Trauma-Informed Advocacy: Practical Advice for Representing Victims of Trauma in the Legal System

June 10, 2019
9:00 a.m. – 11:00 a.m.

Connecticut Convention Center
Hartford, CT

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Lawyers’ Principles of Professionalism

As a lawyer I must strive to make our system of justice work fairly and efficiently. In order to carry out that responsibility, not only will I comply with the letter and spirit of the disciplinary standards applicable to all lawyers, but I will also conduct myself in accordance with the following Principles of Professionalism when dealing with my client, opposing parties, their counsel, the courts and the general public.

Civility and courtesy are the hallmarks of professionalism and should not be equated with weakness;
I will endeavor to be courteous and civil, both in oral and in written communications;

I will not knowingly make statements of fact or of law that are untrue;
I will agree to reasonable requests for extensions of time or for waiver of procedural formalities when the legitimate interests of my client will not be adversely affected;

I will refrain from causing unreasonable delays;
I will endeavor to consult with opposing counsel before scheduling depositions and meetings and before rescheduling hearings, and I will cooperate with opposing counsel when scheduling changes are requested;

When scheduled hearings or depositions have to be canceled, I will notify opposing counsel, and if appropriate, the court (or other tribunal) as early as possible;

Before dates for hearings or trials are set, or if that is not feasible, immediately after such dates have been set, I will attempt to verify the availability of key participants and witnesses so that I can promptly notify the court (or other tribunal) and opposing counsel of any likely problem in that regard;

I will refrain from utilizing litigation or any other course of conduct to harass the opposing party;
I will refrain from engaging in excessive and abusive discovery, and I will comply with all reasonable discovery requests;

In depositions and other proceedings, and in negotiations, I will conduct myself with dignity, avoid making groundless objections and refrain from engaging I acts of rudeness or disrespect;

I will not serve motions and pleadings on the other party or counsel at such time or in such manner as will unfairly limit the other party’s opportunity to respond;

In business transactions I will not quarrel over matters of form or style, but will concentrate on matters of substance and content;

I will be a vigorous and zealous advocate on behalf of my client, while recognizing, as an officer of the court, that excessive zeal may be detrimental to my client’s interests as well as to the proper functioning of our system of justice;

While I must consider my client’s decision concerning the objectives of the representation, I nevertheless will counsel my client that a willingness to initiate or engage in settlement discussions is consistent with zealous and effective representation;

Where consistent with my client's interests, I will communicate with opposing counsel in an effort to avoid litigation and to resolve litigation that has actually commenced;
I will withdraw voluntarily claims or defense when it becomes apparent that they do not have merit or are superfluous;

I will make every effort to agree with other counsel, as early as possible, on a voluntary exchange of information and on a plan for discovery;

I will endeavor to resolve, by agreement, my objections to matters contained in my opponent's pleadings and discovery requests;

I will endeavor to be punctual in attending court hearings, conferences, meetings and depositions;
I will at all times be candid with the court and its personnel;

I will remember that, in addition to commitment to my client's cause, my responsibilities as a lawyer include a devotion to the public good;
I will endeavor to keep myself current in the areas in which I practice and when necessary, will associate with, or refer my client to, counsel knowledgeable in another field of practice;

I will be mindful of the fact that, as a member of a self-regulating profession, it is incumbent on me to report violations by fellow lawyers as required by the Rules of Professional Conduct;
I will be mindful of the need to protect the image of the legal profession in the eyes of the public and will be so guided when considering methods and content of advertising;

I will be mindful that the law is a learned profession and that among its desirable goals are devotion to public service, improvement of administration of justice, and the contribution of uncompensated time and civic influence on behalf of those persons who cannot afford adequate legal assistance;
I will endeavor to ensure that all persons, regardless of race, age, gender, disability, national origin, religion, sexual orientation, color, or creed receive fair and equal treatment under the law, and will always conduct myself in such a way as to promote equality and justice for all.

It is understood that nothing in these Principles shall be deemed to supersede, supplement or in any way amend the Rules of Professional Conduct, alter existing standards of conduct against which lawyer conduct might be judged or become a basis for the imposition of civil liability of any kind.

--Adopted by the Connecticut Bar Association House of Delegates on June 6, 1994
Honorable John A. Danaher III

1. Judge of the Connecticut Superior Court

In March 2010, Governor M. Jodi Rell nominated John A. Danaher III to serve as a Judge of the Connecticut Superior Court. His nomination was confirmed by the House of Representatives and thereafter by the Senate on May 5, 2010. On May 10, 2010, he was sworn in as a Judge of the Superior Court. He is currently assigned to the Litchfield seat of court. Since his appointment, Judge Danaher has authored more than two hundred and fifty opinions.

Judge Danaher has served as an instructor at the Connecticut Judges’ Institute in 2012, 2013, 2014 and 2017. In 2013 he was appointed to serve as a member of the Judicial Department Education Committee. In 2014, Chief Justice Chase Rogers appointed Judge Danaher to represent the Judicial Branch as co-chairman of the Advisory Council for Victims of Crime. In August 2014, Chief Justice Rogers appointed Judge Danaher to the position of Administrative Judge for the Judicial District of Litchfield. In 2015, Judge Danaher was appointed to serve as a member of the Civil Jury Instruction Committee.


2. Commissioner of the Connecticut Department of Public Safety

Governor Rell appointed Mr. Danaher to serve as Commissioner of the Department of Public Safety on March 5, 2007 where he served until May 9, 2010. In that capacity, Mr. Danaher was responsible for the three divisions of the Department: the Connecticut State Police, the State Forensic Laboratory, and the Division of Fire, Emergency and Building Services. During his tenure, Mr. Danaher supported the development of numerous programs to support and assist the members of the Connecticut State Police, including the development of the Peer Support Program, the State Police Chaplaincy Program, the Military Support Program, and others. He took aggressive steps to diversify the Department, which is composed of approximately 1,700 employees. He oversaw a budget of approximately 168 million dollars and advocated for, and against, numerous bills that were considered by the Connecticut State Legislature.

Numerous significant cases arose during Mr. Danaher’s tenure as Commissioner. Cases in which he was personally involved include the Cheshire home invasion case in which three members of the Petit family were murdered (July 2007); the murder of Yale University graduate student Annie Le (September 2009); and the Kleen Energy power plant explosion in which six men were killed (February 2010). Following the Cheshire home invasion case, Governor Rell appointed Mr. Danaher to serve on a commission charged with making improvements to criminal justice information systems. Following the Kleen Energy explosion, Governor Rell appointed Mr. Danaher to serve on a commission charged with determining the cause and origin of the explosion.
3. United States Attorney

Mr. Danaher worked in the United States Attorney’s Office for the District of Connecticut from 1986 to 2007. He served in a variety of capacities with that office, including service as the Deputy United States Attorney and, thereafter, as the United States Attorney from May 2001 through November 2002. During his tenure he co-founded a Crimes Against Children Working Group, served as Antiterrorism Advisory Council Coordinator, International Security Coordinator, Ethics Advisor, Crisis Management Coordinator, Supervisor for the Hartford Weed & Seed Operation, and was a member of the office’s Death Penalty Committee.

Mr. Danaher handled a variety of categories of criminal offenses, including cases involving bank fraud, murder, crimes against children, and other federal crimes. He participated in several notable matters, including the prosecution of a terrorist group known as Los Macheteros, an organization that claimed responsibility for various bombings and murders in Puerto Rico. Mr. Danaher was a member of the team that prosecuted 19 members of Los Macheteros for the 1983 armed robbery of 7.1 million dollars from a Wells Fargo depot in West Hartford. In 1990, in recognition of his work in that case, Mr. Danaher was called to Washington, where Attorney General Richard Thornburgh presented Mr. Danaher with the Attorney General’s Distinguished Service Award. Mr. Danaher also prosecuted the only “murder of a federal employee” case to have been brought in the District of Connecticut.

4. Other

In addition to his career in public service, he also was an Associate Attorney in the Trial Department of Day, Berry & Howard from 1981 to 1986. He began his legal career in 1980 as a law clerk for the Honorable T. Emmet Clarie in the United States District Court, District of Connecticut. Mr. Danaher holds a BA from Fairfield University, an MA from the University of Hartford, and a JD from the University of Connecticut School of Law, where he served as Executive Editor of the Connecticut Law Review. He lives in West Hartford with his wife, Anne. They have four grown children and two grandchildren.
Stacey Forrest, M.Ed., is currently the Assistant Executive Director of Justice Resource Institute’s Connecticut Division, and oversees the provision of services to children, adolescents, and families in that division, including at the Susan Wayne Center of Excellence residential center and River Run Academy Clinical Day School. Stacey has been with JRI for thirteen years, and as an experienced administrator in mental health and special education settings, Stacey maintains a special focus on organizational change initiatives, including transitioning programs and schools to more trauma-informed practices, as well as the implementation of the Attachment, Self-Regulation, and Competency (ARC) model. She has also played key roles in staff development initiatives, as well as the creation of an agency-wide, trauma-based intervention model, called “Building Communities of Care.” As a training faculty for The Trauma Center at JRI, Stacey provides training to organizations seeking to adopt trauma-informed treatment models, as well as presents on this topic nationwide.
Alice Forrester, Clifford Beers Clinic

Alice M. Forrester, PhD, is chief executive officer at Clifford Beers Clinic (New Haven, CT). That agency is featured in the documentary Resilience: The Biology of Stress and the Science of Hope (2016) produced by KPJR Films and directed by Jamie Redford.

Under Dr. Forrester's leadership, the agency provides integrated services to address mental health, physical health and social determinants of health. Because family is so important in recovery, care is "whole"-istic in terms of the whole person and whole family.

Forrester is widely viewed as a thought leader in her field. She has served on multiple local, state and national councils including the National Child Traumatic Stress Network Steering Committee, the State of Connecticut Behavioral Health Partnership Oversight Council, the Tow Youth Justice Institute Advisory Council, the Sandy Hook (CT) Commission, and the City of New Haven Substance Abuse Council. She is sought by government officials to inform policy and implement change, e.g., Forrester was appointed by Gov. Dannel Malloy to the Sandy Hook Commission following the 12/14/12 mass shooting tragedy at Sandy Hook Elementary School (Newtown, CT). She was specifically asked to investigate and recommend changes to child mental health delivery systems via early intervention and prevention.

Her commitment to innovation led Clifford Beers to winning a $9.7 million Centers for Medicare and Medicaid Services Healthcare Innovation grant designed to prove the impact of integrated care combined with in-home intensive care coordination for families living under chronic stress and with complex biopsychosocial issues (currently in progress).

Forrester has traveled the nation addressing vast and varied audiences – from New York City public school physicians to religious leaders in Lake Forest, California – on topics such as trauma, resiliency, the framework for school-based/trauma-informed change, quality management, and integrated care. She has designed and is overseeing a team at the Clinic dedicated to helping schools implement a trauma-informed framework for change at the district-wide level.

Leadership posts in the private sector include board membership at The Alliance (a Connecticut nonprofit action group), and board chair for both the National Association for Drama Therapy and the National Coalition for Creative Arts Therapies Associations.

Dr. Forrester holds an MA from New York University (drama therapy) and a PhD from Fielding University (clinical psychology). She resides in New Haven with her partner and their three adopted children, Elisabeth, Daniel and Camille.

More information about Clifford Beers can be found at www.cliffordbeers.org. Forrester can be reached at aforrester@cliffordbeers.org.
Miriam Gohara is a Clinical Associate Professor of Law at Yale Law School. Before joining the Yale Law School faculty, Professor Gohara spent sixteen years representing death-sentenced clients in post-conviction litigation, first as assistant counsel at the NAACP Legal Defense Fund (LDF) and then as a specially designated federal public defender with the Federal Capital Habeas Project. Professor Gohara has litigated cases in state and federal courts around the United States, including the United States Supreme Court. At LDF, she also spearheaded the Mississippi Gideon Project, a policy and public education campaign which aimed to establish a quality statewide public defender system and became a model for indigent defense reform efforts nationally.

