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Decoupling Trauma and Criminal Behavior Through Restorative Reentry Programs and Their COSAs

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**DECOUPLING TRAUMA AND CRIMINAL BEHAVIOR
THROUGH RESTORATIVE REENTRY PROGRAMS AND THEIR COSAs**

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PIM 74

A Capstone Paper submitted in partial fulfillment of the requirements for a Master of Arts in
Peacebuilding and Conflict Transformation at SIT Graduate Institute in Brattleboro, Vermont, USA

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LIST OF ABBREVIATIONS:

ACE: Adverse Childhood Experiences

BNA: Basic Need Approach

BHN: Basic Human Need

COSA: Circles of Support and Accountability

DOC: Department of Corrections

HCRJC: Hartford Community Restorative Justice Center

GED: General Equivalency Degree

PO: Parole/Probation Officer

P&P: Probation and Parole

PTSD: Post-Traumatic Stress Disorder

SAMHSA: Substance Abuse and Mental Health Services Administration (under the U.S. Department of Health and Human Services)

ABSTRACT

High rates of childhood interpersonal trauma, or adverse childhood experiences (ACEs), exist in criminal offender populations. Childhood trauma is associated with adult mental illness, drug addiction, and crime. This paper explores the following questions: 1) How does childhood trauma lead to adult conflict and crime? 2) How can restorative reentry programs for former prisoners best address offenders' trauma-related behavior and thus reduce conflict? Research was conducted through a review of literature, and findings were substantiated through personal experience working with clients of the Hartford Community Restorative Justice Center Reentry Program in White River Junction, Vermont.

This paper demonstrates how childhood interpersonal trauma can alter identity formation and lead to antisocial behaviors that increase the likelihood of adult crime and recidivism. Childhood trauma can change the way the human body responds to stress and the brain processes information, leading to an increase in aggressive, risky behavior. Evidence is provided for the trauma-healing effects of healthy relationships and community connections. Offenders returning to the community after incarceration often lack healthy relationships and are rejected by their communities. Based on these findings, it is argued that restorative reentry programs and their Circles of Support and Accountability (COSAs) for former prisoners can mitigate trauma-induced antisocial behavior by helping offenders build healthy relationships and community connections, and thus transform "criminal" identities.

The findings indicate that trauma-related criminal behavior is unlikely to be deterred by punitive responses, because that behavior is often an attempt to satisfy a basic human need, such as safety or identity. Human behavior arises from innate evolutionary imperatives, but its manifestation is dependent upon social-environmental context. Humans' innate drives cannot be changed, but the social environment can be changed in ways that reduce the likelihood of criminal conflict. More research should be done to verify these findings.

INTRODUCTION

This paper explores the association between childhood interpersonal trauma and adult criminality, and applies the findings to reentry programs for former prisoners or *offenders*. Based on a review of literature from numerous fields and personal experience working with clients of the Hartford Community Restorative Justice Center Reentry Program, these arguments are made:

1. Childhood interpersonal trauma can alter identity formation and lead to antisocial behaviors that increase the likelihood of adult criminality and recidivism.
2. Restorative reentry programs can mitigate trauma-induced antisocial behavior in offenders through trauma-informed practices and pro-social activities.
3. Healthy relationships are necessary to heal childhood interpersonal trauma.
4. Reentry program Circles of Support and Accountability (COSAs) can help offenders build healthy relationships and thus transform “criminal” identities.

This paper demonstrates how restorative reentry programs and their COSAs can mitigate trauma-induced criminal behavior, providing more evidence for *why* they work.

Restorative Reentry Program

The Hartford Community Restorative Justice Center (HCRJC) in White River Junction, Vermont, has a mission “to reduce crime and rebuild community in the greater Hartford area” (hartfordjusticecenter.org).

HCRJC partners with area residents and law enforcement to provide programs for victims, offenders, and other affected individuals in order to repair the community and empower individuals to be contributing members. Programs are based on principles of restorative justice:

1. Justice requires that we work to restore those who have been injured;
2. Those most directly involved and affected by crime should have the opportunity to participate fully in the response if they wish;
3. Government’s role is to preserve a just public order, and the community’s role is to build and maintain a just peace. (hartfordjusticecenter.org).

The center is run by the director and receives the majority of its funding from the Department of Corrections (DOC). Previously, the center was under the municipal government, but in 2016 it became its own entity as a registered 501c3 (non-profit) and is a member of the Community Justice Center Network of Vermont. The center offers several programs and services, but this paper only focuses on the reentry program.

The reentry program helps formerly-incarcerated individuals, who are still under DOC supervision (e.g., furlough or parole), reenter the Hartford community safely and productively by providing housing, supervision, and support. HCRJC oversees four reentry apartments, with a total of ten beds. Employment and resource assistance and life-skills programs are offered. To increase accountability and support for high-risk reentry clients, they are often part of a COSA (Circles of Support and Accountability). COSAs consist of two to five volunteers, the reentry coordinator, and the core member, who all meet weekly for a year (more information about COSAs is provided later). Clients can also be part of an internship program that helps them develop job-related skills and community connections. The center hosts regular writing, art, and debate classes and helps clients sign-up for other local programs. Clients are required to participate in some activities as a condition of receiving HCRJC's reduced-rent housing, because it is thought that pro-social activities increase a person's sense of connection within their community and reduces recidivism rates (J. Tuthill, HCRJC Reentry Coordinator, personal communication, November 16, 2018). Clients also must join a number of reentry circles, where clients, staff, and volunteers decide together how offenders will make amends and repair the harm of their past actions. If clients do not fulfill their program obligations, they may lose HCRJC housing, which puts them in violation DOC rules, and consequently they may be sent back to prison. Typically, clients spend six months in HCRJC housing, but extensions may be granted. The reentry program receives most of its funding from the DOC and has a good working relationship with DOC's local Probation and Parole Office (P&P).

Clients of HCRJC's reentry program include men and women who have served prison sentences for murder, rape, domestic violence, assault, grand larceny, drug dealing, prostitution, etc. Most of the

clients are returning to the community under conditional reentry status, or furlough, and are monitored by their Probation/Parole Officer (PO). Offenders are considered for furlough if it is 180 days before their minimum release date (reintegration furlough) or at their minimum release date (conditional reentry). In both cases, the offender is supervised by their PO and must follow strict rules. If furlough conditions are violated, the offender is sent back to prison.¹ Offenders are eligible for parole the month before their minimum release date. If they make parole, offenders are still supervised by their PO, but less strictly. During the research period, all clients were white, most were native Vermonters, and many were poor.

From April 2016 to February 2018, my role at the center was primarily to assist the reentry coordinator, especially with female clients. I helped clients move in and out of HCRJC apartments and assisted them with transportation, job applications, health insurance, and life skills. I also volunteered on two COSAs and on many restorative panels and circles. HCRJC is located right on Main Street and is a welcoming space, so clients, former clients, clients' families, POs, volunteers, and other community members frequently drop-in and intermingle. According to the director, my most important job was *listening*.

Research Methodology and Limitations

Research was conducted through: 1) a literature review connecting findings from the fields of psychology, sociology, criminology, restorative justice, and peace and conflict studies; and 2) observations from nearly two years of work with HCRJC's Reentry Program clients. No client was interviewed for the purposes of this research, and no questionnaires or surveys were given (this would have required an extensive Human Subjects Review process). However, many clients wanted to share their experiences and thoughts and did so voluntarily and spontaneously. Anecdotes and client comments are provided herein, anonymously, if the

¹ Jails and prisons have different functions, but in Vermont there are only correctional facilities, which are referred to here as both prisons and jails. In other states, jails are usually run by counties and are short-term holding cells for people who are convicted of minor criminal offenses or who have been arrested but are being held pending trial or sentencing. Prisons are run by the state or federal government and are for people convicted of more serious crimes and serving longer sentences.

subjects are unidentifiable and if their experiences/comments were not confidential in nature but shared publically (i.e., in the very public space of the center).

This is a preliminary study that needs to be verified by further research. This study unexpectedly took me into the field of psychology, in which I have no training. To compensate, in part, for this limitation, many direct quotes from psychologists/psychiatrists are used (and citations provided). Recently, I became an HCRJC Board member. I am biased towards HCRJC, but this bias is balanced, somewhat, by a desire to critically appraise HCRJC programs so they can be improved.

The causes of crime arise from the interaction of many diverse forces—social, cultural, economic, environmental, personal, etc. Childhood trauma is just one of many interrelated factors that can be associated with crime. For instance, opioid use can (but doesn't necessarily) increase crime and also fuel trauma-related addiction (Ball et al., 1983; Lopez, 2018; Quinones, 2016). Rising economic inequality has been associated with higher crime rates and might itself exacerbate childhood trauma (Payne, 2017, p. 213). It is possible that manmade endocrine-disrupting chemicals contribute to crime, because exposure to these chemicals can increase aggressive behavior, mimicking or enhancing the stress response of trauma (Colborn et al., 1996, p. 237). Racism can cause trauma, and racism within the criminal justice system is a problem nationwide (Stevenson, 2014). This paper focuses only on trauma's relationship to crime, but in reality trauma is just one component in a complex crime ecosystem.

Research Questions and Theoretical Approaches

My work at HCRJC partially fulfilled the practicum portion of the master's degree program in Peacebuilding and Conflict Transformation at SIT Graduate Institute in Brattleboro, VT. During my practicum, I applied a conflict analysis approach towards crime. Johan Galtung (1958), a key founder of peace and conflict studies, defines conflict as an incompatibility of goals pursued by two or more parties. I asked a seemingly naïve question: *why do some people (criminals) act in a way that is in conflict with the goals of the larger*

community, and what are the underlying causes of this conflict? More specifically, I asked: 1) *What are the primary causes of criminal behavior?* 2) *What do offenders need to desist from criminal behavior?* 3) *How can HCRJC help meet this need?* I started my research using two compatible approaches: 1) Human Needs Theory, which posits that conflicts are caused when basic human needs (BHNs) are not met (Burton, 1990); and 2) Identity, where issues of identity are believed to be at the root of most conflicts (Lederach, 2003).

Abraham Maslow, an influential 20th century psychologist, conceived of a hierarchy of BHNs where lower levels must be satisfied before higher levels can be achieved. Maslow (1954) believed that a failure to satisfy BHNs would cause illness, especially mental illness. Galtung (1990) created a list of *nonhierarchical* BHNs—security needs (safety), welfare needs (food, water, health), identity needs (belonging, affection, esteem, meaning), and freedom needs (autonomy, choice)—and said “...there is such a thing as basic disintegration or pathology that shows up at individual-personal or societal levels, or both, if and when needs are not met” (needs summarized from p. 309; p. 312). Psychologist Pamela Routledge (2011) made an important point about BHNs: “None of these needs—starting with basic survival on up—are possible without social connection and collaboration.” She reconfigured the diagram of BHNs, putting social connection in the middle because all other needs are dependent upon it.

