety are neglecting opportunities to assist people to make sense of themselves, their lives and the assortment of difficulties and struggles they experience as adults, including the reasons for their poor physical and mental health, their failure to make and sustain healthy relationships including with their own children, their inability to hold down employment, their battles with illegal substances *and* their accumulation of convictions. The correctional focus on quantifying and managing risk rather than recognising and endeavouring to help people understand their experience of childhood trauma, to allow them to remember and recount - if they wish - their painful stories and the ways and means they survived without shame, and support them in their lengthy healing process may, in part, explain why it can be so challenging to get 'criminals' to buy into whole-hearted participation in group work or CBT courses.

The traditional CBT approach preferred by the RNR model tends to problematize and blame them, their thinking styles, distorted cognitions, antisocial personalities and toxic peer influences, rather than accepting that their brains, bodies, behaviour, attitudes, self-perception and interpersonal relationships have been warped by their devastating early experiences. There is, however, always hope for recovery and an improved future – especially once a person learns the root causes of their extensive problems. Realistically, offending behaviour may often be the least of their worries.

Ideally, going forward the ACE questionnaire should be offered to all new prisoners on committal, as well as to all new probation supervisees. If data on ACEs were to be gathered in relation to sitting prisoners and probationers in Ireland, for example, the likely results would show that very high numbers of people have four or more ACEs, as per the Cork Simon findings. It is also probable that people who score as 'high risk' on RNR risk assessment tools such as the LSI-R or the Violence Risk Scale, would, in fact, prove to be highly traumatized individuals whose offending behaviour is just a minor aspect of their wider health, relational and social problems.

Moreover, certain cohorts of prisoners might well have eight or ten ACES, including women, chronically homeless men who may have unmet/undiagnosed mental health needs, or prolific low-level offenders, men who have done a so-called 'life-sentence in instalments' (usually a string of short sentences for acquisitive crime) because of their ritualized compulsive comfort-seeking behaviour, i.e., their debilitating addiction which they feed by violating the rights of others. These individuals are also likely to be people for whom prison may become a respite, or an adaptive response to escaping from the chaotic horrors of their lives outside.

In his classic study of the 'pains of imprisonment', Sykes maintains that it is the deprivation of autonomy arising from the voluminous rules which the prisoner must obey that is most profoundly threatening to his 'self-image', reducing him 'to the weak, helpless, dependent status of childhood'(Sykes, 1965: p. 67). The indignity of depriving people of autonomy and returning them to the vulnerable and dependent status of childhood no doubt applies to, and is keenly felt by, prisoners with higher levels of resilience and less ACEs in their past to grind

them down. However, those who were subjected to an 'overdose of trauma'[9] before they turned 18 may well find a safety in prison that they never knew outside. At best, they can press the pause button on their fight/flight/freeze response for a while and have all their basic needs fulfilled (particularly if such needs were not met when they were hungry, neglected, crying toddlers). They may find comfort in the positive regard and parental type warmth from authority figures such as Class Officers, Governors, teaching and support staff in prison, when the only 'bonds' they may have on the outside have proven lethal to them.

It is no wonder that a small number of prisoners failed first by their families, then by the education, health and social services that remain largely trauma-blind and callous, may actively seek out the 'punishment' of the criminal justice system. Society's most unloved, unseen, unheard, unprotected, abused, desolate children may grow up to develop a secure attachment to imprisonment. Inside the walls, gates, and heavy doors with bars their bodies and minds may find a safe containment (Bion, 1962), a holding environment[10] (Winnicott, 1953) that they have been tragically unable to find anywhere else in the world.

Spending their days in the closed confines of a prison becomes the lesser evil. Crime and its consequences may be a coping strategy, a survival mechanism so that their safety needs are met in a place where they have a clean bed, three meals and some semblance of belonging in a bubble of a world, which is less harsh than the one they have toiled to survive in since birth. In a sense, irrespective of their biological ages, some unrecovered trauma survivors might almost thrive during imprisonment. Such people may relish being dependent, nurtured children in prison. The sacrifice of their autonomy is a price worth paying.