Professor Gohara teaches and writes about capital and non-capital sentencing, incarceration, and the historical and social forces implicated in culpability and punishment.

Professor Gohara is a member of the board of trustees of the Neighborhood Defender Service of Harlem. She is a graduate of Harvard Law School and Columbia University.
Maria Morelli-Wolfe, Greater Hartford Legal Aid

Maria Morelli-Wolfe has been a staff attorney at Greater Hartford Legal Aid (GHLA) since 1997. GHLA’s mission is “to achieve equal justice for poor people, to work with clients to promote social justice, and to address the effects and root causes of poverty.” During her early years at GHLA, Maria practiced disability, family, employment, housing, and child protection law. For the past 14 years, Maria’s work has focused on education, representing families of children with disabilities to enforce their rights to a free appropriate public education and related services, compensatory educational services, and due process in school discipline.

Maria has served at the CLE Liaison for the Education Section of the Connecticut Bar Association since late 2017.

Prior to GHLA, Maria worked as a research for the Connecticut Superior Court. She obtained her J.D., cum laude, in 1996 from The Washington College of Law at American University, where she served as Editor in Chief of the Journal of International Law & Policy. Prior to law school, Maria was a full-time volunteer for a year in East Harlem, New York in a small social service and home health care agency. She obtained her B.A. from Yale University.
Angela Schlingheyde, J.D.
The Center for Family Justice

Angela Schlingheyde, J.D., Director of Civil Legal & Court Advocacy Services, oversees and coordinates all client requests for civil legal services, including, but not limited to, family law, immigration law, housing law, and ensuring that privacy and constitutional rights are protected. Additionally, she oversees the management of the Criminal and Civil Court programs, as well as all public policy and legislative advocacy efforts. In her efforts to address the significant justice gap in Connecticut, Angela spearheaded the Justice Legal Center, CT’s first legal incubator program to assist attorneys in building sustainable law practices dedicated to representing low to moderate income clients. The Justice Legal Center became operational on January 17, 2017. Currently, through her work at The Center for Family Justice, Angela is working on developing a Pro Bono Legal program to assist victims of abuse in family court. Angela began her career 21 years ago as an Assistant State Attorney in Miami-Dade County, Florida, specifically handling cases involving Domestic Violence, Sexual Violence, and Child Abuse.

Angela graduated from Hofstra University School of Law with a Juris Doctor in 1998. She completed her undergraduate work at Boston College with a B.A. in English and Women Studies in 1995.
## Trauma-Informed Advocacy: Practical Advice for Representing Victims of Trauma in the Legal System (CLC2019-A01)

### Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Speaker</th>
<th>Topic</th>
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<tbody>
<tr>
<td>9:00 – 9:02 am</td>
<td>Ndidi Moses</td>
<td>Introductions of Keynote and Moderator</td>
</tr>
<tr>
<td>9:02 – 9:47 am</td>
<td>Alice M. Forrester</td>
<td>Will provide background on topic and discuss science aspect of trauma, including research that has been done</td>
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<tr>
<td>9:47-9:50 am</td>
<td>Angela C. Schlingheyde,</td>
<td>Will introduce panel</td>
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<td></td>
<td>Moderator</td>
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<tr>
<td>9:50 – 10:05 am</td>
<td>Hon. John A. Danaher III</td>
<td>Will discuss types of training Judges receive in this area, accommodations attorneys can try to request for clients. Will also touch on trauma informed advocacy in a civil context.</td>
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<tr>
<td>10:05 – 10:20 am</td>
<td>Miriam Gohara</td>
<td>Trauma informed advocacy in a criminal context and impact on the justice system, sentencing and challenges for clients and families</td>
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<tr>
<td>10:20 – 10:35 am</td>
<td>Maria Morelli-Wolfe</td>
<td>Trauma informed advocacy in the context of educational related proceedings</td>
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<tr>
<td>10:35 – 10:50 am</td>
<td>Stacey Forrest</td>
<td>Trauma informed advocacy in the context of Juvenile Justice</td>
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<tr>
<td>10:50 – 11:00 am</td>
<td>Question &amp; Answer</td>
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<tr>
<td></td>
<td>Angela C. Schlingheyde</td>
<td>Facilitation of Q&amp;A session and link the presentations of panelists together</td>
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Working with the *Whole* Family While In Crisis and Addressing Trauma

Alice Forrester, PhD, CEO
aforrester@cliffordbeers.org
Vision
We believe that every child can succeed, and that every child deserves a chance. As such, we are keepers of these children’s stories, and bearers of hope for their future.

Mission
To provide integrated services addressing mental, physical, and social determinants in order to improve the health, resiliency, and quality of life of children, families, and communities.
We want our children to be healthy, well and productive members of society.

In order for this to happen they must have good mental health. And if they are in distress we must recognize and address it quickly.
Strategic Question: What support would our families need to thrive, be healthy and well?

Clifford Beers believes that a new model of care must address:

1. The Whole Family
2. Reduced Chronic Stress (Trauma)
3. Integrate multidisciplinary services to address Physical, Mental and Social Determinants of Health
Good mental health starts within the FAMILY

Empathetic, responsive parenting provides the safety for children to grow, regulate their emotions and navigate all the learning they must do for stable functioning.

Loving Relationships
Emotional Regulation and Modeling
Attunement
Connections to Community
Not all changes in behavior are serious—every day stress can cause behavior changes. Helping the child understand their feelings can be a good teachable moment for the child to learn good mental health.

**Early intervention can prevent lifelong mental health consequences.**
Chronic stress and adversity can interfere with positive brain development

The neuronal circuits that build strong emotional health can be interrupted or “pruned” with chronic stress exposure.

Under high stress, children can have problems listening, trusting others, feeling safe and secure.
Example of family who did not get what they needed.
OUR VISION FOR CREATING HEALTH AND WELLNESS FOR OUR COMMUNITY
INTENSIVE CARE COORDINATION

- INTENSIVE CARE COORDINATION is the program created after a three-year pilot -- *Wraparound New Haven* -- funded by a $9.7 million innovation grant from the Centers for Medicare & Medicaid Services.

- The pilot began in 2014; 1973 individuals on Medicaid were enrolled through August 2017.

- Partners: DSS, DCF, YNHH
Intensive Care Coordination offers a unique combination of elements designed to get results

- **TEAM APPROACH**: teams consist of a care coordinator, a behavioral health therapist, connections made to relevant community providers, and medical consultation
- **WHOLE-FAMILY APPROACH**: all participating family members receive care
- **WHOLE-PERSON APPROACH**: participants’ needs are addressed across the board – physical, behavioral, and social determinants of health
- **IN-HOME SERVICE DELIVERY**: Intensive Care Coordination is delivered in the home
- **STRENGTHS BASED, FAMILY DRIVEN**: Family’s vision for health and wellness

**INTENSIVE CARE COORDINATION** employs a three-tiered model of care:
1. a **Family Centered Clinical Model** utilizing a wraparound approach to identify and meet family’s needs;
2. a rigorous **Quality Improvement** program that relies on data from families, information from community partners and family feedback, and;
3. **Community Partnerships** integral to program implementation as well as long-term sustainability.
WHAT HAPPENS IN INTENSIVE CARE COORDINATION?

Wrap Around Philosophy: Engage, Educate and Empower

Assessments for all participating family members that explore
- Physical health needs
- Behavioral health needs
- Social well-being

A “playbook” is developed based on what the family wants/needs
- Specific wellness goals for all family members
- Detailed action steps to reach goals
- A crisis plan
- How to manage medication

Delivered in the home – for added convenience and supporting better results:
- Weekly visits/telephone check-ins

THIS IS THE FAMILY’S PLAN OF CARE
Intensive Care Coordination Model of Care Includes:

1. At least one in-person visit per week;

2. A Child and Family Team meeting (CFT) every 4-6 weeks, where the family and multiple providers meet to create and/or continuously refine a written plan of care;

3. Primary care provider (PCP) updates, where the care coordinator shares the family’s plan of care with their PCP;

4. A family review, where a multi-disciplinary clinical team meet weekly to review high-risk families and discuss strategies to better understand, engage and support the family;

5. Following-up with a family within 24-hours of an emergency room visit or inpatient hospitalization to support the family in obtaining follow-up care, reviewing medications and providing medical education regarding health challenges the family is facing.

Flexible funding was provided through CT’s Department of Children and Families and was used to meet an identified need for a given family that could not otherwise be met using existing community resources. Families were eligible to receive flex funds based on a demonstrated need and having been enrolled in WANH for 8 or more weeks.
WRAP AROUND
NEW HAVEN PILOT
OUTCOMES
Overall Program Enrollment

WANH (n=1971)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic or Latino</td>
<td>89</td>
<td>45%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>577</td>
<td>29%</td>
</tr>
<tr>
<td>White</td>
<td>151</td>
<td>8%</td>
</tr>
<tr>
<td>Multi-racial</td>
<td>119</td>
<td>6%</td>
</tr>
<tr>
<td>Asian</td>
<td>6</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>69</td>
<td>4%</td>
</tr>
<tr>
<td>Unknown/Refused</td>
<td>160</td>
<td>8%</td>
</tr>
</tbody>
</table>
MEASURES FOR WANH

Clinical
- Center for Epidemiological Studies Depression Scale – Child (CES-DC)
- PHQ-9 Adults
- Social Connectedness: Kendler Social Support Interview is a 24-item questionnaire designed to assess quality of social support.

Self Empowerment
- Patient Activation Measure (PAM) is a 13-item measure used to assess the skills, basic knowledge and confidence level of an individual in managing their own health and healthcare.
- Kendler Social Support Interview is a 24-item questionnaire designed to assess quality of social support.

Satisfaction
- Client Satisfaction Questionnaire (CSQ-8) is an 8-item self-administered measure of a client's satisfaction with services.

Program Indicators
- Receipt of flex funding was one programmatic outcome of interest. Flex funding was measured in three ways: 1) any flex funding checks received, 2) the number of flex funding checks received, and 3) the total dollar amount of flex funding received.
- Intensity of services received is measured using several indicators, including number of CFT meetings, in-person visits, total (CFT and in-person) visits, and the rate of total visits per month.
- The Wilder Collaboration Factors Inventory is a 40-item, self-report questionnaire that measures collaboration between community partners in 20 different domains.

Cost
- Medicaid claims data were provided by the CT Department of Social Services.
OUTCOMES OF WRAP AROUND NEW HAVEN PROJECT

• A total of 1943 individuals representing 588 families were enrolled in the program.

• For index children who completed assessments at both baseline and discharge (n=92), depressive symptoms significantly decreased over time ($t = -2.77, p = .007$) and 35.1% of these children experienced at least a 50% reduction in depressive symptoms from baseline to discharge.

• For adults who completed assessments at both baseline and discharge (n=249), depressive symptoms significantly decreased over time ($t = -6.50, p < 0.001$), and 44.1% of these adults experienced a clinically significant decrease (at least a 50% reduction) in depressive symptoms from baseline to discharge.
OUTCOMES, CONTINUED:

- **78% of families who completed WANH received flex funding**, with families receiving an average of $942.69. Children (index and other children combined) whose families received flex funding experienced greater decreases in depressive symptoms than children whose families did not receive flex funding, this was the same for the adults.

- **Client satisfaction scores were high across all time points.** Eighty-one percent (81%) of families were “very satisfied” and 18% were “satisfied” with the program upon discharge.