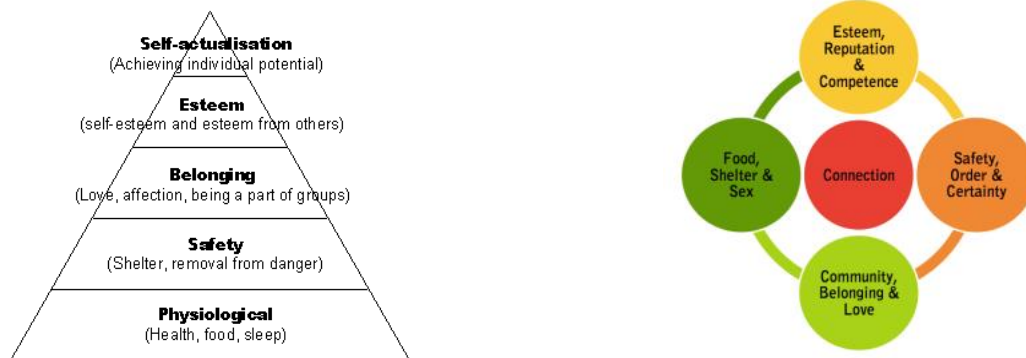


Figure 1: Abraham Maslow’s BHNs pyramid (1954). Figure 2: Pamela Routledge’s (2011) nonhierarchal reconfiguration of BHNs that places social connection in the middle, because all other needs are dependent upon it.

This reconfiguration of BHNs led me to an important realization: what many of the reentry clients shared was a problem with social connection—many of them had experienced childhood interpersonal trauma within their own family, disrupting the most fundamental social connection and thus jeopardizing the satisfaction of *all* their basic human needs. As Maslow and Galtung would have predicted for people whose basic human needs have not been met, mental illness is common among reentry clients, as well as social pathologies like drug addiction and, of course, crime.

Childhood interpersonal trauma also impacts identity formation. Identity develops in relationship to others, and healthy attachments to caregivers (parents, etc.) in childhood are necessary for forming a stable identity and “feeling secure and coherent as an individual” (Brenner, 2017). Forming a stable identity (not a fixed identity) is considered to be a necessary component of becoming a mature, psychologically healthy adult. When childhood trauma disrupts identity formation, it undermines people’s ability to meet their identity needs (belonging, affection, esteem, meaning) and leads to antisocial behaviors that increase the likelihood of conflict and crime. Healthy relationships, even those formed in adulthood, can heal childhood trauma and mitigate trauma-induced antisocial behavior. (Synthesized from Mikulincer & Shaver, 2007; Perry et al., 2018; Perry & Szalavitz, 2006; Vaillant, 2008; Van der Kolk, 2003.)

Based on these findings, my original research question was refined to: *How does childhood interpersonal trauma lead to adult conflict and crime, and how should restorative reentry programs address offenders’ trauma-related antisocial behavior?* To my knowledge, research findings concerning childhood trauma and criminal behavior, and the healing properties of healthy relationships, have not been applied specifically to restorative reentry programs and their COSAs.

This paper provides evidence for the high rate of childhood interpersonal trauma in offenders, describes how such trauma increases the likelihood of criminal behavior, demonstrates how reentry programs can be trauma-sensitive, and shows how COSAs can facilitate trauma healing through relationship-building.

RATES OF CHILDHOOD INTERPERSONAL TRAUMA IN OFFENDERS

Many studies have found that convicted criminals have significantly higher rates of childhood trauma than the general population (Arsenault, 2016; Carlson & Shafer, 2010; Currie & Tekin, 2006; Welfare & Hollin, 2012). Perry et al. state that 90% of incarcerated people have a history of childhood interpersonal trauma (2018, pp. 827-8), and women tend to have higher rates than men (Baglivio et al., 2014; Scott et al., 2016).

Wolff and Shi (2012) studied childhood trauma rates in incarcerated males (n=3,986) and found that 56% of them experienced childhood physical trauma, over 25% had been abandoned as children or adolescents, and 11% had been sexually abused (only these 3 types of trauma were measured). Rates of trauma may have been even higher if the survey had included high-risk inmates such as those housed in the super-max facility or administrative segregation. Wolf and Shi also found that childhood trauma was positively associated with psychopathology. Childhood neglect predicted personality disorder and physical abuse predicted interpersonal conflict and problems with self-regulation and aggression. In addition, childhood trauma significantly increased the likelihood of substance abuse.

Lynch et al. (2017, p. 806) found that 92% of incarcerated women (n=491) reported exposure to interpersonal violence, 68% witnessed violence as children, 47% reported childhood sexual abuse, and 40% were physically abused as children. Over a third reported exposure to five or more forms of violence. Ninety-one percent had some mental health disorder, 53% met the criteria for lifetime posttraumatic stress disorder (PTSD), and 43% had a serious mental illness such as bipolar, schizophrenia, or major depression. Eighty-two percent met the lifetime criteria for a drug and alcohol abuse disorder.

Many male and female reentry clients at HCRJC also had histories of trauma. Some grew up in households plagued with addiction or domestic violence, or they had been neglected or raped. During my time at the center, I knew 11 formerly-incarcerated females, and 10 out of the 11 had a history of childhood trauma. One, to my knowledge, did not. However, she spent only one month in prison, whereas the others

spent a year or more. Most female clients had been exposed to multiple types of trauma. One client had experienced reoccurring rape, physical abuse, parents with addiction problems, a mother who was the victim of domestic violence, death of a parent, and purposeful abandonment—all before the age of 16. The clients who had the greatest difficulty reintegrating were often the ones with the longest histories of abuse. Although my contact with extended families was limited, there was at least one where three generations of women had experienced sexual abuse. Clients reported that they struggled with depression, anxiety, PTSD, bipolar and borderline personality disorders. All of the women but one had a problem with addiction.

Adverse Childhood Experiences (ACE) Survey

The ACE survey has been used nationwide to measure levels of childhood interpersonal trauma. It includes 10 questions that measure a person's exposure to childhood sexual, verbal, and physical abuse; emotional or physical neglect; a parent who is mentally ill, has a drug/alcohol addiction, is incarcerated, or is a domestic violence victim; or the loss of a parent through divorce or abandonment (see Appendix 1 for the ACE survey). Each question has a possible score of 0 or 1, so total ACE scores range from 0 to 10. The original surveys were given in 1995-1997 to over 17,421 participants in a collaboration between the Centers of Disease Control and Prevention and Kaiser Permanente. That study revealed that a greater number of ACEs resulted in a higher risk of medical, mental, and social problems as an adult (Felitti et al, 1998). A summary of the study states:

Compared with people with zero ACEs, those with four categories of ACEs had a 240 percent greater risk of hepatitis, were 390 percent more likely to have chronic obstructive pulmonary disease (emphysema or chronic bronchitis), and a 240 percent higher risk of a sexually-transmitted disease... They were twice as likely to be smokers, 12 times more likely to have attempted suicide, seven times more likely to be alcoholic, and 10 times more likely to have injected street drugs... People with high ACE scores are more likely to be violent, to have more marriages, more broken bones, more drug prescriptions, more depression, more auto-immune diseases, and more work absences. (Stevens, 2012)

In a study focusing only on drug addiction, Felitti (2003) found that males with an ACE score of six had a 4,600% increase in the likelihood of becoming an intravenous drug user compared to males who had a score of zero (p. 7). High ACE scores have also been associated with sexually risky behaviors, such as having 50 or more sexual partners, having intercourse before the age of 15, and becoming pregnant as a teenager (Hillis et al., 2001, 2004). Brown et al. (2009) did a 10-year follow-up of the original ACE survey participants and found that “ACEs are associated with an increased risk of premature death” and that “people with six or more ACEs died nearly 20 years earlier on average than those without ACEs” (p. 389).

Reavis et al. (2013) found that “criminal behavior can be added to the host of negative outcomes associated with scores on the ACE Questionnaire,” and that an “offender group reported nearly four times as many adverse events in childhood than an adult male normative sample” (p. 44). Baglivio et al. (2014) found very high rates of ACEs in juvenile offenders: “Of the 13,692 females with one or more ACE indicators, 92% reported at least two ACEs, 80% reported at least three, 63% reported at least four, and 46% reported five or more. Of the 48,844 males who reported at least one ACE indicator, 89% reported two or more, 71% reported three or more, 48% reported four or more, and 28% reported five or more.”

Baglivio et al. also compared 64,329 juvenile offenders’ ACE scores to their scores on the Positive Achievement Change Tool (PACT), which measures an offender’s risk of reoffending, and found that “increased ACE scores correlate with increased risk to reoffend” (p. 2). ACE survey questions 5 (physical neglect), 7 (family violence), 8 (family substance abuse), and 10 (household member incarceration) were the ACEs most related to a youth’s risk to reoffend (p. 10) (Appendix 1). It is likely that adult offenders would follow a similar risk pattern.

Recommendations for Reentry Programs

Vermont DOC uses the Ohio Risk Assessment System (ORAS) to measure an offender’s risk of recidivism. The ORAS does not cover offenders’ trauma history, or even a proxy for ACE data, but instead includes

domains such as criminal history and criminal attitudes (Latessa et al., 2010; Hartford Probation and Parole, personal communication, October 11, 2017). Therefore, the ACE survey should be given to every willing reentry client so that the relationship between trauma and recidivism can be better defined. In addition, it is possible that the ACE survey alone will provide a good indication of risk, and it could enable clients and staff to better understand the challenges they face. In the original ACE study, it was feared that the ACE survey would force people to revisit painful memories that could be detrimental to their wellbeing. However, it was discovered that most people felt a sense of relief when they filled out the survey—for the first time they understood the reason for their struggles, and they realized that they were not alone (Redford, 2016). Nevertheless, no client should be forced to take the survey, because some people can be retraumatized when they explore their memories (Bicknell-Hentges, 2009). When appropriate, this quick 10-question survey (Appendix 1) should be given when a new client first enters the reentry program. The Resiliency Survey (Appendix 2) should also be given. This 14-question survey determines how much love, support, and positive influences individuals had in their childhood. Positive relationships lessen the impact of trauma, so high resiliency scores can mitigate the effect of high ACE scores, as the sections below explain.

Giving the ACE survey to reentry clients is in line with recent Vermont legislation. In 2017, the Vermont General Assembly passed H.508 (Act 43) that created an ACE Working Group for the purpose of “analyzing existing resources to mitigate childhood trauma, identify populations served, and examine structures to build resiliency” (<https://legislature.vermont.gov/assets/Documents/2018/Docs/BILLS/H-0508/>). Subsequent bills H578, H579, H580, and S.261 all relate to trauma. The Act 43 Working Group concludes:

When we look at the growing populations in Special Education and Corrections, and experiencing chronic health care conditions, addiction, generational poverty and homelessness, childhood trauma is clearly prevalent. Our goal must be to reduce and, or, to provide support for those who experience early childhood trauma. Having data and a better understanding of the stories that accompany that data, is one key to better addressing this challenge here in Vermont. (Lyons et al., 2018)

Reavis et al. (2013) believe that ACEs disrupt neurobiological functioning and cause attachment disorders, which lead to higher rates of criminal behavior (p. 47). The next section explains how childhood adversity affects the development of children.

CHILDHOOD INTERPERSONAL TRAUMA AND CRIMINAL BEHAVIOR

“Crime is a disease like any other malady and is a product of the prevalent social system.”

—Mahatma Gandhi

Bruce Perry, a renowned psychiatrist who studies the effect of trauma on the developing brain, said that “understanding the roots of community and predatory violence will be impossible without examining the effects of intrafamilial violence, abuse and neglect on the development of the child” (1997, p. 3). In a 2018 publication, Perry and his colleagues state that “although our knowledge base about the brain is in its infancy, to date it provides valuable insights into the origins of criminal behavior” (Perry et al., 2018, p. 815).

Wolff and Shi, citing numerous studies, state that traumatic abuse before the age of 18:

- 1) increases the risk for violent and aggressive behavior and criminality in adulthood,
- 2) significantly predicts adult arrests for alcohol and/or drug-related offenses,
- 3) is associated with mental disorders, including depression, anxiety disorders, post-traumatic stress disorder, dissociative disorders, and psychosis, and
- 4) elevates the lifetime risk of re-victimization. (2012, p. 1909-10)

It is important to note that most people who have experienced childhood trauma do not become criminals, but most criminals *do* have a history of trauma. The sections below summarize experts’ findings on how childhood trauma alters identity formation and increases the likelihood of adult criminal behavior.