Conclusions – Daring to care enough to ask "did you feel safe with anybody growing up?"[11]

A psychologist in the Irish Prison Service expressed the view during interview that engaging with psychology services affords imprisoned people a 'safe containment' a space where they can think 'about the impact of each other *on* each other'. A female patient who endured sexual abuse as a child at the hands of her grandfather from the age of 6 to 9 and used excessive eating to live through her ordeal, told Tomlinson that what she was looking for in a doctor was someone 'who looks comfortable when I'm sat in front of them' (Tomlinson, 2017).

All social and public services, including criminal justice agencies and prisons need to become informed about trauma, and *responsive* to it (Kochly, 2016) as a matter of urgency. Becoming trauma-informed means learning about ACEs and their devastating impact on human lives. It means instead of asking a distressed person 'what's wrong with you?' we instead dare to ask 'what happened to you?' A trauma-responsive criminal justice system requires actual changes in practice by police, lawyers, courts, prisons and probation. The lived experience of justice

[9] The Director General of the Irish Prison Service, Michael Donnellan, used this phrase in his welcome address at the CEP-EuroPris workshop on "Mental health in prison and probation" in Dublin on 06 December 2017, when he made reference to the impact of ACEs and their likely high prevalence in the prison population.
[10] See http://changingminds.org/disciplines/psychoanalysis/concepts/good-enough_mother.htm. See also https://www.78stepshealth.us/psychoanalytic-therapy/the-holding-environment.html.
[11] See Bessle Van der Kolk, Changing the Paradigm 2015 Developmental Trauma Panel, available at https://www.youtube.com/watch?v=-pCbbOWKB2I

and punishment must become less brutalizing. This means, for example, that we need to seriously rethink and reduce the use of heavy-handed arrest behaviours, alienating, anti-therapeutic courtroom activities, aggressive strip-searches and solitary confinement in prison. These often unthinking and unnecessary practices have the capacity to trigger and re-traumatize unrecovered trauma survivors.

Professor Harry Kennedy, clinical director of the Central Mental Hospital in Dublin stated during interview that trauma-informed care is about assisting people "with a history" to live and cope with that history, "making sure that everybody is aware of those issues". The 70/30 campaign, the goal of which is to see a 70% reduction in child abuse and neglect by 2030, states that trauma-informed care requires "holistic, multi-agency, non-stigmatizing, information-sharing among all professionals".[12] Vulnerable children become vulnerable adults, with expensive health complaints and problematic relational and social behaviours.[13] The fight/fright/freeze response that is triggered in stressful situations, if understood properly by teachers, doctors, A&E staff, police, lawyers, judges, probation officers and multi-disciplinary prison teams, should lead to superior strategies for interacting with unrecovered trauma survivors, particularly those who are hardest to reach and demonstrate oppositional or aggressive behaviours when fearful.

McNeill, one of Scotland's leading desistance and probation scholars has argued that practitioners need to listen to offenders and respect them "as people with important stories to tell" (McNeill, 2004: p. 243). Traumatized people must be empowered to remember and tell their painful stories if they are willing and able to find the words to give voice to the unspeakable (Burke Harris, 2018). We must not insist that offenders silence their suffering so as to preserve our own fragile comfort. Undigested trauma causes the stress response system to become dysregulated. This dysregulation makes itself viscerally and painfully felt in the body, and leads to illness, addiction, self-harm, uncontrollable anger and sometimes violence.

There is no denying the fact that social injustice precipitates trauma. Van der Kolk states:

> I wish I could separate trauma from politics, but as long as we continue to live in denial and treat only trauma while ignoring its origins, we are bound to fail. In today's world your ZIP code, even more than your genetic code, determines whether you will lead a safe and healthy life. People's income, family structure, housing, employment, and educational opportunities affect not only their risk of developing traumatic stress but also their access to effective help to address it. Poverty, unemployment, inferior schools, social isolation, widespread availability of guns, and substandard housing all are breeding grounds for trauma. Trauma breeds further trauma; hurt people hurt other people. (Van der Kolk, 2014, at p. 350)

If we want to improve criminal justice outcomes, we must not shy away from asking tough questions. Burke Harris claims that resistance to universal screening for ACEs in the health system is born essentially of ignorance and fear on the part of mainstream medical practitioners who would be more at ease if certain hidden harms remained behind the dark, despotic, private walls of the home (Arendt, 1958). In upper income circles familial realities like domestic violence, addiction, mental illness and incest "just aren't talked about" (Burke

[12] See http://www.70-30.org.uk/infographics/.
[13] See http://www.70-30.org.uk/our-campaign/.