- **79% of Participants had utilized the ED in pre-enrollment period (40 months pre)** and those folks during the enrollment reduced their ED visits by 20%.
There was an increase of **Patient Activation**, skills, basic health knowledge and managing their care.
Total Costs: Regression Results
Outpatient: Regression Results

Inpatient: Regression Results
<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Pre-Period (PMPM) (40 Months)</th>
<th>One-Month Prior to Enrollment (PMPM)</th>
<th>Post-Period (PMPM) (20 Months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Patients (n=1,075)</td>
<td>$1,370</td>
<td>$1,906</td>
<td>$1,284</td>
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</table>
COST PER FAMILY PER MONTH SIGNIFICANTLY DECREASES DURING INTERVENTION
Logistic analysis of completion status

Logistic regression analyses show that the likelihood of WANH completion is significantly higher for:

- Older persons than younger persons
- Persons with more chronic conditions than few chronic conditions
- Males than females
- Whites than Black, Hispanic, multi-racial, and other ethnic identity
- Highest completion rate for persons with diabetes, prediabetes, and depression
- Lowest for persons with obesity, heart disease, hypertension, and asthma
Families who received flex funding generally experienced better child outcomes than families who did not receive flexible funds.

Despite not seeing better adult outcomes for families who received flex funding compared to those who did not, we do see a positive association between flex funding and adult outcomes, such as patient activation and instrumental social support.

These combined findings suggest that flexible funding is a critical component to positive clinical outcomes for families.
A care coordinator helped a family obtain a reliable source of transportation because, without it, the parent had found it difficult to maintain regular employment and get to the child’s medical appointments.

Another care coordinator noted one mother’s improved medication adherence for herself and her children, including refilling prescriptions on time and maintaining medical appointments.

One care coordinator spoke of a father who no longer used the ED as his first entry to care. The care coordinator worked with him to improve medication compliance and adherence to his treatment plan in order to be eligible for a liver transplant. His visits to the ED decreased from six times in one year to once within the past nine months.

“I just did a Child and Family Team meeting with one of my moms and, since she started three weeks ago, she’s lost 2.5 pounds. She’s exercising more. The nutritionist comes in with some great ideas. She brings copies of health recipes for the family. I think it’s a great add-on to the program.”

—Care Coordinator
School Based Services - Differences in Symptoms

While NHTC caregivers are less likely to report problem behaviors and functioning for their children...

Their children actually have higher rates of PTSD at intake than do children whose parents walk through the doors of 93 Edwards Street.

Figure 4. Clinical for Overall PTSD Symptoms

<table>
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<th>NHTC (n=262)</th>
<th>Outpatient (n=751)</th>
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</thead>
<tbody>
<tr>
<td>45%</td>
<td></td>
<td>18%</td>
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</table>
2016-2017 NHPS Data CB Whole School/Embedded Clinician
N=200 5 Schools, K-8 (3) 9-12 (2)

Model of services offered:
School identifies at least 40 children with most concerns
Family agrees to receive services
Family Plan of Care created; Children Screened
Child can receive clinical services (including CBITS)
Care coordination by Itself
Or “Comprehensive” Both Clinical and Care Coordination
Some Children have received 2 years of clinical services
All school received Professional Development Training

Results:
48% reduction of PTSD
46% Improved GPA

MOVING FAMILIES FORWARD
Our students are attending **more** days of school.

**Attendance Results with Clinical Services**

**Number of Days Attended 2014-15 and 2015-16 (n=118)**

Days Attended 2014-15: 156

Days Attended 2015-16: 171 (n=22)

Days Attended 2014-15: 164

Days Attended 2015-16: 177
Lessons Learned

Creating an integrated system of care is particularly challenging for various reasons:

- **Logistical constraints**, such as a lack of structure to support reimbursement for care coordination.

- **Expectations of partners** are sometimes unclear, and partner relationships must be repeatedly renegotiated.

- **Social determinants of health** heavily affected our clients which exacerbated both their physical and mental health outcomes.
Every New Haven child must be SAFE, HEARD, ENCOURAGED, SUPPORTED and VALUED.

VISIT US ON THE WEB

www.cliffordbeers.org
Acknowledgements

This publication was developed under the leadership of SAMHSA's Trauma and Justice Strategic Initiative Workgroup: Larke N. Huang (lead), Rebecca Flatow, Tenly Biggs, Sara Afayee, Kelley Smith, Thomas Clark, and Mary Blake. Support was provided by SAMHSA's National Center for Trauma-Informed Care, contract number 270-13-0409. Mary Blake and Tenly Biggs serve as the CORs.

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Originating Office

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Introduction

Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. In order to maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. \(^1\,^2\,^3\,^4\,^5\) Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. \(^6\,^7\,^8\,^9\) However, most people go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical diseases. \(^1\,^10\,^11\)

With appropriate supports and intervention, people can overcome traumatic experiences.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma. \(^12\,^13\) Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. \(^5\,^14\) Young people bring their experiences of trauma into the school systems, often interfering with their school success. And many patients in primary care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions. \(^15\,^16\,^17\)

In addition, the public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing. The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.
Thus, the pervasive and harmful impact of traumatic events on individuals, families and communities and the unintended but similarly widespread re-traumatizing of individuals within our public institutions and service systems, makes it necessary to rethink doing “business as usual.” In public institutions and service systems, there is increasing recognition that many of the individuals have extensive histories of trauma that, left unaddressed, can get in the way of achieving good health and well-being. For example, a child who suffers from maltreatment or neglect in the home may not be able to concentrate on school work and be successful in school; a women victimized by domestic violence may have trouble performing in the work setting; a jail inmate repeatedly exposed to violence on the street may have difficulty refraining from retaliatory violence and re-offending; a sexually abused homeless youth may engage in self-injury and high risk behaviors to cope with the effects of sexual abuse; and, a veteran may use substances to mask the traumatic memories of combat. The experiences of these individuals are compelling and, unfortunately, all too common. Yet, until recently, gaining a better understanding of how to address the trauma experienced by these individuals and how to mitigate the re-traumatizing effect of many of our public institutions and service settings was not an integral part of the work of these systems. Now, however, there is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their “business” under the framework of a trauma-informed approach.

Purpose and Approach: Developing a Framework for Trauma and a Trauma-Informed Approach

PURPOSE

The purpose of this paper is to develop a working concept of trauma and a trauma-informed approach and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups. SAMHSA puts forth a framework for the behavioral health specialty sectors, that can be adapted to other sectors such as child welfare, education, criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual’s capacity to cope with traumatic experiences. In fact, many people with behavioral health problems receive treatment and services in these non-specialty behavioral health systems. SAMHSA intends this framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families and communities. The desired goal is to build a framework that helps systems “talk” to each other, to understand better the connections between trauma and behavioral health issues, and to guide systems to become trauma-informed.

APPROACH

SAMHSA approached this task by integrating three significant threads of work: trauma focused research work; practice-generated knowledge about trauma interventions; and the lessons articulated by survivors
of traumatic experiences who have had involvement in multiple service sectors. It was expected that this blending of the research, practice and survivor knowledge would generate a framework for improving the capacity of our service systems and public institutions to better address the trauma-related issues of their constituents.

To begin this work, SAMHSA conducted an environmental scan of trauma definitions and models of trauma informed care. SAMHSA convened a group of national experts who had done extensive work in this area. This included trauma survivors who had been recipients of care in multiple service system; practitioners from an array of fields, who had experience in trauma treatment; researchers whose work focused on trauma and the development of trauma-specific interventions; and policymakers in the field of behavioral health.

From this meeting, SAMHSA developed a working document summarizing the discussions among these experts. The document was then vetted among federal agencies that conduct work in the field of trauma. Simultaneously, it was placed on a SAMHSA website for public comment. Federal agency experts provided rich comments and suggestions; the public comment site drew just over 2,000 respondents and 20,000 comments or endorsements of others’ comments. SAMHSA reviewed all of these comments, made revisions to the document and developed the framework and guidance presented in this paper.

SAMHSA’s approach to this task has been an attempt to integrate knowledge developed through research and clinical practice with the voices of trauma survivors. This also included experts funded through SAMHSA’s trauma-focused grants and initiatives, such as SAMHSA’s National Child Traumatic Stress Initiative, SAMHSA’s National Center for Trauma Informed Care, and data and lessons learned from other grant programs that did not have a primary focus on trauma but included significant attention to trauma, such as SAMHSA’s: Jail Diversion Trauma Recovery grant program; Children’s Mental Health Initiative; Women, Children and Family Substance Abuse Treatment Program; and Offender Reentry and Adult Treatment Drug Court Programs.

The key questions addressed in this paper are:

- What do we mean by trauma?
- What do we mean by a trauma-informed approach?
- What are the key principles of a trauma-informed approach?
- What is the suggested guidance for implementing a trauma-informed approach?
- How do we understand trauma in the context of community?
The concept of traumatic stress emerged in the field of mental health at least four decades ago. Over the last 20 years, SAMHSA has been a leader in recognizing the need to address trauma as a fundamental obligation for public mental health and substance abuse service delivery and has supported the development and promulgation of trauma-informed systems of care. In 1994, SAMHSA convened the Dare to Vision Conference, an event designed to bring trauma to the foreground and the first national conference in which women trauma survivors talked about their experiences and ways in which standard practices in hospitals re-traumatized and often, triggered memories of previous abuse. In 1998, SAMHSA funded the Women, Co-Occurring Disorders and Violence Study to generate knowledge on the development and evaluation of integrated services approaches for women with co-occurring mental and substance use disorders who also had histories of physical and or sexual abuse. In 2001, SAMHSA funded the National Child Traumatic Stress Initiative to increase understanding of child trauma and develop effective interventions for children exposed to different types of traumatic events.

The American Psychiatric Association (APA) played an important role in defining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the recently released DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970’s. National trauma research and practice centers have conducted significant work in the past few decades, further refining the concept of trauma, and developing effective trauma assessments and treatments.

With the advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the life-span.
With the growing understanding of the pervasiveness of traumatic experience and responses, a growing number of clinical interventions for trauma responses have been developed. Federal research agencies, academic institutions and practice-research partnerships have generated empirically-supported interventions. In SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP) alone there are over 15 interventions focusing on the treatment or screening for trauma.

These interventions have been integrated into the behavioral health treatment care delivery system; however, from the voice of trauma survivors, it has become clear that these clinical interventions are not enough. Building on lessons learned from SAMHSA’s Women, Co-Occurring Disorders and Violence Study; SAMHSA’s National Child Traumatic Stress Network; and SAMHSA’s National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraints, among other developments in the field, it became clear that the organizational climate and conditions in which services are provided played a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served. SAMHSA’s National Center for Trauma-Informed Care has continued to advance this effort, starting first in the behavioral health sector, but increasingly responding to technical assistance requests for organizational change in the criminal justice, education, and primary care sectors.

**FEDERAL, STATE AND LOCAL LEVEL TRAUMA-FOCUSED ACTIVITIES**

The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being, have propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma. This has been happening in state and local systems and federal agencies.

States are elevating a focus on trauma. For example, Oregon Health Authority is looking at different types of trauma across the age span and different population groups. Maine’s “Thrive Initiative” incorporates a trauma-informed care focus in their children’s systems of care. New York is introducing a trauma-informed initiative in the juvenile justice system. Missouri is exploring a trauma-informed approach for their adult mental health system. In Massachusetts, the Child Trauma Project is focused on taking trauma-informed care statewide in child welfare practice. In Connecticut the Child Health and Development Institute with the state Department of Children and Families is building a trauma-informed system of care throughout the state through policy and workforce development. SAMHSA has supported the further development of trauma-informed approaches through its Mental Health Transformation Grant program directed to State and local governments.