Attachment Problems, Identity Issues, and Antisocial Behavior

Healthy relationships, or *attachments*, in childhood are necessary for optimal identity formation and are crucial for emotional stability, mental health, and satisfying relationships in adulthood. An *attachment figure* is anyone who “provides a safe haven and a secure base in times of need,” and is usually a child’s parent or caregiver (Mikulincer & Shaver, 2007, pp. 17-18). Interpersonal trauma disrupts a child’s ability to form

healthy attachments. When severe, this trauma can lead to identity diffusion and borderline personality disorder (pp. 398-404). Psychiatrist Bessel Van der Kolk (2003) states: “disturbance in identity formation is observed as a persistent problem in patients known to have been subjected to chronic recurrent trauma in childhood,” and “such patients display identity diffusion, splitting of the good and bad self, and a relentless sense of inner badness” (p. 115). As Brenner (2017) summarizes, “identity—including one’s sense of being good enough...feeling secure and coherent as an individual, and even the basic experience of who one actually is—is disrupted by developmental trauma.” Identity issues can lead to an unstable self-image, contradictory character traits, relationship difficulties, feelings of unreality or emptiness, gender dysphoria, impulsivity, anger problems, etc. (Mukilincer & Shaver, 2007; van der Kolk, 2003, 2014; Wilkinson-Ryan & Westen, 2000). Several reentry clients had identity disorder diagnoses and displayed these symptoms. Holding them accountable for their actions was difficult, as *who* they were changed from day to day (in appearance and behavior). One client experienced dissociation (a coping mechanism for trauma), which complicated her ability to have a coherent sense of herself and take responsibility for her actions.

Identity develops in relationship to others. A person who has grown up with loving and responsive attachment figures is *securely attached* and has “a solid sense of personal safety and inherent value” (Mikulincer & Shaver, 2007, p. 472). A person who has grown up without such a loving relationship is *insecurely or anxiously attached* and for them “many everyday experiences threaten the sense of safety and raise doubts about one’s tenuous hold on life, identity, and knowledge of the world” (p. 468). Reentry clients with traumatic childhoods have made comments that indicate an unstable identity. One woman said, “I have to be with people, or I don’t know who I am.” Another said, “I never feel safe unless I am with someone.” And one stopped by the center “just to see someone to know I’m alive.” Psychiatrist George Vaillant says it is our “memory of past attachments that helps to make us feel real” (2008, p. 86). Human beings rely on others for survival and thus we need to belong, and identity is tied to a feeling of belonging. One client, whose childhood trauma destroyed all family ties, said, “without belonging in a family, it is hard

to belong anywhere.” Some reentry clients seemed to need to belong and would readily attach themselves to others, even when those others were abusive or detrimental to their wellbeing.

Attachment behaviors are inborn because they biologically evolved to protect individuals, especially in dangerous situations, and increase their chances of survival. Attachment is most critical early in life, but it is important at every stage and drives certain behaviors, such as seeking loved ones in times of threat or need. Adults who had caring attachment figures in their youth have the ability to self-soothe and regulate their emotions without actually connecting to an attachment figure because they can simply “recall” past support. However, people with significant childhood trauma rarely feel safe alone and continually seek out attachment figures trying to satisfy their safety needs (Mikulincer & Shaver, 2007; pp. 10-13). A reentry client undergoing a stressful experience once called to say that she needed a hug from someone at the justice center, and when she was asked if a near-by friend could give her a hug instead, she said “hugs from friends and family don’t make me feel as safe as a hug from one of my support people.” She experienced severe trauma at home as a child, and family members were unable to provide her with protection then, so it appears as if she was trying to find safety through new, non-familial attachments. This client was unable to self-soothe and needed constant support from others to regulate her emotions.

Safety is such a biological imperative that attachment behaviors generally override other behaviors. Adults with traumatic childhoods may be so focused on unmet attachment needs, that they resist engaging in other, less critical activities (Mikulincer & Shaver, 2007, p. 224). Many reentry clients seemed to prioritize personal relationships over other goals, and sometimes became upset when they had to take classes or other programming. It is possible that their attachment needs were so great that they could not focus on anything that they felt was nonessential (an outcome Maslow would have predicted). Severe attachment needs also affect how people relate to others, because “they are likely to be so self-focused (so focused on their need for protection) that they lack the mental resources necessary to attend empathically and altruistically to others’ needs and provide care” (p. 17). Clients’ focus on relationships—often difficult

ones—complicated their reintegration into the community. They usually had restrictions from P&P about who they could see and when and where. Rule violations could, and did, land them back in prison.

People often unconsciously seek to reconfirm their belief systems. If they have grown up believing that intimate relationships are abusive, they find new attachments (e.g., romantic relationships) that are abusive, thereby maintaining a coherent worldview. In addition, they can “behave in ways that elicit expectation-consistent reactions from attachment figures, which in turn reinforce existing working models—e.g., anxious, clinging behavior often annoys a partner and causes the partner to become more avoidant, thus confirming an anxiously attached person’s chronic fear of rejection and abandonment” (Mikulincer & Shaver, 2017, p. 117). This process of re-victimization was evident in a few clients with childhood trauma.

However, victims also can become abusers. The type of relationship between an abuser and victim influences the victim’s subsequent behavior. People who were sexually abused by a nonfamily member were found to be 26 times more likely to perpetrate violence when they were older, but they were 46 times more likely when they had been sexually abused by a family member (Reavis, 2013, p. 45). The authors state that “these results suggest that...poor treatment from their attachment figures are associated with either an avoidance of intimacy, or a ‘bleeding out’ of the feelings into their intimate relationships, in the form of violence” (p. 47). Perry states:

Attachment, then, is a memory template for human-to-human bonds. This template serves as your primary “world view” on human relationships. It is profoundly influenced by whether you experienced kind, attuned parenting or whether you received inconsistent, frequently disrupted, abusive, or neglectful “care.” (Perry & Szalavitz, 2006, p. 91).

This cycle of abuse was apparent among some clients.

Adults who are insecurely attached because of childhood trauma are more likely to be involved in conflicts, because they “are likely to appraise interpersonal conflicts in more threatening terms and apply less effective conflict resolution strategies” (Mikulincer & Shaver, 2007, pp. 268-70; p. 371). Perry et al. (2018) explain how attachment problems can lead to antisocial behavior:

The individual with attachment problems and relationally-mediated abuse will find relational cues (e.g., eye contact, tone of voice, touch, and physical proximity) threatening. A person with a high degree of relational sensitivity will often misinterpret neutral or positive social interactions from peers as threatening and respond by either avoiding or disengaging...or, worse, by using aggressive, hostile, or hurtful words or behaviors... In extreme cases, as the child grows up, this relational sensitivity can result in significant antisocial or even assaultive behaviors...and they will often respond to personal space violations with aggressive and violent behaviors. (p. 826-27)

When people's sense of security cannot be obtained because of unhealthy or absent attachment figures, they also might "react with frustration, protest, angry demands, and aggression on the one hand, or defensive detachment, narcissistic self-aggrandizement, and lack of attention to inner experiences on the other" (Mikulincer & Shaver, 2007, p. 472). In addition, they may overreact or shut down emotionally in order to maintain control. One client, who was asked about a problem with housemates, shut down and would not say a word or even move for about an hour, as if catatonic.

Trauma and relationship insecurities can also lead to substance abuse (Mikulincer & Shaver, 2007, pp. 397; 395-98). Experiments show that "opiates are the only chemicals that can comfort a baby animal separated from its mother" (Vaillant, 2008, p. 98). The area of the human brain that is involved in human attachment is dependent on the neurotransmitter dopamine and also contains opiate receptors linked to heroin addiction. For people abandoned as children, opioids might fill the void of missing attachment. Vaillant quotes an addict: "You don't really get lonely on smack [heroin]—it's like having a lover" (p. 98). Approximately 60% of the female clients with childhood trauma were also heroin addicts.

Adults who experienced severe childhood trauma often feel threatened—both in relationship to others *and* internally (*who* they are). Their very identity (including belonging, affection, self-esteem, meaning) is endangered. Even when they are physically safe, their basic human need to *feel* safe is jeopardized by their social disconnection (attachment problems). This sense of threat and a perceived need to protect the self can lead to conflict. Difficulties regulating emotions and constructively dealing with conflict, as well as a susceptibility to drug addiction, can escalate conflict and lead to crime. Destructive conflicts also cause further damage to relationships. Healthy attachment figures are supportive and help

people meet *all* their BHNs, alleviating stress and making people more resilient. Without these healthy relationships, people are more vulnerable to the stress responses described below.

Stress and Maladaptive Behavior

Threatening situations produce two basic responses in people: arousal (fight or flight) or dissociation (curl up and create psychological distance from what is happening). When fight or flight is not possible—which is often the case for young children—the dissociative response prepares the body for injury by slowing the heart rate (to reduce blood loss) and flooding the body with natural opioids to lessen pain and bring calmness (Perry & Szalavitz, 2006, p. 49). When children are exposed to moderate and predictable amounts of stress, they become *resilient*. When they are exposed to extreme, unpredictable, or long-term stress they become *sensitized*, which means their brains and bodies become so fine-tuned to stress that even mildly stressful events will activate a full-blown stress response (Perry et al., 2018). A heightened stress response is critical to survival in dangerous environments, but when it continues in other environments it produces maladaptive behavior. A sensitized stress system causes:

- 1) hyper-arousal or overreaction to stress, often expressed aggressively (fight response);
- 2) dissociation, or an involuntary escape from reality, where people experience a disconnection between their thoughts, memories, actions, and sense of identity; and
- 3) compromised executive functioning leading to impulsivity and poor judgment, because the stress reaction disables higher brain functions in favor of more primal, reactive brain regions related to immediate survival.

The more frequently neural networks are activated the stronger they grow. Individuals who have been exposed to toxic levels of stress throughout their childhoods are therefore wired more for the “battlefield” than for college and careers.

Hyper-arousal and aggression. People who are sensitized to stress through trauma will respond to most future challenges in the same way they responded in their past. For instance, “a young boy growing up in a

domestic violence situation who used a fight or flight response during those traumatic experiences may respond to authoritarian males – even when they are not being threatening – with hostility and aggression” (Perry et al., 2018, p. 824). In *Hillbilly Elegy* (p. 228), Vance, whose mother once tried to kill him, states:

For kids like me, the part of the brain that deals with stress and conflict is always activated—the switch flipped indefinitely. We are constantly ready to fight or flee, because there is constant exposure to the bear, whether that bear is an alcoholic dad or an unhinged mom. We become hardwired for conflict. And that wiring remains, even when there’s no more conflict to be had.

For individuals whose primary childhood relationships were abusive, often “intimacy is associated with threat and loss, and infringement of personal space violations can trigger aggressive and violent behavior” (Perry et al., 2018, pp. 815-16). Even “a neutral or minimally negative relational interaction can be enough to move the individual along this arousal continuum and result in maladaptive social interactions and very impulsive (often aggressive) responses” (p. 825). One reentry client who was reprimanded for smoking in the apartment was very quick to conclude “everyone hates me,” and she began shouting. Later, when she realized she would not lose the apartment, and her stress decreased, she was apologetic. Perry points out: “The aggression and impulsivity that the fight or flight response provokes can also appear as defiance or opposition, when in fact it is the remnants of a response to some prior traumatic situation...” (Perry & Szalavitz, 2012, p. 51).