Harris, 2018 at p.171). This desire to suppress and refute certain unpalatable truths (Herman, 2015: p.14), means that as a society we make it difficult for people to admit what they have borne as children. "ACES and toxic stress thrive on secrecy and shame, both at the individual level and the society level. We can't treat what we refuse to see" (Burke Harris, 2018 at p. 171).

We need to equip specialised healthcare staff with the skills to uncover the truth about the prevalence of ACEs in our prison population and deal with them in a healthy, holistic way. We should consider devising individual and group work courses about ACEs and their impact for both short and long-term prisoners, because self-understanding is vital to healing and personal development. Well-resourced prison systems which are committed to enhancing the wellbeing of people in their care should consider blending a range of top-down approaches (to activate social engagement) with bottom-up methods (to calm the physical tensions in the body) (Van der Kolk, 2014: p. 88), including body based interventions such as yoga and mindfulness, specialised forms of therapy like sensorimotor therapy, Eye Movement Desensitization and Reprocessing (EMDR) and psychomotor therapy (a type of heavily managed psychodynamic role play), as well as neurofeedback (e.g., alpha-theta training) which teaches self-regulation of the brain function, and theatre programmes. According to Van der Kolk, these have all demonstrated successes in treating trauma, boosting the brain's natural neuroplasticity (Van der Kolk, 2014).

Criminal justice professionals are likely to experience secondary trauma[14] without even being aware of it (Lambert & Gill-Emerson, 2017). In prisons, daily contact with unrecovered trauma survivors can lead to burn-out, absenteeism and the adoption of negative coping strategies such as addictive behaviours or a propensity to dehumanize and abuse prisoners. Training on the impact of both childhood trauma and secondary trauma is crucial for all staff working in prisons, as is information about positive coping strategies and mental health supervision (Herman, 2015: p.153).

In terms of bearing witness to trauma in prisons, we need to cultivate relationship-based practice across all services that fosters dignity, respect, honesty and hope, dispels with shame and blame, focuses on personal strengths, building competence and the possibility of positive change and the acquisition of "primary human goods in more socially acceptable ways" (Ward & Gannon, 2006, p. 78). We cannot expect people to live lives that are fundamentally *avoidant*. There must be something palpable and valuable for them in the new narrative we would like them to populate with a positive future self. It is, after all, *their* narrative.

If an offender's story is to change, they must take ownership of it. Initially, they may only be strong enough to make modest adjustments to the plot, but over time they might be sufficiently strong to not only contemplate, but execute massive alterations to their narrative ark. At all points of their journey of self-discovery, practitioners must be willing to sit with them and their distress, to look them in the eye, create a safe holding environment for them, laugh with them, support them in their dilemmas, be there for them and quite frequently focus on things other than criminogenic needs regardless of the wisdom of the RNR framework. Recovery from trauma, addiction and concomitant criminality is 'all about relationships' and

[14] See Law and Justice podcast with Dr Sharon Lambert, 2017 available at https://podtail.com/podcast/law-and-justice-podcast/law-and-justice-episode-6-december-6-2017/

taking one's power back.[15] Constructing a positive future self, an authentic self,[16] is not, however, feasible unless and until the person's basic human needs are fully met, as per Maslow's theory of human motivation. If a person is released from prison in a rushed, reckless manner, without housing, food, access to healthcare and sufficient money for the necessities of life, the goal of desistance from crime will, understandably, remain low down his or her list of priorities.

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[15] See Law and Justice podcast, Critical Voices Network of Ireland Conference, available at https://podtail.com/podcast/law-and-justice-podcast/law-and-justice-episode-6-december-6-2017/ See Dr Karen Treisman, Good Relationships are the key to healing trauma, available at https://www.youtube.com/watch?v=PTsPdMqVwBg&feature=youtu.be

[16] See Dr Gabor Maté, The need for authenticity, available at https://youtu.be/pUGGNPAK6uw

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