Increasing examples of local level efforts are being documented. For example, the City of Tarpon Springs in Florida has taken significant steps in becoming a trauma-informed community. The city made it its mission to promote a widespread awareness of the costly effects of personal adversity upon the well-being of the community. The Family Policy Council in Washington State convened groups to focus on the impact of adverse childhood experiences on the health and well-being of its local communities and tribal communities. Philadelphia held a summit to further its understanding of the impact of trauma and violence on the psychological and physical health of its communities.

**SAMHSA continues its support of grant programs that specifically address trauma.**

At the federal level, SAMHSA continues its support of grant programs that specifically address trauma and technical assistance centers that focus on prevention, treatment and recovery from trauma.
Other federal agencies have increased their focus on trauma. The Administration on Children Youth and Families (ACYF) has focused on the complex trauma of children in the child welfare system and how screening and assessing for severity of trauma and linkage with trauma treatments can contribute to improved well-being for these youth. In a joint effort among ACYF, SAMHSA and the Centers for Medicare and Medicaid Services (CMS), the three agencies developed and issued through the CMS State Directors’ mechanism, a letter to all State Child Welfare Administrators, Mental Health Commissioners, Single State Agency Directors for Substance Abuse and State Medicaid Directors discussing trauma, its impact on children, screening, assessment and treatment interventions and strategies for paying for such care. The Office of Juvenile Justice and Delinquency Prevention has specific recommendations to address trauma in their Children Exposed to Violence Initiative. The Office of Women’s Health has developed a curriculum to train providers in primary care on how to address trauma issues in health care for women. The Department of Labor is examining trauma and the workplace through a federal interagency workgroup. The Department of Defense is honing in on prevention of sexual violence and trauma in the military.

As multiple federal agencies representing varied sectors have recognized the impact of traumatic experiences on the children, adults, and families they serve, they have requested collaboration with SAMHSA in addressing these issues. The widespread recognition of the impact of trauma and the burgeoning interest in developing capacity to respond through trauma-informed approaches compelled SAMHSA to revisit its conceptual framework and approach to trauma, as well as its applicability not only to behavioral health but also to other related fields.

**SAMHSA’s Concept of Trauma**

Decades of work in the field of trauma have generated multiple definitions of trauma. Combing through this work, SAMHSA developed an inventory of trauma definitions and recognized that there were subtle nuances and differences in these definitions. Desiring a concept that could be shared among its constituencies — practitioners, researchers, and trauma survivors, SAMHSA turned to its expert panel to help craft a concept that would be relevant to public health agencies and service systems. SAMHSA aims to provide a viable framework that can be used to support people receiving services, communities, and stakeholders in the work they do. A review of the existing definitions and discussions of the expert panel generated the following concept:

*Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.*
THE THREE “E'S” OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

Events and circumstances may include the actual or extreme threat of physical or psychological harm (i.e., natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA’s concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as “trauma and stressor-related disorders” to include exposure to a traumatic or stressful event as a diagnostic criterion.

The individual’s experience of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one’s country differently from another refugee; one military veteran may experience deployment to a war zone as traumatic while another veteran is not similarly affected). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, or a force of nature) has power over another. They elicit a profound question of “why me?” The individual’s experience of these events or circumstances is shaped in the context of this powerlessness and questioning. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When a person experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self-blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal, shattering a person’s trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help.

How the event is experienced may be linked to a range of factors including the individual’s cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure), or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, fifteen, or fifty). The long-lasting adverse effects of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual’s inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one’s neurobiological make-up and ongoing health and well-being. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events. Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.
SAMHSA’s Trauma-Informed Approach: Key Assumptions and Principles

Trauma researchers, practitioners and survivors have recognized that the understanding of trauma and trauma-specific interventions is not sufficient to optimize outcomes for trauma survivors nor to influence how service systems conduct their business.

The context in which trauma is addressed or treatments deployed contributes to the outcomes for the trauma survivors, the people receiving services, and the individuals staffing the systems. Referred to variably as “trauma-informed care” or “trauma-informed approach” this framework is regarded as essential to the context of care.22,32,33

SAMHSA’s concept of a trauma-informed approach is grounded in a set of four assumptions and six key principles.

A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.

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**THE FOUR “R’S: KEY ASSUMPTIONS IN A TRAUMA-INFORMED APPROACH**

In a trauma-informed approach, all people at all levels of the organization or system have a basic realization about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals. People’s experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand experiences of another (i.e., secondary traumatic stress experienced by a direct care professional). There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in prevention, treatment, and recovery settings. Similarly, there is a realization that trauma is not confined to the behavioral health specialty service sector, but is integral to other systems (e.g., child welfare, criminal justice, primary health care, peer-run and community organizations) and is often a barrier to effective outcomes in those systems as well.

People in the organization or system are also able to recognize the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.
The program, organization, or system responds by applying the principles of a trauma-informed approach to all areas of functioning. The program, organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve. The organization has practitioners trained in evidence-based trauma practices. Policies of the organization, such as mission statements, staff handbooks and manuals promote a culture based on beliefs about resilience, recovery, and healing from trauma. For instance, the agency’s mission may include an intentional statement on the organization’s commitment to promote trauma recovery; agency policies demonstrate a commitment to incorporating perspectives of people served through the establishment of client advisory boards or inclusion of people who have received services on the agency’s board of directors; or agency training includes resources for mentoring supervisors on helping staff address secondary traumatic stress. The organization is committed to providing a physically and psychologically safe environment. Leadership ensures that staff work in an environment that promotes trust, fairness and transparency. The program’s, organization’s, or system’s response involves a universal precautions approach in which one expects the presence of trauma in lives of individuals being served, ensuring not to replicate it.

A trauma-informed approach seeks to resist re-traumatization of clients as well as staff. Organizations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfillment of the organizational mission. Staff who work within a trauma-informed environment are taught to recognize how organizational practices may trigger painful memories and re-traumatize clients with trauma histories. For example, they recognize that using restraints on a person who has been sexually abused or placing a child who has been neglected and abandoned in a seclusion room may be re-traumatizing and interfere with healing and recovery.

**SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH**

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific.

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<th>SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH</th>
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<td>5. Empowerment, Voice and Choice</td>
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<td>6. Cultural, Historical, and Gender Issues</td>
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From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA’s definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.
The six key principles fundamental to a trauma-informed approach include:​

1. **Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.

2. **Trustworthiness and Transparency:** Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.

3. **Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term “Peers” refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as “trauma survivors.”

4. **Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: “one does not have to be a therapist to be therapeutic.”

5. **Empowerment, Voice and Choice:** Throughout the organization and among the clients served, individuals’ strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery. Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.

6. **Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.
Guidance for Implementing a Trauma-Informed Approach

Developing a trauma-informed approach requires change at multiples levels of an organization and systematic alignment with the six key principles described above. The guidance provided here builds upon the work of Harris and Fallot and in conjunction with the key principles, provides a starting point for developing an organizational trauma-informed approach. While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives. Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.

The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a “checklist” or a prescriptive step-by-step process. These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care. What makes it unique to establishing a trauma-informed organizational approach is the cross-walk with the key principles and trauma-specific content.

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<th>TEN IMPLEMENTATION DOMAINS</th>
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<td>3. Physical Environment</td>
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<td>4. Engagement and Involvement</td>
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<td>9. Financing</td>
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<td>10. Evaluation</td>
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GOVERNANCE AND LEADERSHIP: The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within the organization to lead and oversee this work; and there is inclusion of the peer voice. A champion of this approach is often needed to initiate a system change process.

POLICY: There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be “hard-wired” into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

PHYSICAL ENVIRONMENT OF THE ORGANIZATION: The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety. The physical setting also supports the collaborative aspect of a trauma-informed approach through openness, transparency, and shared spaces.

ENGAGEMENT AND INVOLVEMENT OF PEOPLE IN RECOVERY, TRAUMA SURVIVORS, PEOPLE RECEIVING SERVICES, AND FAMILY MEMBERS RECEIVING SERVICES: These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.) This is a key value and aspect of a trauma-informed approach that differentiates it from the usual approaches to services and care.

CROSS SECTOR COLLABORATION: Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization’s mission is a critical aspect of building collaborations. People with significant trauma histories often present with a complexity of needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

SCREENING, ASSESSMENT, AND TREATMENT SERVICES: Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed approach. Trauma screening and assessment are an essential part of the work. Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

TRAINING AND WORKFORCE DEVELOPMENT: On-going training on trauma and peer-support are essential. The organization’s human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals with complex trauma.

PROGRESS MONITORING AND QUALITY ASSURANCE: There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments and treatment.
FINANCING: Financing structures are designed to support a trauma-informed approach which includes resources for: staff training on trauma, key principles of a trauma-informed approach; development of appropriate and safe facilities; establishment of peer-support; provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and development of trauma-informed cross-agency collaborations.

EVALUATION: Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

To further guide implementation, the chart on the next page provides sample questions in each of the ten domains to stimulate change-focused discussion. The questions address examples of the work to be done in any particular domain yet also reflect the six key principles of a trauma-informed approach. Many of these questions and concepts were adapted from the work of Fallot and Harris, Henry, Black-Pond, Richardson, & Vandervort, Hummer and Dollard, and Penney and Cave.39, 40, 41,42

While the language in the chart may seem more familiar to behavioral health settings, organizations across systems are encouraged to adapt the sample questions to best fit the needs of the agency, staff, and individuals being served. For example, a juvenile justice agency may want to ask how it would incorporate the principle of safety when examining its physical environment. A primary care setting may explore how it can use empowerment, voice, and choice when developing policies and procedures to provide trauma-informed services (e.g., explaining step by step a potentially invasive procedure to a patient at an OBGYN office).

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

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<td>Peer Support</td>
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<td>Collaboration and Mutuality</td>
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<td>Empowerment, Voice, and Choice</td>
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<td>Cultural, Historical, and Gender Issues</td>
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<th>Governance and Leadership</th>
<th>Policy</th>
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<tr>
<td>• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach?</td>
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<td>• How do the agency’s mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports?</td>
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<td>• How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?</td>
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<td>• How do the agency’s written policies and procedures include a focus on trauma and issues of safety and confidentiality?</td>
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<tr>
<td>• How do the agency’s written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery?</td>
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<td>• How do the agency’s staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training?</td>
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<td>• How do human resources policies attend to the impact of working with people who have experienced trauma?</td>
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<tr>
<td>• What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?</td>
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**SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH (continued)**

<table>
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<th>10 IMPLEMENTATION DOMAINS continued</th>
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<tr>
<td><strong>Physical Environment</strong></td>
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<tr>
<td>• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff?</td>
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<td>• In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this?</td>
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<td>• How has the agency provided space that both staff and people receiving services can use to practice self-care?</td>
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<td>• How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities).</td>
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<tr>
<td><strong>Engagement and Involvement</strong></td>
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<tr>
<td>• How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services?</td>
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<tr>
<td>• How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information?</td>
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<tr>
<td>• How is transparency and trust among staff and clients promoted?</td>
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<td>• What strategies are used to reduce the sense of power differentials among staff and clients?</td>
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<td>• How do staff members help people to identify strategies that contribute to feeling comforted and empowered?</td>
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<tr>
<td><strong>Cross Sector Collaboration</strong></td>
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<tr>
<td>• Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions?</td>
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<td>• Are collaborative partners trauma-informed?</td>
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<tr>
<td>• How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services?</td>
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<tr>
<td>• What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?</td>
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<tr>
<td><strong>Screening, Assessment, Treatment Services</strong></td>
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<tr>
<td>• Is an individual’s own definition of emotional safety included in treatment plans?</td>
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<tr>
<td>• Is timely trauma-informed screening and assessment available and accessible to individuals receiving services?</td>
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<tr>
<td>• Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services?</td>
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<tr>
<td>• How are peer supports integrated into the service delivery approach?</td>
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<tr>
<td>• How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women?</td>
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<tr>
<td>• Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding?</td>
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<tr>
<td>• How are these trauma-specific practices incorporated into the organization’s ongoing operations?</td>
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</table>
### 10 IMPLEMENTATION DOMAINS (continued)

| Training and Workforce Development | - How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences?
| - How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions?
| - How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions?
| - How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person’s experience of trauma, access to supports and resources, and opportunities for safety?
| - How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors.
| - What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work?
| - What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization’s workforce?

| Progress Monitoring and Quality Assurance | - Is there a system in place that monitors the agency’s progress in being trauma-informed?
| - Does the agency solicit feedback from both staff and individuals receiving services?
| - What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency?
| - How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes?
| - What mechanisms are in place for information collected to be incorporated into the agency’s quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?

| Financing | - How does the agency’s budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development?
| - What funding exists for cross-sector training on trauma and trauma-informed approaches?
| - What funding exists for peer specialists?
| - How does the budget support provision of a safe physical environment?

| Evaluation | - How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach?
| - How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey?
| - What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality?
| - What measures or indicators are used to assess the organizational progress in becoming trauma-informed?
Next Steps: Trauma in the Context of Community

Delving into the work on community trauma is beyond the scope of this document and will be done in the next phase of this work. However, recognizing that many individuals cope with their trauma in the safe or not-so-safe space of their communities, it is important to know how communities can support or impede the healing process.

Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect. 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 often be re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community.

A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may be subjected to a community-threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma.

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. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.

Many people who experience trauma readily overcome it and continue on with their lives; some become stronger and more resilient; for others, the trauma is overwhelming and their lives get derailed. Some may get help in formal support systems; however, the vast majority will not. The manner in which individuals and families can mobilize the resources and support of their communities and the degree to which the community has the capacity, knowledge, and skills to understand and respond to the adverse effects of trauma has significant implications for the well-being of the people in their community.

Conclusion

As the concept of a trauma-informed approach has become a central focus in multiple service sectors, SAMHSA desires to promote a shared understanding of this concept. The working definitions, key principles, and guidance presented in this document represent a beginning step toward clarifying the meaning of this concept. This document builds upon the extensive work of researchers, practitioners, policymakers, and people with lived experience in the field. A standard, unified working concept will serve to advance the understanding of trauma and a trauma-informed approach for public institutions and service sectors.
Endnotes


SAMHSA’s National Center for Trauma-Informed Care (2012), *Report of Project Activities Over the Past 18 Months, History, and Selected Products*. Available from:


29 Goodwin, L. and Rona, R.J. (2013) PTSD in the armed forces: What have we learned from the recent cohort studies of Iraq/Afghanistan?, *Journal of Mental Health* 22(5), 397-401.


39 Henry, Black-Pond, Richardson and Vandervort. (2010). Western Michigan University, Southwest Michigan Children’s Trauma Assessment Center (CTAC).


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A very special thank you to the Expert Panelists for their commitment and expertise in advancing evidence-based and best practice models for the implementation of trauma-informed approaches and practices.
Child sex trafficking is a severe form of trauma exposure that has significant immediate and long-term consequences for survivors. According to the United Nations International Labor Organization, in 2016 more than 1 million children worldwide were victims of commercial sexual exploitation. Currently, no reliable estimate of the prevalence of child sex trafficking in the US exists, in part due to its hidden nature, disparities in definitions, and methodological challenges.

What is Child Sex Trafficking?

According to the Trafficking Victims Protection Act, the sex trafficking of minors is the recruitment, harboring, transportation, provision, obtaining, patronizing, or solicitation of a person under the age of 18 for the purposes of a commercial sex act, defined as any sex act for which anything of value is given or received by any person.

Who is at Risk of Child Sex Trafficking?

Child sex trafficking is a geographically broad-based and growing concern across urban, suburban, and rural communities in the US, including in American Indian communities. It transcends racial, ethnic, gender, and socio-economic boundaries, although some youth appear to be at greater risk, including those who are racial and ethnic minorities; Lesbian, Gay, Bisexual, and Transgender; runaway and homeless; and economically disadvantaged. In addition, male survivors appear to be under-identified and underserved compared to female survivors.

Exposure to childhood trauma and adversities contributes to subsequent vulnerability to being trafficked. Many trafficked youth have experienced childhood sexual abuse, physical abuse, neglect, traumatic loss, separation from caregivers, and family and community violence. Such experiences can profoundly impact social-emotional development in complex ways that affect the child's understanding of personal safety, sexual boundaries, and healthy relationships, leaving them vulnerable to exploitation and trafficking.

Trafficked youth often are involved with formal child-serving systems. Estimates suggest that as many as 50-90% have histories with the child welfare system, with particularly high rates of foster care placement and juvenile justice system involvement. Trafficked youth also often have significant histories of school truancy and educational disruption. These systems represent important prevention and intervention opportunities. However, many trafficked youths exit out of these systems at age 18. The associated loss of structural and financial supports puts them at high risk for further trafficking.

What are the Consequences of Child Sex Trafficking?

Child sex trafficking experiences can lead to sexual, physical, and emotional injuries and severe lifelong health, social, educational, legal, and economic problems for survivors. Survivors experience significant traumatic stress symptoms, as well as depression, anxiety, substance abuse, unplanned or forced pregnancy, sexually transmitted infections, malnutrition, suicide and self-injury, incarceration, social isolation, school drop-out, unemployment, and re-victimization.
Due to early chronic trauma exposure and trauma experienced while being trafficked, survivors often have challenges across an array of critical domains of development and functioning. These challenges include significant emotional and behavioral dysregulation; problems with attachment and relationships; problems with attention, learning, and planning; and distortions in self-concept.  

Trafficked youth are often difficult to identify and engage in services. The commercial sex economy is largely hidden and survivors rarely acknowledge to others, especially authorities, that they are being trafficked. This may be out of fear, shame, a belief that others will not help or support them, or because they do not recognize their circumstances as exploitive. Survivors may fear for their own safety or the safety of their family; the loss of relationship with or protection of their exploiter(s); arrest, deportation, or return to an abusive home; or the inability to care or provide for loved ones. Many survivors have had multiple, often negative, contacts with formal systems and, due to their prior experiences, no longer view these systems as sources of support or safety.  

What Can Be Done to Address Child Sex Trafficking?

Factors that contribute to risk and vulnerability to trafficking are complex, as are the consequences and pathways to recovery. Comprehensive and targeted interventions are needed within and across the systems with which trafficked youth are often involved (e.g., child welfare, law enforcement, juvenile justice, runaway and homeless youth; refugee and immigrant services; educational, mental health, and medical services). Trauma-informed care and trauma-focused treatments that are adapted to trafficking survivors’ unique needs are essential.

Policymakers can help ensure the needs of survivors of child sex trafficking are part of all relevant national and state policies and programs. Specifically, policymakers can expand support for the following:

- **Multi-pronged services** to address an array of needs, such as housing and placement, educational and vocational supports, mentoring programs to foster engagement with caring adults, and evidence-based trauma-focused mental health treatment, medical care and reproductive health, and parenting support
- **Flexible services** and reimbursement structures that recognize the greater intensity and complexity of the trauma-informed intervention needs of child sex trafficking survivors
- **Training and education** of the full spectrum of professionals in child- and family-serving systems and professionals working with refugees, immigrants, and asylees to institutionalize awareness of child sex trafficking, its traumatic impact, and linkage to trauma-informed evidence-based services and treatments
- **Inclusion of child sex trafficking survivors** in the development of policies, community response protocols, and delivery of comprehensive trauma-informed services
Understanding and Addressing Trauma and Child Sex Trafficking

- **Child Welfare** efforts to improve early identification, intervention for at-risk youth, and support for survivors through enhanced investigation, linkage to comprehensive services that address safety needs and trauma history and impact, and specialized foster care programs that provide training and support for caregivers with whom high risk or trafficked youth are placed and broadly educate all foster parents and youth.

- **Law enforcement and juvenile justice** programs that include universal screening for child sex trafficking and traumatic stress, incorporate a trauma-informed survivor-centered and restorative justice approach, offer alternatives to detention and incarceration, prevent transfer of youth into the adult criminal justice system, decriminalize the commercial sex and related acts of trafficking survivors, remove third party control requirements, and establish a streamlined trauma-informed process for expunging related criminal records.

- **Improved identification and response to under-identified and underserved populations** including trafficked boys, LGBTQ, homeless and runaway, American Indian, and refugee, immigrant, and undocumented youth.

- **Policies and practices that support transition-age youth** and ensure continuity of services into adulthood through the full process of disengagement from trafficking and recovery.

- **Evaluation** of all publicly-funded child sex trafficking programs and research that establishes and expands the evidence base of effective interventions, including newer efforts such as specialty dockets designed to decrease child trafficking activity, promote alternatives to detention, and improve youth health and mental health outcomes, with accelerated dissemination of findings to the field.

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**How Does the NCTSN Serve as a Resource?**

Authorized by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a federally funded child mental health service initiative designed to raise the standard of care and increase access to services for traumatized children and their families across the US. The broad mission of the NCTSN includes assessment, treatment and intervention development, training, data analysis, program evaluation, policy analysis and education, systems change, and the integration of trauma informed and evidence-based practices in all child-serving systems. The UCLA-Duke University National Center for Child Traumatic Stress (NCCTS) coordinates the work of the NCTSN, a national network of 100 funded and over 150 affiliate members, and hundreds of national and local partners.

The NCTSN has developed resources for professionals, policymakers, and the public, including a series of webinars that assist stakeholders in understanding the complex nature of working with and providing services for child survivors of sex trafficking and provide guidance on effective collaboration with key child serving systems, including medical, mental health, juvenile justice, and child welfare; the *12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families–Adapted for Youth Who Are Trafficked*, which covers a broad range of considerations for practitioners and agencies as they strive to assess, understand, and assist survivors; and the *NCTSN Bench Card for the Trauma-Informed Judge to Address Child Trafficking and Trauma*, which assists judges in their work with youth who have been trafficked.

For more information about child trauma and the NCTSN, visit [www.nctsn.org](http://www.nctsn.org) or contact the NCCTS Policy Program at [policy@nctsn.org](mailto:policy@nctsn.org).