Because stress is more tolerable when it is predictable, people who have been severely mistreated often provoke others “in an attempt to elicit a predictable response from the ‘environment’” (Perry, 2007, p. 11). A reentry client who had been purposely abandoned by her mother when she was young often lashed out at her COSA team, perhaps in an unconscious attempt to elicit a predictable response. Unfortunately, her COSA did end prematurely.

Cocaine, amphetamines, and other stimulant drugs mimic the hyper-arousal state. Both increase the release of dopamine and noradrenaline and make people feel more powerful and elevate their heart rate—both necessary for flight or fight. Perry said that “brain changes related to hyper-arousal may make

some trauma victims more prone to stimulant addiction” (Perry & Szalavitz, 2006, p. 212). New research now makes the connection between stress and addiction definitive (Friedman, 2017).

People who have been conditioned to respond aggressively are more likely to be charged with a violent offense. If they are also susceptible to stimulant drug addiction, their risk of offending is even greater. As Perry (1997) says, “it is often the intoxicating agents that allow expression of the neurodevelopmentally-determined pre-disposition for violence” (p. 11).

Dissociation and mental illness, opioid addiction, and cutting. Individuals who have repeatedly responded to threats through dissociation are more likely to experience involuntary dissociation even when there isn’t a major threat. Involuntary dissociation makes it difficult to function in every day life and leads to an increased likelihood of PTSD and mental illness (dissociative amnesia, dissociative identity disorder, and depersonalization-derealization disorder) (Porter & Kaplan, 2011).

The process of dissociation also primes the body for opioid addiction. Many people do not readily respond to opioids but instead may experience them as uncomfortably numbing (Perry & Szalavitz, 2006, pp. 39 & 211). However, people whose bodies were sporadically exposed to high levels of natural opioids (endorphin and enkephalin hormones) through the dissociative response during childhood may have become sensitized to opioids, making them especially blissful (hormone receptors can be down- or up-regulated depending on level and pattern of hormone exposure; Vandenberg et al., 2012). Self-harm or cutting also releases natural opioids, “which makes it especially attractive to those who have been previously traumatized and found relief in dissociation” (Perry & Szalavitz, 2006, p. 211). A heroin addict and former cutter once explained why she liked getting tattoos: “I don’t even care what tattoo I get—I just really like the feeling of the needle.”

People who struggle with mental illness, try to self-medicate, and are “programed” to be especially responsive to opioids are more likely than the average population to become addicted to illegal drugs and

end up in the criminal justice system, either because of drug possession or criminal activities related to supporting their addiction. In addition, dissociative tendencies complicate an offender's ability to take responsibility for their actions.

Compromised executive functioning and impulsive behavior. Executive functioning is a set of higher-order brain processes that are in charge of self-regulation, attention, flexible problem solving, and managing other cognitive processes. In addition, executive functioning establishes temporal sequencing and is important to planning, organizing, prioritizing, delaying gratification, and establishing cause and effect (Vaillant, 2008, p. 35). During extremely threatening experiences, executive functioning is effectively shut down, allowing the body to react more quickly and instinctually to immediate threats—"the more threatened, the more primitive (or regressed) thinking and behaving becomes" (Perry et al., 2018, p. 824). Executive functioning is located in the frontal lobe (including prefrontal cortex) of the brain, which continues to develop throughout childhood and adolescence, making its growth heavily dependent on the environment (Hughes, 2013, p. 430). When people are exposed to prolonged threats when young, this repeated shut-down of higher brain functions actually inhibits normal development, leading to compromised executive functioning in adulthood (Nikulina & Widom, 2013). Compromised executive functioning can lead to impulsive, risky behavior, difficulties regulating emotions and learning new things, and an inability to fully consider cause and effect.

People who have executive functioning difficulties, and a sensitized stress response, are easily overwhelmed by simple challenges and struggle with new skills, academic concepts, and unfamiliar social situations. Adults who have been severely mistreated as children have trouble paying attention, following instructions, and even sitting for sustained periods of time (Perry et al., 2018, p. 827). People experiencing stress need to move, because movement provides a way for the body to use up the stress hormones (as would happen in fight or flight responses), so they do not build up in the body in a damaging way (Tippet,

2017). A reentry client with a long history of childhood trauma once said, “I can’t work on getting my GED, my head is not right now, and I can’t even sit down for long.”

Executive functioning and the ability to problem solve and manage thoughts and emotions has been linked to “perceived control,” “or the belief in one’s own ability to overcome whatever adversity is being faced” (Vitelli, 2018). *Perceived control* is the opposite of “learned helplessness,” which occurs when people are conditioned to think that they are helpless and cannot get out of a negative situation. People repeatedly abused as children often have *learned helplessness* as adults. Animals too can be trained to become helpless—dogs administered electric shocks that they cannot control do not seek to escape from shocks even when they *can*, but instead lie down, unlike dogs who have not been conditioned (Maier & Seligman, 1976). Trauma survivors might think they have no control, and thus have no personal agency.

Executive brain functions help people self-regulate, plan for the future, and ultimately take control of their lives. Without this ability, individuals are more likely to be impulsive, engage in risky behavior, and relinquish control, raising their risks of offending and reoffending. In addition, the prefrontal cortex is also “in charge of estimating rewards and punishments and plays a critical role in adapting and regulating our emotional response to new situations” (Vaillant, 2008, p. 35). Therefore, the criminal justice system’s traditional way of influencing behavior through punishments and rewards is unlikely to be effective for many trauma survivors (Kirk, 2017; Perry et al., 2018, p. 830).

Poor Life Expectancy and “Fast Strategy” of Living

As the ACE survey showed, childhood trauma can significantly lower life expectancies. Lower life expectancy has been linked to earlier and higher reproduction rates. As Keith Payne (2017) describes, “...from an evolutionary perspective it is life expectancy that is the most important source of pressure for reproducing earlier” (p. 68). The evolution of the human species obviously depends on humans surviving and reproducing, but the best time to reproduce is dependent on circumstances. Payne states:

When times are prosperous and the future looks secure, it is a sign that you are likely to live a long and healthy life. You will leave more descendants if you bide your time and wait to have children until you are really ready to support them well. You should devote everything you can to extensive parenting to make sure that they survive to reproduce themselves, and maybe you can even help raise your grandchildren. When times are hard, the future is uncertain, and enemies are lurking behind every patch of grass, the odds favor an entirely different approach. You might not live long enough to have children later. Under those conditions, it pays to reproduce early and often. If you are going to reproduce at all, the best bet is to do so as soon as possible. (pp. 65-66)

Evolutionary biologists call the first strategy the “slow strategy,” which is essentially an investment in the future, and the second the “fast strategy” or “live fast, die young” (Payne, 2017, p. 66). In a study of birth and death rates in Chicago, researchers discovered that “as life expectancy decreased, so did the women’s age when they started having children” (p. 68). In fact, puberty actually occurs earlier when girls live in dangerous environments. Many studies have documented that “girls raised in harsh, poor, or chaotic homes reached puberty earlier than those raised in more stable homes” and that “earlier puberty and earlier childbirth were linked not only to life expectancies, but also to poverty, to homes with an absent father, and to the degree of economic inequality in the region” (p. 69).

Reproducing earlier and more frequently is not necessarily a fully conscious choice so much as it is a biological and psychological response to the environment (Payne, 2017, p. 68). A heroin addict visiting the Justice Center said that her pregnancies were not mistakes—she intended to have children, even when she knew she would lose custody—but she could not explain her reasoning. Unfortunately, the stress conditions of parents can affect infants in the womb. There is increasing evidence that the effects of trauma can be handed down from parents to children epigenetically—i.e., that genes in utero can be turned on or off through biological signals from the parent (even via sperm) rather than through an alteration of the genetic code itself (Shulevitz, 2014). Stress levels in parents can create lasting changes in their own hormonal response system, and those changes can be passed on to their children, making them more susceptible to PTSD and other pathologies (Shulevitz, 2014).

Early and frequent reproduction is not a criminal act, but it is often accompanied by other “live fast, die young” risky behavior, which can increase the likelihood of criminal charges (as noted below). In addition, the birth of a child can create an incredible amount of financial, psychological, and relationship stress, which for trauma survivors can exacerbate all the stress-related maladaptive responses discussed above. The stress of trying to reunite with children and custody issues also complicates offender reintegration. Lastly, the effects of trauma can be passed on to offspring, making them more susceptible to an overactive stress response.

Poverty/Inequality and Risky Behavior

The ACE survey does not include a question specifically related to poverty. However, many researchers believe there is a connection between poverty and ACEs—some think that poverty can trigger childhood trauma, or be a result of it, or that it is simply an ACE itself (Evans & Kim, 2013; Felitti et al., 1998; Hughes & Tucker, 2018). Poverty and relative poverty (or inequality) can create stress and impact people’s thinking and behavior (Payne, 2017).

In our society, wealth is a prime measure of social status. In *The Broken Ladder*, Payne explains how important status is to humans. Status-seeking is also important to other primates, showing that it is an evolutionary trait related to primates’ reliance on social connections for survival and reproduction (pp. 21, 28). A heightened stress response was found in low-ranking baboons—“because it was the low-ranking animals who were most likely to be beaten, bitten, and deprived of their dinner”—and also in poorer, low-ranking humans (p. 130). In the United States, wealth inequality is now higher than it has been in many generations. Poverty or simply *feeling* poor can make people act as if they have low-status and are threatened—essentially it can make them behave like they have a poor life expectancy, causing them to take the short-view of life and employ the riskier “live fast” strategy of instant gratification at the expense of the future (as noted above). Lower status has also been linked to higher drug use in animal studies.

Isolated monkeys will frequently self-administer cocaine, but when they are placed with other monkeys, the dominate high-status monkeys—who get lots of positive attention (grooming, food)—will stop taking cocaine so frequently, but the low-status monkeys will actually *increase* their cocaine usage (Friedman, 2017). The positive attention given to high-status monkeys increases the D2 dopamine receptors in their brains, giving them a greater capacity to feel happy naturally. This indicates that environment and status can affect hormone receptor levels and increase or decrease susceptibility to drug addiction.

In a series of experiments, Payne demonstrated that “feeling poor made people more willing to roll the dice” (p. 71). Poverty equates to a greater number of unmet needs, and “as needs increase, so, too, does risk taking”—in fact, bumblebees and other species also take greater risks when they have greater needs, even when the odds are not in their favor (pp. 73-74). Payne says that even though risky actions (or just playing the lottery) have a low probability of success and are sometimes not only irrational but self-destructive, “it is rational in another sense, because meeting basic needs is sometimes more important than the mathematically best deal” (p. 75). Many reentry clients are poor, which may be partly because of the injustices in the system (e.g., cash bail and inadequate public defenders) and the “live fast” approach:

The live fast, die young approach that is motivated by an uncertain future leads to shortsighted decisions, from payday loans to selling drugs to dropping out of school, that provide short-term rewards but sabotage the future...the emergency response of our stress and immune systems to daily crises gives us the energy to get out of those scrapes, but at the expense of sabotaging our future well-being. (Payne, 2017, p. 197)

There is evidence that inequality is associated with higher rates of crime, and shortsighted decisions may be why (Payne, 2017, p. 213). For someone who experienced childhood trauma, and is *insecurely attached* with no support system, poverty/relative poverty may elicit a full-blown stress response. Poverty is not necessarily “traumatic,” but it can multiply the effects of trauma. It can increase stress levels, exacerbate or contribute to childhood trauma, and may on its own lead to risky behavior that lands a person in jail, or back in jail.

Recommendations for Reentry Programs

Childhood interpersonal trauma creates behavioral responses that can lead to crime and higher recidivism rates. The recommendations in this section are approaches designed to mitigate trauma-induced antisocial behavior simply by *not triggering* it. While some of the approaches may help *heal* trauma, healing is mainly addressed in the next section. Notably, *restorative* reentry programs are inherently “trauma-informed” in many ways, as noted below.

Childhood trauma and its effects often prevent people from satisfying their basic human needs (BHNs). The recommendations below target trauma-related behavior and the unmet BHNs that may be associated with that behavior. However, clients are not just trauma survivors but convicted criminals, a population that some consider to be manipulative (VT DOC, n.d.). Reentry staff needs to be trauma sensitive while at the same time not condone the “abuse excuse” and permit harmful behavior. Reentry programs work hand-in-hand with DOC’s Probation and Parole (P&P), which can be very helpful for some clients. Some offenders need strict rules and supervision to be successful. As one offender said, “I never had any rules growing up, so it was hard at first to accept P&P’s rules, but now I know I need them.” Another said, “I need to know that I am going to be UAed [urine analysis]—it helps me stay sober.” Because P&P provides this disciplinary structure, the reentry program should focus more on supporting offenders so their reintegration is successful. The ultimate goal of reentry programs is *no more victims*, so preventing crime is the top priority. Some of the recommendations here might be perceived as being “soft” on offenders, but the intent is that they are *effective*—they try to target the root causes of criminal behavior.

Trauma in general.

1. All reentry program staff and COSA volunteers should have some basic training in trauma psychology and trauma-informed practices, because trauma-induced behavior impacts clients’ risks of reoffending and because clients can easily be re-traumatized.

2. The reentry coordinator should be in contact with client therapists to gain a better understanding of any trauma-related behaviors (clients can choose to sign off on this confidentiality agreement or not).
Psychologists can preemptively alert reentry staff to possible problems and also help guide staff as problems come up. In addition, there may be benefits to having a coordinated approach between key people in clients' lives so they receive consistent messages.
3. The types of trauma clients experienced should be shared with staff and COSA volunteers if possible. P&P usually knows the life history of each client and usually shares this information with the reentry coordinator, who then shares it with others as appropriate, but it is not always done thoroughly and systematically. The ACE survey would help fill the gaps and should be given to every willing client. Clients should be told what the survey is about, and why it is helpful, but that it is their choice to take it. Although many clients share their trauma histories voluntarily, discussions about trauma should be client-initiated since talking about trauma can exacerbate some people's symptoms (Bicknell-Hentges, 2009). If completed, the ACE survey would ensure that staff had at least a basic understanding of the challenges clients face. Without that knowledge, antisocial behavior may be unwittingly triggered (e.g., if a client was physically abused by his father, a reprimand from a male authority figure may elicit hostility rather than compliance). If the extent of trauma is not known, staff and volunteers are also at risk of over-estimating a client's abilities and holding them to standards that are unachievable.
4. A trauma-informed survey (Appendix 3) should be given to each client after they have spent a month or more in the reentry program, so the program can monitor its effectiveness. In addition, entry and exit surveys (Appendix 4 & 5) could be given and compared to monitor program effectiveness.

Attachment/Identity issues and relationship needs.

1. Clients' basic human need for security-providing relationships (or *attachments*) should be recognized. Clients sometimes have few or no healthy relationships. In addition, P&P initially restricts offenders'

contacts with family and friends who are associated with their criminal behavior, so offenders can be quite isolated when they first come out of prison. They may feel especially insecure as a result of their prison time. As Wolff and Shi (2012) point out, “rejection by family members and friends upon incarceration in combination with the social isolation and material deprivation associated with prison may feel like abandonment to incarcerated people and may trigger memories and emotional feelings associated with childhood experiences of abandonment” (p. 1909). Therefore, clients may have a particularly strong need to form secure attachments. This need plus the potential for risky behavior mentioned above, means that unapproved visitors/relationships will be a likely violation.

2. If clients have a support person who they are restricted from seeing, supervised visits should be arranged if allowed (in hopes of preempting unapproved visitors).
3. If a client has no supportive relationships, COSAs should be recommended for them based on their need for social relationships alone. (This is discussed more in the following section.)
4. For some clients, housemates are necessary for them to feel safe, and every effort should be made to meet this need. (One client was returned to prison in part for repeatedly violating visitor rules when she found herself in an apartment alone. She had been raped multiple times as a child and said, “bad things always happen to me when I am alone, so I cannot be alone.”)
5. In the absence of other relationships, staff should understand that they might serve as a client’s primary social connection. Mikulincer and Shaver (2008) recommend maintaining “unconditional positive regard” when interacting with insecurely attached people, because this regard provides the conditions necessary for people to change and to learn to accept and take responsibility for themselves (pp. 49, 414, 472; Rogers, 1951). Unconditional positive regard is described as the acceptance and support of a person regardless of their behavior. Behaviors can be judged, but the person should not be (Rogers, 1951).

6. Angry outbursts and behaviors designed to “elicit expectation-consistent reactions” should be anticipated from some clients. Ideally, therapists could help staff respond appropriately. Withdrawing acceptance and support as a consequence of such behavior might simply confirm expectations rather than teach anything new. Perry said that trauma victims often “project their self-hate onto the world and become sensitized—indeed, hypersensitive—to any sign of rejection” (Perry & Szalavitz, 2006, p. 217).
7. Misunderstandings with clients should be anticipated and efforts made to communicate especially calmly and clearly. As Perry et al. (2018) say, “a person with a high degree of relational sensitivity will often misinterpret neutral or positive social interactions from peers as threatening” (pp. 826-27).

Overactive stress responses and safety needs.

1. It is likely that some clients will have an overactive stress response and rarely feel safe, so the reentry program must maintain a non-threatening environment, keeping in mind that even normal interactions could be perceived as threatening. Perry et al. (2018) say that for youth with a sensitized stress response due to previous interpersonal harm, “a simple redirection, reminder of rules, or expressions of frustration can precipitate a major behavioral outburst” (p. 825). Although Perry focuses on youth, the responses of adults who have been traumatized as children follow similar patterns, according to Diane Vines of The ChildTrauma Academy, Houston (personal communication, December 15, 2017). Some clients may benefit from being firmly reminded of rules and consequences, but others may not or may simply need a “soft” delivery.
2. Clients should be allowed to stay in one reentry apartment for the duration of their stay. While some reentry programs never move clients, HCRJC clients sometimes have to be moved when the ratio of males to females changes as space is made for new clients to come out of prison. HCRJC does not have permanently designated apartments for each sex, so expanding housing to meet this need is currently part of HCRJC’s strategic plan (and requires increased funding). Because clients are likely to

be sensitized to stress, moving apartments can cause a full-blown stress response that jeopardizes their reintegration. (One client had an angry, aggressive outburst when she was asked to move apartments, and that precipitated a series of responses that ultimately landed her back in jail.)

3. Single apartments should be provided for clients who feel threatened by others.
4. Rent demands should be reduced when appropriate to lessen stress levels. (Currently HCRJC's reentry program extends client move-out dates, is flexible with rent payment plans, and helps clients find new housing *when appropriate*.)
5. Rules should be simple and clear. As Vaillant says, "ambiguity makes us anxious; certainty calms us..." (2008, p. 75). Community Connections also recommends "trustworthiness: being reliable, making tasks clear, maintaining appropriate boundaries" for trauma-informed service (www.ccdc1.org).
6. The justice center office should serve as a safe space that is always available to clients when the office is open. (Clients often voluntarily visit HCRJC, and they have said they like to visit because "it is a safe space" and "people listen" and are "nonjudgmental.")
7. Stress reactions resulting from unfamiliar situations must be anticipated in some clients. A safe environment is important, but it may be that very sense of safety that alarms some clients. Perry states: "Because new situations are inherently stressful, and because youth who have been through trauma often come from homes in which chaos and unpredictability appear 'normal' to them, they may respond with fear to what is actually a calm and safe situation. Attempting to take control of what they believe is the inevitable return of chaos, they appear to 'provoke' it in order to make things feel more comfortable and predictable" (Perry & Szalavitz, 2006, p. 56). Perry discusses youth, but he points out that the need for familiarity relates to all of us—"we tend to prefer the 'certainty of misery to the misery of uncertainty'" (p. 56). (A client illustrated this point. When she was congratulated for all her new success, the client responded: "I know, but everything is unfamiliar. People caring for me is unfamiliar,

having a job is unfamiliar, living in a clean house is unfamiliar, having a boyfriend is unfamiliar, being sober is unfamiliar. Everything is f---ing unfamiliar, and, you know what, it doesn't always feel good!")

8. Staff must remain calm. Perry says, "because of the mirroring neurobiology of our brains, one of the best ways to help someone else become calm and centered is to calm and center ourselves first—and then just pay attention." He points out that no one can help others if they are "overwhelmed, stressed out and in state of alarm themselves" (Perry & Szalavitz, 2006, pp. 71, 274).

Compromised executive functioning and autonomy needs.

1. Clients should be allowed to exercise personal agency whenever possible (e.g., by making choices, creating individual goals and action plans, etc.). Executive functions are the skills that enable us to organize and control our actions to achieve a goal, and they cannot be improved without practice. In prison there are few opportunities to do so, and having a sense of control ("perceived control") is an important aspect of recovering from trauma. Trauma survivors may have "learned helplessness" as described above. Perry explains: "After all, one of the defining elements of a traumatic experience—particularly one that is so traumatic that one dissociates because there is no other way to escape from it—is a complete loss of control and a sense of utter powerlessness. As a result, regaining control is an important aspect of coping with traumatic stress" (Perry & Szalavitz, 2006, p. 52). Exercising control is suggested on most trauma-informed guidelines. For example, the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) recommends "empowerment, voice and choice" as one of their six key principles of a trauma-informed approach (samhsa.gov/nctic/trauma-interventions). When clients first come out of prison, P&P often requires them to do many things. In addition, most clients have to partake in reentry program activities. As a small step towards regaining control and exercising personal agency, clients should choose which reentry program classes to attend. Clients usually *do* have some choice, except when they are

sanctioned or when there aren't choices available. More program options should be made available by collaborating with local organizations. High perceived control makes people less vulnerable to stress, and there is evidence it may reduce recidivism (Vitelli, 2018; Engelstatter, 2004). Studies also found that "individual agency was a key factor distinguishing the paroled lifers from the re-incarcerated lifers" and "post-prison programs should focus on restoring agency to ensure successful reentry" (Liem & Richardson, 2014). (Note: restorative justice programs are inherently trauma-informed in many ways, because they embrace "a collaborative, inclusive process" (cjnvt.org)—e.g., the director of HCRJC rarely gives instructions to clients but instead empowers them to gain control over their own lives by listening and facilitating a decision-making process.)

2. On entry surveys and on some weekly check-ins clients should write about (or dictate) an experience that made them feel successful and proud, because studies have shown that this empowered people to take positive action for themselves (Payne, 2017, p. 217) (Appendix 4).
3. Hope should be emphasized, because hope is linked to regaining control and autonomy. Vaillant (2008) explains: "Suffering equals hope destroyed, and suffering is more than pain: it is loss of control, it is despair, it is the loss of hope. However, if the loss of hope transforms pain into suffering, the return of hope transforms suffering back again into manageable pain. Suffering is the loss of autonomy; hope is its restoration" (p. 103).
4. Resistance to classes and other programming should be anticipated from some clients. They may perceive these activities as interfering with their basic human needs satisfaction, e.g. attachment security, as mentioned above. In addition, a person sensitized to stress often finds simple challenges overwhelming and fear-inducing.
5. Program expectations should be in line with client abilities. Clients, particularly younger clients, may be more immature than their chronological age suggests. Perry et al. (2018) said that "maltreatment and trauma will...result in emotional, social, cognitive, and behavioral functioning that is well below the

chronological age of the youth” (pp. 827-28). They may struggle to learn or to manage their emotions because of compromised executive functioning.