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References


*1 IN DEFENSE OF THE INJURED: HOW TRAUMA-INFORMED CRIMINAL DEFENSE CAN REFORM SENTENCING

I. INTRODUCTION

Justice O'Connor's oft-cited concurrence in California v. Brown declared that, “Evidence about the defendant's background and character is relevant because of the belief, long held by this society, that defendants who commit criminal acts that are attributable to a disadvantaged background, or to emotional and mental problems, may be less culpable than defendants who have no such excuse.” That principle has guided the Supreme Court's holdings that hardships including poverty, neglect, and exposure to violence are centrally relevant to capital and juvenile life without parole sentencing. In those contexts, when the harshest sentences available to adults and children, respectively, are at stake, defense advocates have persuaded the Court that serious adversity in their clients' backgrounds differentiated them from those who deserved the ultimate penalties. In capital cases, the Court has therefore held that defense lawyers are constitutionally obligated to investigate such adversity. Yet, the Court has never recognized a constitutional obligation of noncapital attorneys to investigate adult clients' backgrounds for the barest sentencing mitigation, even in cases where defendants face life without the possibility of parole. This article presents reasons why noncapital defense lawyers should do just that and builds on my prior writing explaining why individualized mitigation sentencing should not be reserved for capital defendants. First, the same moral obligation that the Supreme Court has recognized in its capital jurisprudence warrants sentences less than death for defendants who have suffered extreme lifetime adversity applies with equal force to noncapital defendants. Second, within our current sentencing framework, defense advocacy is the mechanism for bringing forth evidence supporting sentencing discounts, or leniency, for the societal injuries that defendants have experienced before they have victimized others. Third, in the years since the Court decided its seminal cases recognizing that serious, overwhelming adversity--trauma--is relevant to culpability, science has vindicated that intuition.
Yet, in the vast majority of criminal cases--the ones in which the death penalty or juvenile life without parole are not at stake--evidence of a defendant's exposure to trauma remains legally irrelevant. Trauma, of course, presents in many forms and may be triggered by many events. For this argument, the focus is primarily on the complex trauma that results from repeated exposure to or victimization by violence, often coupled with severe environmental deprivation associated with endemic poverty. As research on this kind of trauma now demonstrates, the disjuncture between capital and noncapital sentencing has become vanishingly defensible, particularly because the quality and extent of trauma in noncapital cases is often indistinguishable from that in capital or juvenile life without parole cases. The aim of this article is to operationalize an argument I pioneered that best practices in capital mitigation ought to be applied to noncapital sentencing. Specifically, this article proposes that defense lawyers need to create records in a breadth and depth of noncapital cases explaining why trauma is relevant to their clients' punishments so that courts will begin to change their approaches to sentencing.

Questions remain about whether, hypothetically, mitigation of a certain sort--in this inquiry, trauma--should result in a blanket discount when the vast majority of defendants may suffer that category of harms. For example, if a lawyer can show that her client has suffered sexual abuse, should the sentencing court automatically deduct five years from his minimum sentence? If he has only been beaten, should the deduction be two years? I decline to prescribe this approach because moral responsibility ought to be evaluated in degrees. Moreover, the particular relationships between lifetime adversities and human frailties and their impact on an individual will be infinitely varied. This is why a discount in punishment on account of various traumatic exposures must be individualized and account for the fact that severe deprivations impair defendants' moral capacities and abilities to abide by the law.

This piece proposes immediate mechanisms, within existing sentencing regimes, for bringing to light the relevance and practical impacts of extreme adversity to defendants' actions and sentencing deserts. It also describes reasons why, in particular, people with multiple adversities that arise from unchecked social harms deserve sentencing leniency. Legislative and policy interventions could be a sweeping and welcome means of achieving the ends proposed here. However, if history is a guide, those interventions will most likely follow litigation records demonstrating the legitimacy and efficacy of sentencing leniency on the basis of trauma. The hard work of making that record remains ahead, and defense attorneys have the imperative to operationalize it. This article explains why.

A. Case Examples

Consider the cases of two of my clients. In the first client's capital case, his trial lawyer had a constitutional obligation to present evidence of his traumatic childhood but failed to do so, and an appellate court vacated the resulting death sentence on that basis. In the second client's noncapital case, the defense team had no constitutional obligation to present evidence of his traumatic background but nevertheless did so, securing a better outcome at their client's sentencing than the years of prison time for which he was eligible.

My first client was convicted of capital murder based on an offense he committed when he was nineteen years old. His father had brutalized him throughout his childhood, beginning when he was four. Among other inflictions, my client's father “whipped” him several times a week with both ends of a belt until the father was too exhausted to continue. He also routinely attacked my client's mother in front of him and his siblings, once forcing her onto all fours and threatening to decapitate her with a machete in front of their children. On another occasion, my client witnessed his father throw his two-year-old brother against a wall with such force that the toddler, whose infraction was ingesting his father's stash of marijuana, remained mute for several ensuing years.
The second client stood accused at sixteen of adult felony robbery of cell phones and cash from other teenagers. He had been removed at the age of one from his mentally ill and cognitively impaired mother's custody to that of his grandmother. Social service records showed that his grandmother's paramour raped him when he was a toddler. In later years, his grandmother was found guilty of educational neglect, and he was removed from her home, which commenced a period during which he moved through at least ten foster care placements.

He faced years of prison time for the robbery. Had he been represented, as most defendants are, by lawyers untrained to investigate trauma, my second *5 client would likely have been sentenced to prison without any exploration of the formative experiences fundamental to his life's trajectory. Thanks to his defense team, which included attorneys at an innovative public defender's office working with clinical law students, this client avoided a maximum term of seven years in prison when the court sentenced him to a twelve-month therapeutic program. The law students investigated his social history and uncovered the crucial records. They explained how the client's trauma and low cognition made him susceptible to dominant boys who goaded him into robbing others. 11 They thereby persuaded the court to grant him “youthful offender” status, ensuring that this offense would not mark him with a felony record. They also secured a non-prison sentence that offered him a chance at rehabilitation instead of incarceration. The defense team's work demonstrates how trauma-informed sentencing representation works effectively: they identified the sources of the client's trauma; they described how the traumatic exposure impacted the client's behavior; and they explained why his impaired behavior meant that he deserved more lenient punishment.

**B. Why Defense Lawyers, Why Trauma?**

In previous work, I have interrogated the puzzle of American sentencing practice and doctrine that insists on the relevance of social history in capital proceedings and yet permits its routine disregard in nearly all noncapital cases. Put another way, just as trauma mitigation has been instrumental in reducing the imposition of death sentences, introducing and explaining trauma mitigation ought to be instrumental in ameliorating noncapital sentences. I have considered and rejected justifications for this disparity, examined the professional and cultural practices that produced it, and proposed a path for noncapital defense lawyers to align their sentencing practices with those of capital defenders. 12 This article builds on the argument that defense lawyers ought to present evidence of their clients' social histories in sentencing proceedings, with a particular and more probative focus on the impact of trauma's relationship to behavior that diminishes blameworthiness. It deepens the exploration with examples, discusses why this is a critical moment to move past antiquated sentencing practices, and describes the social science behind trauma as a theory of mitigation.

Reasons to concentrate on the mitigating relevance of trauma are manifold. First, many people convicted of crime, including those convicted of the most violent offenses, have been exposed to trauma. 13 Forty percent of *6 youths in the United States have been exposed to family violence by the time they reach adolescence. However, by some estimates, up to 75% of incarcerated men and women have experienced interpersonal violence, abuse, or childhood neglect. 14 Statistics show that prisoners report rates of victimization by prior abuse up to twice that of the general population, and justice-involved youth experience chronic trauma at rates triple those of youth in the general population. 15 Women are often criminalized for behavior correlated with their own sexual victimization. 16 Besides family violence, millions of people are exposed to community violence annually, which is also a well-known risk factor for future commission of violence and incarceration. 17

Second, exposure to violence has been well documented to damage the very behavioral domains that are centrally relevant to an assessment of a person's blameworthiness. 18 This principle is firmly established in social science and child
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In welfare circles and has been central to Supreme Court capital and juvenile jurisprudence. Yet, it has by and large eluded noncapital adult criminal defense practice, as though the adverse impacts of early lifetime exposure to violence vanish when a child reaches the age of eighteen. To the contrary, social science establishes the enduring impact of trauma and provides practical underpinning to the theoretical consideration of why adversity should matter at sentencing. Capital and juvenile jurisprudence has established that certain penalties require an individualized consideration to establish whether those punishments are impermissible, or ought to be discounted, for people with certain characteristics. Drawing on this principle, and as I describe in Section II, noncapital sentencing hearings should permit evidence that exposure to trauma is one of those characteristics. Philosophically, this is because trauma is often the result of conditions that flourish as a direct result of social policies that divest the persons harmed of influence over the framework within which they are being punished. Practically, it is because complex trauma impacts behavior in ways that the law already recognizes diminish sentencing liability.

In addition to examining theoretical questions, this article is prescriptive, because advocacy and a persuasive public record drive doctrinal and policy change. Certainly, judges and legislators should heed the strong link between traumatic victimization and criminal offending. However, until defense lawyers, the actors in the justice system with the ethical imperative to argue for leniency, present convincing evidence, jurists and lawmakers are likely to remain uninformed about the myriad practical ways in which trauma influences behavior relevant to culpability. Defense lawyers must advance the arguments, including moral ones, necessary to correct the misalignment that permits courts to view trauma as centrally relevant to capital and juvenile life without parole sentencing but irrelevant to all other punishment. Defense lawyers who provide trauma-informed representation will accomplish additional sentencing goals. They will present courts with a basis for proportionate sentences as well as penalties that will enhance public safety by addressing the root causes of serious crime.

C. Additional Tenets

Two additional tenets of my argument bear mentioning. The first tenet is that mitigation is never an excuse for crime. Mitigation is sentencing information that explains a person's life in context before he is punished. Nothing in the call for increased awareness of trauma's salience in mitigation negates the fact that in some cases, long prison sentences are going to be appropriate penalties. Another concern is that emphasis on defendants' damaged backgrounds might be an attempt to diminish or distract from the very real harms they have caused to victims of their criminal offenses. This article suggests the opposite: explaining how defendants' own victimization has influenced their behavior will provide context that may be illuminating to some crime victims. It will also interrupt the cycle of violence by pointing to the need for meaningful treatment to prevent traumatized defendants from harming again. In fact, as described later in the article, victims' advocacy groups themselves are beginning to propose treatment-based sentencing alternatives to prison.

However, the argument for presenting trauma history in even the most difficult cases is twofold. It is about making sure sentencers view defendants' actions in context of their own victimization, to the extent that that is relevant in any given case. Of course, the fact of a defendant's own abuse history is not alone mitigating, and it is his or her advocate's job to unearth and describe the mitigating behavioral impact of the defendant's victimization. Presenting a client's trauma history and explaining its salience is also about uncovering why people committed terrible offenses, in an effort to provide them with meaningful help while they are incapacitated so that when they are released they are better, not worse off, than when they went into prison. In this vein, and as I explain in later sections, rehabilitation of injured people is essential to public safety.
The first aim fits squarely within the longstanding principles of American criminal jurisprudence. One such principle is that moral retributive punishment must be proportionate. A second is that proportionality requires an accounting of both the circumstances of the offense and the culpability of the offender. Proportionate retribution applies to trauma-informed sentencing because trauma in the lives of many defendants results from circumstances intimately tied to economic and social deprivations that raise profound questions about the moral obligations of our social compact with the most vulnerable. More tangibly, exposure to trauma impacts defendants' behavior in ways relevant to their blameworthiness. Trauma conditions responses that impair defendants' decision-making and judgment, and thereby diminishes their culpability. Another aim of trauma-informed representation is identifying the root causes of criminogenic behavior in order to provide people with ameliorative treatment. This fits within the rehabilitative ideal of punishment and also enhances public safety. One challenge to my proposal, though, is that the retributive and rehabilitative penal goals may be in tension with each other. For example, the more damaged a person is by trauma, the less culpable he may be under retributive theory (if his advocate is able to explain mitigating behavioral consequences of his trauma). On the other hand, the more traumatized the individual is, the less amenable to treatment a judge might perceive him to be under rehabilitative theory. Even severely traumatized people benefit substantially from treatment. However, defense lawyers delivering trauma-informed representation may therefore find reconciling the two strategies in a single representation challenging.

At the same time, the threshold investigation of trauma is necessary under any valid theory of punishment, as even incapacitation requires proportionality for its just implementation. However, without meaningful defense investigation and advocacy, no one in the justice system will learn the degree to which trauma is mitigating and relevant to imposition of individual penalties. In addition, as a utilitarian matter, justice systems should direct as many resources as possible to minimizing the risk that punishment will damage a defendant and the risk that he will reoffend after serving his sentence. One scholar has suggested that if proportionate retributive punishment of a person with diminished capacity to obey the law is insufficient to protect public safety, then this creates incentive for policymakers to allocate resources toward mental health programs or other noncriminal alternatives that meet both goals.