6. Yoga, martial arts, fitness classes, or other physical programs should be available for clients to choose. Dr. Bessel van der Kolk, professor of psychiatry at Boston University Medical School and founder of a community-based trauma center, explains how trauma gets lodged in the body and how cognitive processes and language are often ineffective at dealing with it: “This is not about something you think or something you figure out. This is about your body, your organism, having been reset to interpret the world as terrifying place and yourself as being unsafe. And it has nothing to do with cognition...Yoga turned out to be a very wonderful method for traumatized people to activate exactly the areas of cautiousness, areas of the brain, the areas of your mind that you need in order to regain ownership over yourself” (Tippet, 2017). He advises that anything that “engages your body in a mindful and purposeful way—with a lot of attention to breathing in particular—resets some critical brain areas that get very disturbed by trauma.” He concludes, “what we have learned is that what makes you resilient to trauma is to own yourself fully” (Tippet, 2017).

Lower life expectancy and the need for hope.

Hope should be modeled, because “hope reflects our ability to imagine a realistic positive future” (Vaillant, 2008, p. 104) and is associated with increased life expectancy (Stern et al., 2001). Curt Richter, a Johns Hopkins neuropsychologist, discovered that “if rats swim until exhausted and are then rescued, in the future they can swim much longer without drowning than can naïve rats without a history of prior rescue” (Vaillant, 2008, p. 108). Vaillant points out that “negative emotions help us to survive in time present, while positive emotions help us to survive in time future” (p. 16). He says that “we cannot learn hope without experience and without models,” but “hope is contagious” (pp. 118, 116). As described in the sections above, trauma results in lower life expectancy, which can lead to riskier behavior, but hope may act as an antidote.

Poverty/inequality and esteem needs.

1. Equal status between staff/volunteers and clients should be demonstrated through respect, mutual decision-making, and transparency. One of Howard Zehr's signposts of restorative justice is to "show respect to all parties—those harmed, those who have harmed, their friends and loved ones, and justice colleagues" (Zehr, 2015). Skeptics might wonder why criminals should be treated with respect, but respect can be *effective*. Bastøy, a prison in Norway, has one of the lowest rates of reoffending in the world at 16% (the comparable rate in the US is about 60%²), which the prison director Arne Nilson attributes to how the prisoners are treated: "You don't change people by power...Here I give prisoners respect; this way we teach them to respect others" (Snelle, 2015). Reentry staff ultimately has the power to permit or deny housing, and thus freedom, but that power position must be deemphasized. Payne (2017) demonstrated that even relatively small differences in status, such as is evident between first and economy class airline passengers, resulted in aggressive behavior and conflict (p. 3). Subjective measures of status also influence how risky one's decisions are (pp. 13, 76), and low status has been linked to higher drug use, as described above. Self-esteem is also based partly on status, because our sense of self-competence is judged through comparison to others, their respect for us, and social acceptance (Rock, 2009). Equalizing the status between clients and staff may minimize some of the harmful behaviors linked to low status and help improve clients' self-esteem.
2. On entry surveys and weekly check-ins clients should write about values that are important to them (Appendix 4). Payne (2017) states: "spending a few minutes writing about cherished values also made people less impulsive and more likely to delay immediate gratification for longer-term benefits. These studies suggest that the live fast, die young mind-set cued by inequality can be mitigated by re-centering attention on what one really cares about" (p. 217).

² Countries measure recidivism differently so it is hard to compare. Norway measures the 2-year rate and the US measures 3 and 5-year rates, so 60% is an approximation. National Institute of Justice reports that the 5-year recidivism rate in the US is 76.6% (www.nij.gov/topics/corrections/recidivism/Pages/welcome.aspx).

3. One additional question related to poverty/relative poverty should be included in the ACE survey, as shown in Appendix 1, to get a better understanding of its role in criminal behavior.

REDUCING TRAUMA-ASSOCIATED CRIMINAL BEHAVIOR THROUGH COSAs

“Simply punishing the broken—walking away from them or hiding them from sight—only ensures that they remain broken and we do, too. There is no wholeness outside our reciprocal humanity.”
—Bryan Stevenson, *Just Mercy*

Evidence suggests that incarceration and other traditional approaches to crime are unlikely to be an effective deterrent of trauma-associated criminal behavior (Kirk, 2017; Perry et al., 2018). Reavis et al. (2013) stated: “It is our belief that treatment interventions that focus on the outcome variable (crime) without attempting to heal these neurobiologic wounds are destined to fail,” and suggest instead “attachment-based interventions designed to normalize brain functioning” (p. 47-48). This section presents evidence for the healing effects of healthy *attachments*, describes the role of community in trauma healing, and explores reentry program COSAs as a means of helping offenders build healthy relationships and social connections and thus transform “criminal” identities.

Healthy Relationships and Trauma Healing

Trauma and trauma healing always occur within the context of relationships—in fact, “healing and recovery are impossible—even with the best medications and therapy in the world—without the lasting, caring connections to others” (Perry & Szalavitz, 2006, p. 232). Therapy can also be effective, but research studies show that the type of therapy is not nearly as important as the quality of the relationship between the client and therapist (p. 85). Perry’s book *The Boy Who Was Raised as a Dog* provides many examples of the curative effects of healthy relationships for child trauma victims. Diane Vines at the ChildTrauma Academy (Houston, TX) clarified that relationships are also key to healing adult trauma: “relationships are

crucial to any therapeutic progress...all of the relationships impact progress as well as the therapeutic relationship, and for inmates who are released, their community also needs to be involved in their continued journey toward healing” (personal communication, December 15, 2017). As Perry says, “people, not programs, change people” (p. 85).

Childhood interpersonal trauma disrupts people’s ability to form healthy attachments. Although the attachment system is most active in childhood, attachment problems can be healed in adulthood. Mikulincer and Shaver (2007) state: “At any point in life—infancy, childhood, adolescence, or adulthood—important and long-lived changes in the quality of interactions with primary attachment figures, due either to changes in their sensitive responsiveness or to discrepancies between the responses of earlier caregivers (e.g., parents) and new attachment figures (i.e., close friends, romantic partners, therapists), can produce discontinuities in attachment patterns” (p. 135). They conclude: “Evidence amassed by attachment researchers suggests that security-enhancing interactions with loving attachment figures...provide people with the ‘confidence in themselves as trustworthy instruments for encountering life,’” and “that such confidence emerges in the context of another person’s ‘unconditional positive regard’” (p. 472). Co-workers, therapists, friends, and other caring people can provide the healthy attachments that adults need to overcome trauma-related attachment problems from their childhood.

George Vaillant, M.D., a psychiatrist and professor at Harvard Medical School, directed the Grant Study on human development from 1938 until present. This study demonstrated that human development is not confined to childhood but continues throughout life and that the brain continues to change. In his book based on the study, *Spiritual Evolution: A Scientific Defense of Faith*, Vaillant describes incidences of childhood trauma being healed through the development of healthy relationships in adulthood. He states that “loving, selective, enduring attachment allows the severely deprived to heal” (p. 87). Vaillant points out that behavioral self-regulation comes from “one brain’s evolving and becoming shaped through attachment to a beloved other,” and that “sustained loving environments in adulthood can help undo the damage of

childhood isolation” (pp. 98-99). Vaillant discusses healing love and compares it to the love of a grandmother, who embodies “the connectedness, the passion, the commitment, and the wise limits that create therapeutic love” (p. 100). Caseworkers, nurses, friends, etc. can also provide that therapeutic love to other adults. Vaillant concludes, “love, especially unconditional love, also cures people—both those who give it and those who receive it. To receive love is transformational” (p. 99).

Many trauma-specific interventions focus on relationships as a means of healing. The Sidran Institute, a nonprofit focused on traumatic stress education and advocacy, states: “We believe that healthy relationships are the active ingredient in healing from the wound of traumatic stress, and we believe that true recovery requires that treatment providers and other helpers risk connecting with survivors as people first” (<http://Sidran.org>). Sidran’s *Essence of Being Real* is a peer-to-peer approach intended to address the effects of trauma and “is geared to promoting relationships rather than focusing on the ‘bad stuff that happened.’” The model *Risking Connection* helps people recover from trauma through RICH® relationships “hallmarked by Respect, Information Sharing, Connection, and Hope” (<http://riskingconnection.com>).

Relationships and group bonding have also been shown to help with trauma-related addiction. Thomas Insel, director of the National Institute of Mental Health, said “the neural mechanisms that we associate with drug abuse and addiction might have evolved for social recognition, reward and euphoria—critical elements in the process of attachment” (Vaillant, 2008, p. 198). The attachment behaviors—sex, cuddling, or just social bonding between people in a group—release the hormone oxytocin. Vaillant says, “oxytocin release, another accompaniment of loving attachment, inhibits tolerance to (and thereby dependence on) alcohol” (p. 198). Animal studies have shown that oxytocin also prevents developing a tolerance to opiates and cocaine and reduces withdrawal symptoms (Kovacs et al., 1998). As Vaillant sums up, “the brain chemistry of both addiction and attachment is the same” (p. 197). Therefore, loving relationships and social bonding are likely to decrease a person’s susceptibility to drug addiction.

Community and Trauma Healing

Perry stresses the importance of community for trauma healing, pointing out that community has been essential to our evolution and is what makes us human: “only through cooperation, sharing with members of our extended family, living in groups and hunting and gathering together could we survive” (Perry & Szalavitz, 2006, p. 70). Only very recently in human history are children being raised by parents in nuclear families rather than by multiple adults in extended families. Perry states:

We need to change our childrearing practices, we need to change the malignant and destructive view that children are the property of their biological parents. Human beings evolved not as individuals, but as communities.... We survived and evolved as clans—interdependent—socially, emotionally and biologically. Children belong to the community, they are entrusted to parents. American society, and its communities, have let down parents and children. (Perry, 1997, p. 12)

People who have been traumatized are the least likely to come from a healthy community. Perry states:

“Because healthy communities themselves are often what prevents interpersonal traumatic events (like domestic violence and other violent crime) from occurring in the first place, the breakdown of social connection that is common in our highly mobile society increases everyone’s vulnerability...we need to build a healthier society” (Perry and Szalavitz, 2006, p. 232). Perry et al. (2018) conclude: “promoting relational health by increasing the quality, number, and density of supportive, nurturing and trauma-informed people is the most effective and enduring form of intervention. Connection to family, community, and culture facilitate healthy development, including healing from traumatic experiences, minimizing substance abuse, and developing of new skills” (p. 818). Healthy communities can prevent childhood trauma and help heal traumatized children and adults, including those with addictions.

Research shows that the brain’s dopamine reward system that is activated by drugs is also activated when people give to charity or do other altruistic deeds (Vaillant, 2008, p. 158-59). This indicates that “the limbic brain circuitry underlying addiction may have evolved originally to facilitate the human attachment, social cohesion, and spiritual community so necessary to survival” (p. 198). Vaillant says that “opiates are what you do if you are without community” (p. 131). He believes that “AA [Alcoholics

Anonymous] achieves relapse prevention by providing a loving community” (p. 195). Quinones, author of *Dreamland: The True Tale of America’s Opiate Epidemic*, concludes: “I believe more strongly than ever that the antidote to heroin is community. If you want to keep kids off heroin, make sure people in your neighborhood do things together, in public, often. Break down those barriers that keep people isolated. Don’t have play dates, just go out and play” (p. 353). Or, as Hari says in *Chasing the Scream*, “the opposite of addiction is not sobriety, the opposite of addiction is connection.” A video adapted from the book states:

Humans have an innate need to bond and connect. When we are healthy and happy we bond with those around us. When we can’t because of trauma, isolation, we bond with something that gives us relief (drugs)... we will bond with something because that is our human nature ... addiction is just one symptom of crisis of disconnection...and rather than helping people heal we imprison them, casting them out of society, take people who are not well and put them where they feel worse and then hate them for not recovering. (<https://www.youtube.com/watch?v=ao8L-0nSYzg>)³

Strong communities can prevent childhood trauma, they can help heal trauma in both children and adults, and can help prevent or mitigate drug addiction. As Vermont Attorney General TJ Donovan stated: “To fix the criminal justice system, you must fix community” (speech, Re-Imagining Justice: A Conference by Vermont Law School, South Royalton, VT, December 1, 2016).

Offenders often come from dysfunctional families and/or the DOC has rules restricting them from contacting family and friends when they first come out of prison. In addition, the communities they return to often do not want them because of their criminal record. Thus, offenders are often denied the very things that are instrumental to their healing and to preventing relapse into criminal behavior. COSAs are essentially a readymade group of friends that can provide the supportive relationships offenders need. COSAs can also help offenders develop social connections in the community.

³ Hari and the research studies he cites (e.g., Bruce Alexander’s Rat Park) have been criticized for being overly simplified and not always replicable. However, many people in the field of addiction appreciate that these studies have at least highlighted *environment* as a factor in drug addiction.

COSAs

Circles of Support and Accountability (COSAs) are designed to increase accountability and support for high-risk offenders when they reenter society. The Vermont DOC offers some offenders the opportunity to join COSAs, which are then managed by community justice center reentry programs. COSAs consist of two to five volunteer community members, the reentry coordinator, and the core member (offender), who all meet weekly, for one to two hours, for at least a year. COSAs provide a circle of friends for offenders, who often have few or no healthy (or approved) social connections when they come out of prison. COSA volunteers offer practical support to offenders—e.g., transportation to important appointments, etc.—and moral support and help keep offenders accountable. In short, COSAs are “derived from a restorative justice perspective with respect to its focus on restoring offenders to and with communities...and is a nonprofessional, community-based approach that targets social isolation as the risk factor and the creation of social capital as its goal” (Fox, 2016, p. 74). The Vermont legislature’s report on Act 43/ACEs recommends exploring COSAs for their potential to heal trauma (Lyons et al., 2018, p. 10). (For more information on the origins of COSAs, their effectiveness, and important findings about how they work, see Kathryn Fox’s articles listed in the references. For an intimate look at COSA relationships, see Bess O’Brien’s documentary *Coming Home*.)

Sociologist Kathryn Fox did an in-depth qualitative analysis of *how* COSAs work (see Fox, 2012, 2013, 2015, 2016). Fox did not specifically examine the trauma-healing potential of COSAs, but her findings demonstrate that COSAs that build genuine relationships and focus more on support than accountability are more successful than those that do not. She noted that “the less successful COSAs were characterized by a more shallow involvement, which often appeared heavier on accountability than support...and might be more proscriptive or risk-focused, rather than attempting to tailor the group to the basic human needs of the core members” (2016, p. 78-79).

Fox's findings indicate that the COSAs that work best are those that provide *attachment figures* to offenders: "Trust takes time to build, and trust is only possible if the team members demonstrate that they will stand by the core member no matter what happens. In fact, several volunteers continued to visit core members in prison once they were returned for violations. Core members expressed that they had never experienced such unconditional support, and it motivated them to make their team proud" (2016, p.77- 78). COSA volunteers can offer advice and hold offenders accountable but only after developing a supportive relationship and trust: "The teams that seemed the most functional, based on reports by team members, and their core members, were ones in which the team was long on support initially and the press for accountability came only with time and trust. In other words, to establish moral authority rather than some other kind of authority, the team had to invest socially and emotionally in the core member by demonstrating support and exhibiting faith in the core member" (2016, p. 77). Volunteers can question core members' decisions but should not devalue the core members themselves like in a "family model"—one in which unacceptable acts are sanctioned but the person remains in the fold" (Fox, 2013). This is what Mikulincer and Shaver refer to as "unconditional positive regard," a necessity for healing trauma-related attachment issues. A core member stated: "I'm changed and I feel better about myself. I feel more confident that I can do what I need to do and achieve...It's a lot because of the COSA because before, I was like 'I'm just a nobody, nobody really cares about me'...but now I actually can truly see there's people out there that do care for me and they care for me for who I am" (Fox, 2016, p. 85-86). As Perry says, "relationships are the agents of change" (Perry & Szalavitz, 2006, p. 258).

Fox discusses the importance of personal agency. She states: "Social support is a critical component to increasing a sense of agency among offenders. The COSA model acknowledges the importance of self-determination for offenders and the pursuit of human, positive goals rather than simply avoidance of criminal activity" (Fox, 2016, p. 89). COSA volunteers can help the core member figure things out, but "modeling, and talking through challenging situations is distinct from more control-oriented

solutions, and affords core members a measure of 'autonomy' in making choices" (Fox, 2015, p. 88). Fox points out that "the more successful COSA teams worked to help the core member achieve his or her goals, rather than explicitly imposing their views" (p. 76). Regaining control is necessary for trauma survivors to heal, and personal agency is linked lower recidivism rates, as described above.

Fox's findings suggest that focusing on positive emotions, rather than on criminality, is important. Fox states: "COSA promoted desistance by holding up a non-criminal mirror to the core member and showing the way to a good life, while expressing faith that s/he can have a good life" (Fox, 2016, p. 85). Fox concludes that her qualitative study of COSAs "demonstrates quite starkly that released offenders need support and respond more positively to respectful and encouraging monitoring than negative and discouraging monitoring" (Fox, 2013, p. 51). This supports Perry's assertion that "punitive practices do not result in the intended decrease in recidivism, offending, or rehabilitation," but "respectful, relationally enriched, humane and trauma-informed interventions will have highest probability of success" (Perry et al., 2018, 817-18). George Vaillant (2008) found a similar positivity in the healing relationships formed in AA: "weekly AA home group meetings focus only on positive emotions. Ritually, criticism is replaced by 'loving suggestions' and unconditional positive regard" (p. 196). In his book, Vaillant argues that positive emotions (e.g., love, faith, hope, joy) are necessary evolutionarily because they allow humans to connect to and help each other, strengthening the communal bonds we rely on for survival (p. 8). Vaillant states that "hope comes from viscerally feeling, not cognitively knowing, that we matter," and "joy is all about connection with others..." (pp. 118; 124). Through volunteering their time, COSA volunteers demonstrate that offenders are "worthy of investment" (2016, p. 79)—that they *matter*—and COSA gatherings provide the joy of connection. It is possible that COSAs not only provide healing relationships but also help offenders "behave more communally" by focusing more on positive emotions than on criminality. In addition, the positive emotion of hope makes the future seem possible and helps offenders move beyond the risky "live fast, die young" approach of many trauma survivors, as mentioned previously.

COSAs also help relieve some of the stress that offenders experience, which can be critical for those with a trauma-induced, overactive stress response and associated maladaptive behavior. Fox writes, “core members sometimes expressed being overwhelmed in the grocery store, by the array of choices, and having someone to shop with them helped. Others felt that they had to be constantly looking over their shoulders—a habit hard to break from prison—and being with another person distracted and relaxed them” (Fox, 2013, p. 29). Vaillant says that “people experience relief from emotional distress when they feel held by...a ‘social cocoon’” (p. 200). In addition, “the COSA team as community members model for the core member what ordinary, pro-social, noncriminal life is like, and in talking through the many issues that come up, the group can orient the core member toward better ways to handle stress, or resolve relationship issues, or conflicts with employers and the like” (Fox, 2015, p. 88).

COSA is governed by rules that address appropriate boundaries and transparency, and thus foster trust, which fall in line with trauma-informed guidelines. Restrictions on loaning money etc., and norms concerning “no secrets” and a team approach, are all stressed in DOC’s volunteer training and help maintain personal boundaries (Fox, 2016, pp. 81-82). As Vaillant says, “healing love, of course, always involves appropriate boundaries” and is “more about witnessing (making the other person feel ‘seen’) than about rescuing” (pp. 99-100). One core member summed up why he values his COSA: “these are people I can talk to, people I can trust” (Fox, 2016, p. 78). Perry emphasizes that trust is key for trauma healing and is “the currency for systemic change” (Perry & Szalavitz, 2006, p. 85).

The fact that COSA team members are volunteers is important to core members: “Several core members mentioned in interviews that it mattered substantially that the people spending their time devoted to supporting them and holding them accountable were volunteers. It created a sense of mutual respect and obligation that could not be easily forged with professional staff” (Fox, 2013, p. 12). Community members “breaking bread” and recreating with offenders (Fox, 2016, p. 83-84) communicates respect and may help to equalize status differences that can drive risky behavior, as described above and in *The*

Broken Ladder (Payne, 2017). More importantly, “community members can validate offenders’ place(s) within a moral network by envisaging the worth and dignity of offenders” (Fox, 2016, p. 70). Laura Hillenbrand, the author of *Unbroken*, considers dignity to be a basic human need. She writes, “dignity is as essential to human life as water, food, and oxygen” (p. 141). She continues:

This self-respect and sense of self-worth, the innermost armament of the soul, lies at the heart of humanness; to be deprived of it is to be dehumanized, to be cleaved from, and cast below, mankind. Men subjected to dehumanizing treatment experience profound wretchedness and loneliness and find that hope is almost impossible to retain. Without dignity, identity is erased. In its absence, men are defined not by themselves, but by their captors and the circumstances in which they are forced to live. (p. 182)

Fox (2012) says, “with offenders, preserving and enhancing their own human dignity is key to reintegration,” and “prison does nothing positive to that end” (p. 114). Fox (2016) links dignity to identity change in core members: “The deep casework assistance that the reentry coordinator provides, combined with the volunteers’ efforts, validates the core members’ essential worth as fellow human beings, which in turn, motivates and inspires the identity change” (p. 86). Fox asserts that “community-level social relationships promote identity change in released inmates” (p. 70). This could be because “creating a noncriminal identity occurs in interaction with others as a new narrative is constructed and reflected back to the offender” (pp. 89-90). Abernathy (2008) explains that “individuals make sense of experiences and re-narrate events for coherence with narratives, or life stories, providing a vehicle for identity construction,” but that “trauma shatters understanding of self and the world” (pp. 200-201). Mikulincer and Shaver (2007) describe how identity is formed through interactions with attachment figures, and that positive identities are connected to “prior unconditional support and acceptance by caregivers” (p. 233-34). It is possible that COSA relationships—if genuine, supportive, and respectful—can help offenders regain dignity and create a new narrative and a “noncriminal” identity, and that this effect is mediated, in part, through the trauma-healing aspects of attachment relationships and “unconditional positive regard.” Further research should be done to explore this further. As Fox says, “understanding the nature of relationships between ordinary community

members and serious offenders can shed light on the desistance process, and what role the *social aspects* of reentry play in encouraging optimism, reciprocity, and belonging” (2016, p. 70).