A second major tenet of my argument is that urging defense lawyers to investigate trauma by no means requires throwing open prison doors. Rather, it reminds defense attorneys of their existing professional obligations to look for and present any information likely to obtain a favorable outcome at their clients' sentencings and highlights trauma as a fruitful source of mitigation. It follows that as advocates adopt trauma-informed practices, courts will consider trauma's salience to criminal behavior. They may then begin to view routine criminal offenses in new light. That change of perspective may in turn lead judges to seek additional and varied sentencing options for traumatized people, many of whom may never have had access to mental health services. After all, if traumatized defendants are left untreated, they may pose a greater threat to public safety than if they are provided meaningful therapeutic interventions. Accordingly, as defense lawyers routinize trauma-informed sentencing practices, individual defendants, their families, their neighborhoods, and the communities we mutually inhabit will reap the benefits of more just punishment and safer streets.

**D. Why Now?**

The current political turning point surrounding punishment is ripe for trauma-informed defense. In fact, today's bipartisan reckoning aimed at correcting America's decades-long over-reliance on incarceration will remain inadequate at best, or completely ineffective at worst, unless reformers come to terms with the principal causes of violent crime. One factor to consider is that people who are victims of or witnesses to physical harm themselves are at far greater risk of harming others (than are those without such exposure). Relentless focus on non-violent drug offenses distract
from the violent-crime sentencing that fuels mass incarceration. Further, no serious effort to reverse decades of over-punishment will succeed until resources are directed to treating the factors underlying the household and community violence that destroys so many families and neighborhoods. Similarly, reversing overreliance on incarceration will require establishing means of treatment and support for traumatized people, even after--perhaps especially when--they are implicated in crime themselves.

*11 For the first time in a generation, reconsiderations of punishment invite changes in the sentencing habits that have driven prison growth. When punishment accounts for trauma, the justice system will have a sound basis upon which to fashion penalties that are more proportionate, in that they heed Justice O'Connor's long-recognized principle. Penalties will also be more effective insofar as they meet the treatment needs of traumatized people to enhance their chances of abstaining from future crime.

Skilled defense work can build this foundation by prying open a window into defendants' adverse life circumstances and highlighting interventions that both prevent harms from recurring for any individual and stop him from revisiting them on others in his community. Defense attorneys need to be at the vanguard of encouraging that redirection of resources by bringing to light in noncapital cases the relevance of their clients' injuries to their criminal involvement. Over time, this work has the power to illuminate roots of serious crime and justify a new punishment paradigm that privileges healing and treatment in order to break the cycle of harm.

This article proceeds in six more parts: first, a review of a number of sources of trauma as well as basic social science establishing how trauma impacts behavior that is centrally salient to culpability; second, a description of policy and doctrinal developments pertaining to the consideration of trauma in noncapital cases; third, an explanation of defense lawyers' professional obligations to investigate and explain the import of trauma in their clients' lives; fourth, a practical primer to trauma-informed defense work; fifth, a description of capital and juvenile life without parole precedent on which defense attorneys should draw in fashioning routine trauma-informed practices; and sixth, a conclusion discussing resources, consequences, and the future of punishment.

II. WHY TRAUMA MATTERS

Constitutional precedent, discussed in later sections, requires that juries or judges consider exposure to violence, childhood abuse and neglect, and even combat trauma in capital and certain juvenile sentencing proceedings. This mandate turns out to be not simply a charitable, Dickensian notion but is empirically well-founded. Social and behavioral science provide sound bases for deepening and expanding consideration of trauma in determinations of punishment. For example, in considering just sentencing of youth, the Supreme Court recognized in *Miller v. Alabama* that “immaturity, impetuosity, and failure to appreciate risks and consequences” are all “incompetencies” that warrant individualized punishment. The maturation pattern of the brain, a factor the Supreme Court considered carefully in deciding the juvenile life without parole and capital cases, continues into young adulthood. Therefore, advocates seeking to relate the reasoning of *Miller* and *Graham* to young adult clients who exhibit trauma-related impairments may have an avenue to do so. They might argue that, to the extent that immaturity and prospects for rehabilitation matter to proportionate sentencing, which they plainly do in the Supreme Court's juvenile cases, they should also matter to the sentencing of young adults whose exposure to trauma has impaired their behavior akin to the neurological immaturity central to the Court's reasoning in *Miller* and *Graham*. 
Moreover, as discussed below, traumatic experiences alter neurodevelopment. Science shows that many traumatized adults exhibit an array of the very same incompetencies Miller enumerated, a fact implicit in capital cases. However, noncapital prisoners have also been exposed to trauma at high rates. For example, in one study, 56% of incarcerated men reported experiencing childhood physical trauma and one-quarter reported being abandoned in childhood. This is no coincidence; decades of scientific research suggest that the effects of trauma can offer persuasive explanations for behavior that brings people into contact with the law.

Finally, a number of philosophical arguments may justify why trauma should mitigate punishment. My arguments are principally pragmatic and empirical. They hinge on the regard we owe to the least advantaged among us, whose deprivations and disenfranchisement arise from--and exacerbate-- the harms described here. They are impoverished and, by design, deprived of basic educational and social services essential to providing the means to shape their circumstances and the legal order governing their lives. Yet the law punishes them for behavior explicable by, indeed arising from, their wretched social conditions. This article's aim is to help expand the lens of culpability by explaining trauma's mitigating force. Effective trauma-informed defense will locate a client's wrongdoing within the social context that harmed him, failed to protect him, and left him with little political or legal recourse over his punishment. It will also make a record demonstrating why a society that fails to afford its constituents basic protection and necessities for a minimally decent life loses moral authority to impose maximum punishment.

A. A Brief History of Traumatology

“Trauma” derives from the Greek for “wound” and is the emotional state that results from experiencing a threat to life or physical wellbeing that overwhelms an individual's ability to cope. Trauma may also result from witnessing, or becoming aware of, an event or events that involve serious threat to others. As described below, trauma sculpts neurology in ways that impact behavior. Many traumatized people cycle between “fight or flight” responses and numbing or shutting down when overwhelmed by stimuli. Psychological symptoms of trauma also include overreactions to perceived threats, anxiety, depression, emotional detachment, and even heightened risk of psychosis.

In the words of Dr. Bessel Van Der Kolk, trauma is not an event limited to a person's past. Rather, it is the imprint that an overwhelming adverse experience leaves on one's mind, brain, and body, and it results in tangible impairments in how people manage and survive daily life.

Some of the earliest scholars of psychiatry and neurology recognized that trauma is at the root of a great deal of emotional disturbance and may cause persistent mental pathology. During World War I, physicians began attributing unusual psychological symptoms appearing among a number of British soldiers to “shell shock” resulting from their exposure to combat violence. The medical treatment of veterans exhibiting symptoms of what psychiatrists came to call Post-Traumatic Stress Disorder (PTSD) continued through the Second World War, but by and large the study of trauma remained dormant thereafter until physicians began treating veterans returning from the Vietnam War, which occasioned something of a renaissance in the awareness and study of trauma. During the 1980s and 1990s, scientific and popular self-help literature further expanded on the understanding of trauma in the contexts of sexual assault, rape, and domestic violence.

In the 1990s, medical doctors Vincent Felitti and Robert Anda conducted a groundbreaking study of the lifetime impacts of trauma. The Adverse Childhood Experiences (ACE) study compiled data on the effects of childhood exposure to a
range of adverse events on 17,421 HMO patients. Doctors Felitti and Anda presented the patients with ten questions about whether they had experienced enumerated ACEs, including verbal and physical maltreatment, sexual contact with an adult, witnessing violence against their mothers, and having parents addicted to drugs or alcohol. Each affirmative answer was worth a point, and each participant would be assigned an ACE score of zero to ten, based on her responses.  

Their results showed that of the two-thirds of respondents who reported an ACE, 87 percent scored two or more. The researchers also noticed a “dose response,” meaning that the more ACEs a patient reported, the greater the toll that persisted into the patient's adult life. That damage included employment difficulties, chronic depression, suicide attempts, addiction, smoking, obesity, unintended pregnancies, and other health problems in rates that increased substantially in correlation to the patients' ACE scores. Moreover, among the survey's respondents, who were “mostly white, middle class, middle aged, well educated, and financially secure enough to have good medical insurance,” only one-third reported zero ACEs, leading Dr. Anda to conclude that child maltreatment is “the gravest and most costly public health issue” in the United States.

Since the 1990s, advances in neuroscience have allowed trauma researchers to learn through neuroimaging that overwhelming adversity alters the physiology of the brain. As described more fully below, trauma fundamentally changes neurobiology, causing psychological symptoms and social maladaptations. Of important note, the effects of trauma are by no means limited to PTSD. In fact, exclusive focus on this diagnosis will miss other profound effects of trauma on people whose symptoms, though debilitating, may fall short of the disorder's clinical definition. Complex trauma, for example, is the developmental consequence and emotional dysregulation resulting from childhood exposure to multiple or prolonged traumatic events. For this reason, this article discusses the significance of trauma symptoms and associated behavioral effects rather than focusing on PTSD as a requirement of sentencing mitigation.

The next section details the compound injuries that often afflict criminal defendants, especially people living in depleted communities. The injuries they survive in their homes and in the public spaces in which they forge their lives enhance their risk of breaking the law.

**B. Geneses of Trauma**

The central concern of this article is the trauma resulting from repeated exposure to violence. For traumatized youth, the idea of traditionally safe havens at home, school, and in their neighborhoods is destroyed. Instead, the impulse to survive endemic violence dictates nearly every aspect of their lives. Scientific evidence such as the ACE study demonstrates that adults who survive early lifetime brutality remain yoked to their formative experiences. After all, their early years are ones in which “the family and home environment ... from which [they] cannot usually extricate--no matter how brutal or dysfunctional” inflict enduring injury. Moreover, for countless criminal defendants, their traumatic exposures take place not only at home--or in many cases, not at home at all--but in communities riddled by violence and bankrupted of resources and social services. African-American youth are nearly three times as likely, and Latino youth are two times as likely, as white children to witness a shooting, bombing, or riot. Black and Latino children are more than seven times more likely to lose a person close to them to murder than are white children. Witnessing assaults, robberies, shootings, and homicides scars children, hampers their social development, and puts them at risk of committing violence themselves. Put another way, for many,
living in particular zip codes equates with inescapable trauma, and advocates ought to explain that trap's mitigating force: a defendant's neighborhood is both evidence of his exposure to violence and his experience of loss, and it is proof of his disenfranchisement. Therefore, any comprehensive explanation of the social context of criminality must account for the role of community environments in introducing and encouraging behavior that offends the law. Even children who do not witness violence suffer the detriments of living in violent communities when they cannot play outside, or “when they must sleep on the floor to be out of range of random bullets coming through the windows of their home.”

In addition, contact with the justice system itself is traumatic. Detained youth suffer the stress of separation from their families and may be subjected to shackling, strip-searches, or solitary confinement. Prisoners of all ages also face physical, sexual, and psychological abuse by correctional officers or other prisoners. Competent defense sentencing advocacy must account for such institutional harm and explain its mitigating force, especially because courts and prosecutors invariably count prior criminal and imprisonment history as a reason for harsher punishment. Without explanation of how those previous justice contacts have contributed to a client’s trauma-related symptoms and behaviors, punishment will compound harm the justice system inflicted in the first place.