Recommendations for Reentry Programs

Vermont Legislature’s report on ACEs suggested that COSAs may provide a “modality for support” for trauma healing, and this should be explored further (Lyons et al., 2018, p.10). Current research on the neurobiology of addiction and attachment behavior indicates that COSAs may help alleviate trauma-related drug addiction as well. If COSAs do play a role in trauma healing, the DOC’s COSA training should include information on trauma-related behaviors and trauma-informed approaches. COSAs should be specifically recommended for those offenders who have experienced significant childhood trauma. It is important to note that the more severe the trauma, the more difficult it is likely to be for the offender to respond positively to COSA relationships. The antisocial behavior that may have landed an offender in prison is the same behavior that will make it difficult to bond with COSA team members. Additional research should explore the impact of COSAs on offenders with severe childhood trauma.

Although the trauma-healing effects of COSAs have not been definitively determined, there is enough data to recommend that COSA volunteers should focus more on genuine, positive, supportive relationships than on accountability to help offenders heal from trauma and develop “noncriminal” identities. COSA volunteers should be engaged with core members beyond the one-hour-per-week meeting, and they should maintain unconditional positive regard towards offenders (but not necessarily towards their actions/behaviors). The more trauma-informed reentry programs are as whole, the more effective COSAs will be, because “all relationships impact the therapeutic progress.” The restorative justice approach is relationship-based and is inherently trauma informed in many way, so restorative reentry programs are well suited to facilitate trauma healing through relationship building.

CONCLUSION

“It’s when mercy is least expected that it’s most potent—strong enough to break the cycle of victimization and victimhood, retribution and suffering. It has the power to heal the psychic harm and injuries that lead to aggression and violence, abuse of power, mass incarceration.”

—Bryan Stevenson, *Just Mercy*

Numerous studies document the high rates of childhood interpersonal trauma, or ACEs, in offender populations, with the very highest rates of trauma in female offenders. Childhood trauma is associated with adult mental illness, drug addiction, and crime. Trauma disrupts the human relationships that are critical for optimal brain and neurobehavioral development during childhood and is related to difficulties in identity formation throughout adulthood. Childhood trauma can change the way our bodies respond to stress, creating maladaptive behaviors, cognitive limitations, and shortened lifespans. Childhood interpersonal trauma can lead to the development of unhealthy relationships and antisocial behavior in adulthood that increases the likelihood of crime and recidivism. Since humans are social beings who rely on each other for survival and thus are hardwired for social connection, these dysfunctional relationships jeopardize the attainment of all basic human needs.

Galtung said “conflicts are not a game to be won or lost, but are often a struggle to survive, for well-being, identity—all basic human needs” (2004, p. viii). When we view crime as a conflict, it is apparent that most criminal behavior cannot successfully be controlled through the threat of punishment—except maybe when the threat is obvious and immediate—or corrected through education because that behavior is often serving a purpose, one that may be integral to someone’s sense of wellbeing or identity. A more effective approach is to change the root causes for that criminal behavior, or to find a healthy way of satisfying the underlying needs. Human behavior arises from innate evolutionary imperatives, but its manifestation is dependent upon social-environmental context, and thus is flexible. We cannot change humans’ innate drives, but we can change the context so that those drives are satisfied in ways that do not lead to crime. As Payne (2017) stated: “It may indeed be difficult if not impossible to pull someone out of a

self-destructive cycle once he is firmly entrenched in it. But throwing up our hands and declaring the situation hopeless is not only a moral evasion, it also ignores the fact that people's behaviors are responses to their environments, and those environments *can* be changed" (p. 201). Perry suggests that one of the most important ways we can change the environment is to mend "frayed communities" and "create a world that respects our biological needs, one that enhances our connections to others rather than ignores or disrupts them" (Perry & Szalaviz, 2006, pp. 263, 270).

The Vermont Act 43/ACE report says, "without addressing the trauma underlying many non-productive behaviors, we are just spinning our wheels and 'putting Band-Aids' on serious injury" (Lyons et al., 2018), and Reavis et al. (2013) said that "purely 'offense-specific' models of treatment, which pay little heed to the early lives of offenders, have shown scant effects in decreasing recidivism" (p. 47). Recovery from trauma requires the development healthy relationships, and increasing the number of supportive, nurturing relationships and trauma-informed people is "the most effective and enduring form of intervention" (Perry et al., 2018, pp. 817-18).

Restorative reentry programs and their COSAs can mitigate offenders' trauma-related criminal behaviors by providing pro-social activities, engaging in trauma-informed practices, and providing the supportive relationships that can heal trauma. They can also help offenders reintegrate into the community and, ideally, help educate community members about trauma and its impact. SAMHSA's 2014 report states: "Communities that provide a context of understanding and self determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or misunderstand the impact of trauma may be re-traumatizing and interfere with the healing process" (p. 17).

The dynamics of individual trauma and conflict share some similarities to the dynamics of collective trauma and group conflicts, as described by Bar-Tal (2013), Volkan (2004), and SAMHSA (2014). SAMHSA states:

Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. (p. 17)

Vermont communities trapped in intergenerational poverty and devastated by the current opioid epidemic may need to address their collective trauma. The Vermont Legislature's report on Act 43/ACEs says that "common, statewide standards for addressing trauma are key. Evidence-informed programs can turn the tide on drug addiction, homelessness abuse, and other trauma that Vermont families are facing" (Lyons et al., 2018, p. 14). The report suggests that COSAs not only are effective for offenders, but may also be effective in addressing trauma in the larger community: "An idea is to transpose this modality of support [COSA] into other areas of support for those struggling to break the cycles of generational poverty, etc. and provide the ongoing, positive support that has been so helpful to those working with Justice Centers" (p. 10).

This paper provides evidence that COSAs, and restorative reentry programs as a whole, can help offenders build healthy relationships and heal childhood interpersonal trauma that leads to antisocial criminal behavior. More research should be done to verify these findings and to determine the best ways for COSAs and reentry programs to address trauma. In addition, further research could explore the feasibility of the COSA model being utilized in Vermont communities that are suffering from intergenerational cycles of poverty and trauma.

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APPENDIX ONE: ACE SURVEY

What's Your ACE Score? Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
No___If Yes, enter 1 __
2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
No___If Yes, enter 1 __
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
No___If Yes, enter 1 __
4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
No___If Yes, enter 1 __
5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
No___If Yes, enter 1 __
6. Were your parents ever separated or divorced?
No___If Yes, enter 1 __
7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
No___If Yes, enter 1 __
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
No___If Yes, enter 1 __
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? No___If Yes, enter 1 __
10. Did a household member go to prison?
No___If Yes, enter 1 __

Now add up your "Yes" answers: ____ This is your ACE Score

Extra question: Did you feel poor growing up, or feel that your family had less money than most other people around you? No___ Yes ____

APPENDIX 2: RESILIENCE QUESTIONNAIRE (from: traumainformedcareproject.org)

1. I believe that my mother loved me when I was little.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

2. I believe that my father loved me when I was little.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

3. When I was little, other people helped my mother and father take care of me and they seemed to love me.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

6. When I was a child, neighbors or my friends' parents seemed to like me.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

8. Someone in my family cared about how I was doing in school.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

9. My family, neighbors and friends talked often about making our lives better.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

10. We had rules in our house and were expected to keep them.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

11. When I felt really bad, I could almost always find someone I trusted to talk to.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

12. As a youth, people noticed that I was capable and could get things done.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

13. I was independent and a go-getter.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

14. I believed that life is what you make it.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

(extra question) I did well in school.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

APPENDIX 3: REENTRY PROGRAM TRAUMA-INFORMED SURVEY

1. When I am at the Justice Center I feel safe (both physically and emotionally).

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

2. I trust the people at the Justice Center.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

3. The people at the Justice Center give me moral support.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

4. When working with the Justice Center, I am given the opportunity to make choices.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

5. The people at the Justice Center are my friends.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

6. The Justice Center is always honest with me.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

7. I feel like the Justice Center and I work together as a team, and make decisions together.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

8. When I am at the Justice Center I feel people really listen to me.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

9. The Justice Center has helped me feel more connected to the community.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

10. When I am at the Justice Center, they make me feel better if I am sad or worried.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

11. Since working with the Justice Center, I feel my communication skills have improved.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

12. When I am at the Justice Center, I feel I am respected.

Definitely true -- Probably true -- Not sure -- Probably Not True -- Definitely Not True

APPENDIX 4: ENTRY SURVEY

(Measures the wellbeing of clients and assesses their needs so HCRJC can better help them. Also helps measure effectiveness of HCRJC programming when compared to the exit survey.)

NAME: _____ DATE: _____

1. How do you feel physically? (1 means awful; 10 means great)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

2. How do you feel emotionally? (1 means awful; 10 means great)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

3. How do you feel socially? (1 means you feel isolated and alone; 10 means you have lots of social support and feel connected to your community)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

4. How hopeful do you feel about your future? (1 means *not* hopeful; 10 means really hopeful)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

5. What do you most ***need now*** to help you be successful/happy in the community? Put a **✓** next to the top **5** things you most need. Put two checkmarks **✓ ✓** next to the number **1** thing you think you need most of all.

- _____ safe housing
- _____ a job or money
- _____ people who care about you, friends, moral support, acceptance in the community
- _____ transportation
- _____ medicine, including for drug/alcohol addiction (Saboxin, Methadone, marijuana)
- _____ therapy or counseling (group or individual)
- _____ support group (for example AA)
- _____ activities that are safe and fun
- _____ education (GED or higher education) or skills training
- _____ supervision (rules, UAs, someone holding you accountable for your actions)
- _____ church, religion, spiritual practices
- _____ other (please fill in) _____

6. What can HCRJC do to help you the most?

7. What worries you the most?

8. What are you most proud of in your life? What are your greatest strengths? What do you value most about your life? What are you most excited about?

APPENDIX 5: EXIT SURVEY

(Evaluates the effectiveness of HCRJC programming when compared to the entry survey.)

NAME: _____ DATE: _____

1. How do you feel physically? (1 means awful; 10 means great)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

2. How do you feel emotionally? (1 means awful; 10 means great)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

3. How do you feel socially? (1 means you feel isolated and alone; 10 means you have lots of social support and feel connected to your community)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

4. How hopeful do you feel about your future? (1 means *not* hopeful; 10 means really hopeful)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

5. Put a ✓ next to anything that HCRJC helped you with or provided. Put two checkmarks ✓✓ next to the number 1 thing that means the most to you (if anything).

- _____ housing
- _____ jobs (STAR program, resume/application help)
- _____ finances or budgeting
- _____ transportation
- _____ getting a better education or skills training
- _____ fun social activities (holiday parties, bingo, trivia night)
- _____ classes (safe driver, writing center, arts class, debate club, etc.)
- _____ re-entry or restorative circles
- _____ COSA
- _____ moral support, friendship
- _____ a safe place to visit
- _____ supervision and accountability
- _____ other. Fill in: _____

6. How much did HCRJC help you? Circle a number from 1-10 (1 means HCRJC has not helped you at all, and 10 means they have really helped you.)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

7. What people or organizations have helped you the most since you left prison? _____

8. Since working with HCRJC, do you feel any differently about yourself?

Yes or No or Maybe

Please explain: _____

9. Do you feel any differently about your relationships or community?

Yes or No or Maybe

Please explain: _____

10. Do you manage stress and conflict any differently?

Yes or No or Maybe

Please explain: _____

11. What is the best thing about HCRJC?

12. What is the worst thing about HCRJC? (Or what could it do better?)

Additional comments: _____