Of course, for far too many people, interactions with law enforcement are degrading and brutal. A collective trauma in the aftermath of police killings of civilians hovers in many African-American communities, compounded in recent years many times over. For example, a textbook case of trauma-associated numbing is evident in the remarkable calm Diamond Reynolds displayed in the aftermath of her boyfriend, Philando Castile's, July 2016 shooting death during a routine police traffic stop. Ms. Reynolds was driving the car that her four-year-old daughter and Mr. Castile were riding in when an officer shot and killed him. Ms. Reynolds maintained the presence of mind to film the encounter, and Mr. Castile's death, on her phone and broadcast it live on Facebook. She did so all while responding politely to the officer who had just fired shots into her companion, and as her preschooler looked on and offered her mother words of consolation. Ms. Reynolds later delivered cogent, composed remarks during a press conference. Trauma experts have described her response in the immediate aftermath of the events as typical of trauma-related dissociation.

Some crime victims in violent communities find that law enforcement criminalizes them rather than redressing their injuries. When meaningful police protection is absent, people often substitute self-help organizations, vigilantism, or a complicated code of street justice as a means of maintaining social order. Poverty exacerbates the dangers of violent communities with its own panoply of risks: substandard housing, poor medical care, inadequate schools, malnutrition, family disruption, and the endemic stress underlying a good deal of domestic violence.

* The indifference to the toll violence exacts on poor, usually black or brown, communities aggravates trauma. Individuals and neighborhoods are at once under-protected and over-surveilled, while being choked of resources to ameliorate the damage wrought by years of violence. For example, white families who suffer extreme adversity are more likely to receive private mental health care, while families of color, particularly those with lower incomes, are more likely to be referred to public agencies such as criminal or child welfare departments, which, as noted, often compound harm. On the other side of the coin, Author Jill Leovy has reported that very few of the murders of young African-American men in South Central Los Angeles that she covered as a reporter for the Los Angeles Times were reported in the media, and “[e]ven when cases got some public attention, the tilt often seemed off. Gangs were a big topic, but atrocity, trauma, and lifelong sorrow were not part of the public's vocabulary about ... [the] violence.” Homicides also represent only a small fraction of the pervasive violence plaguing many black and Latino communities.
person killed, several more survive stabbings or gunshots maimed, disfigured, or permanently disabled. Yet, even fewer of those workaday lesser crimes are reported in the media, investigated, or ever solved.  

Such willful neglect, heaped atop contempt used to diminish some murder victims' standing as less than “innocent,” inspires some marginalized young people to transgress the law. Some do so as a form of resistance to a legal system that criminalizes but fails to protect them. Others do so as a means of self- and community protection, or in search of a semblance of dignity and authority. As one group of social scientists has written, “A brother who is shot in a gang shoot-out does not command the same community regard as a brother who is shot in a war.” And yet the consequences for survivors and witnesses may be indistinguishable from trauma symptoms that combat triggers.  

*19 The foregoing was only a sample of conditions that traumatize countless ordinary people. Recounting trauma histories faithful to the experiences of individuals will depend on the thorough defense work recommended in the following sections.  

C. Effects of Trauma  

Regardless of its source, trauma impacts behavior. Understanding how is critical to defense lawyers' effective advocacy on behalf of injured clients. The manifestations of trauma often provide context and explanation for why they broke the law.  

Beginning in the 1960s, psychological literature explicitly linked childhood exposure to trauma and adult criminal behavior, a correlation that social scientists today accept as axiomatic. For example, boys who witness domestic violence are at a sevenfold increased risk of abusing their own partners. In addition, approximately one-third to one-half of severely traumatized people develop addictions to drugs or alcohol. Child sexual abuse is strongly associated with sexual violence in adulthood. Exposure to community violence inspires some young people to join social organizations that they believe will protect them, or to adopt a persona of bravado and ready employ of violence. In fact, gang-involved youth experience PTSD at more than twice the rate of other young people. Dr. John Rich has described some of the young, mostly African-American inner-city patients he treats as associating with gangs as a way “to try to build an identity and to keep from vanishing into invisibility.” Others, already conditioned into compliance by a lifetime of abuse, simply accede to the orders of domineering peers.  

Moreover, children who grow up in chronically violent communities often suffer from symptoms that disrupt their learning and limit their futures: difficulty concentrating because of insomnia and intrusive thoughts; memory impairment; anxious attachment with caregivers; aggressive play mimicking observed behaviors; desperate efforts to protect themselves; adopting tough exteriors to mask their fears; seemingly heedless behavior resulting from their own experiences of hurt and loss; and severe constriction in activities that foster exploration, creativity, and learning for fear of re-experiencing traumatic events. Later, many of these children, after years of being frightened to death and fighting for survival in abusive homes and dangerous streets, grow into adults who develop fatalism, “a narrow horizon of possibilities,” and a foreshortened sense of their own futures.  

In addition to these social maladaptations, trauma affects human behavior by altering neuroanatomy. Experience sculpts the brain. Neural wiring is the substrate of psychology and behavior. Neuroscientists have demonstrated that trauma alters the brain’s pathways that govern: cognition; judgment; impulse control; empathetic understanding; regulation of
emotions; perception of threat; ability to differentiate past, present, and future; and the filtering of information. Early lifetime exposure to trauma activates the brain's stress response in ways that affect brain development and the interaction of neural synapses. The resulting neuropsychiatric vulnerabilities lead to enhanced risk for development of a host of symptoms.

The behavioral impacts of trauma generally fall into two broad categories: hypervigilance (a heightened state of awareness) and dissociation (numbing and detachment). The following are hallmarks of trauma.

1. Hypervigilance and Impaired Judgment

When traumatized people perceive threats, their emotional brains take the reins and supersede their executive functions. Repeated exposure to trauma causes the normal human stress response to become a person's default mode of functioning. The “fight or flight” reaction that is adaptive when someone is actually in danger becomes detrimental to wellbeing when it becomes overactive and eclipses judgment in unwarranted situations. The clinical term for this phenomenon is “hypervigilance.” In lay terms, this means that many traumatized people are wired for survival and likely to erupt at the slightest perceived threat. A traumatized person's intense focus on survival also diminishes his ability to think past the present moment, control impulses, or delay gratification.

2. Numbing

On the other end of the spectrum from hypervigilance is another hallmark of trauma: numbing. Traumatized people often seek escape from the overwhelming realities of their experiences by detaching physically or psychologically. Victims of traumatic events dissociate (detach from their own physical sensations or feel disembodied), “blank out,” or depersonalize--a clinical term for going numb--in order to cope. This detachment can also cause a traumatized person to lose awareness of his own sensations or surroundings, and to fail to protect himself. Dissociation thus results in high rates of revictimization. In fact, victims of violent crime are four times as likely to experience repeat victimization, which increases the risk of harming others. As is true with other trauma symptoms, numbing alone is not mitigating, and in fact, people may lack empathy for myriad reasons that may or may not be mitigating. This is why the advocate's role is, again, critical. The advocate must describe the events that have caused the client's emotional distancing and explain why the client's desensitized affect should not count against him, but rather is a symptomatic reaction to horrible events, and why it should ameliorate his sentence.

3. Difficulty Regulating Emotions and Interpreting Stimuli

Traumatized people expend extraordinary efforts maintaining control and fighting for survival. Trauma also interferes with the brain's gatekeeping functions and ability to filter information, which in turn impairs attention, concentration, and capacity for learning. This hyperarousal may leave them easily distracted at work or at school. It disrupts emotional regulation and the ability to attune to social cues in interpersonal exchanges. It hampers the skills necessary to evaluate and respond appropriately to disagreements. This explains why people who live with violence at home or in their communities have difficulty succeeding in school, which is fundamental to the direction of one's life course. In addition, emotional dysregulation causes some traumatized people to substitute external regulations such as drugs, alcohol, or capitulation to the bidding of others.
Trauma symptoms are frequently misinterpreted as aggression or irritability or labeled as a conduct disorder or antisocial personality disorder (ASPD). Absent a social context explaining antisocial behavior as the result of victimization or other exposure to violence, prosecutors or probation officers often point to these diagnoses as aggravating evidence supporting enhanced punishments. Yet conduct disorders and ASPD are behavioral labels; without consideration of their underlying causes' mitigating force, they may be used to support harsher sentences without justification and without attention to the efficacy of treatment in ameliorating symptoms. Here again, the role of the defense team is critical to explaining why symptoms resulting from traumatic exposure are normal responses to dismal social conditions. These conditions might warrant leniency, particularly given the question of who and what engineered and perpetuated the triggering social context.

4. Difficulty Interpreting Experience

Traumatized people often experience disrupted memories such that past events continue to gnaw at them in the present, and of course, for many, traumatic events are not really in their pasts. The neurological changes wrought by traumatic experiences interfere with people's abilities to interpret and navigate their present experiences. This leaves them on edge, distracted, and saddled with imminent doom, even when they are in no objective danger.

Substance abuse often accompanies this panoply of trauma symptoms which, when layered over the other difficulties, puts people at significant risk of making poor decisions or violating the law.

D. Case Examples

The following vignettes describe how trauma's constellation of symptoms plays out in three criminal justice scenarios.

*23 1. Hypervigilance and Inability to Interpret Social Cues

Symptoms of trauma are likely to manifest in the many instances in which a young man has witnessed friends or family members killed or injured by gun violence and has grown up in a home in which his parents were terrified for his survival. They therefore subjected him to corporal punishment and other harsh methods of discipline in efforts to keep him safe and off the streets. This young man has been mugged in his neighborhood and forced to walk past debilitated drug addicts who hassle him along his way to work. He has become hypervigilant and suffers from a hair-trigger response to any person he believes threatens his physical or emotional integrity. He has started carrying an unlicensed gun for protection. He has used marijuana to cope with his overwhelming anxiety and cocaine to energize him after nights of insomnia. He overreacts when his buddy throws a playful punch while they blow off steam in a bar, which then escalates into a serious fight. This scenario might well result in the young man's arrest for felony assault, drug possession, and illegal possession of a gun. These are serious charges indeed, but ones that, when viewed against the backdrop of the young man's entire life, might make him less blameworthy than someone who commits such acts in the absence of this explicative social history. Explanation of that social history would demonstrate why he is more in need of treatment than incarceration.

2. Impaired Judgment, Dissociation

The impaired decision-making and (often misinterpreted) depersonalization that result from trauma are evident in the case of a young man convicted of an armed attempted robbery and shooting of a storeowner. This example also
illustrates how traumatized people who dissociate are at risk of enhanced penalties for their perceived lack of empathy or appropriate emotional affect. The defendant in this case had lived a life marked by chronic trauma—a violence-riddled housing project; addicted, neglectful, parents; and extreme poverty. He had also survived a freak accident. He had been a talented athlete until he and some friends jumped onto a commuter train. The train caught his leg in the gap while pulling out of the station. Witnesses to the incident described the young man's leg muscles and skin pulling off of his shinbone and his foot being torn from his ankle. Friends accompanying him put the young man's foot into a bucket and took it to the hospital in the hopes that it could be reattached. Instead, the injuries resulted in a partial amputation of his leg.

The train accident ended this defendant's athletic career and also prevented him from performing his role as the man in his family. He had been the protector of his younger siblings, who were living with him and their crack-addicted mother in a large city's notoriously violent public housing project. This defendant's disability left him especially vulnerable in his chaotic neighborhood. In fact, shortly after the train accident, someone assaulted him in the head with a brick. He subsequently obtained a gun to protect himself. Some months later, after managing mobility on an ill-fitting prosthesis, this young man learned of a costlier but possibly more effective prosthesis and hatched a plan to commit a robbery in order to afford it. During the attempted robbery of a convenience store, the store's proprietor brandished a gun; the defendant panicked and fired shots, injuring the storeowner.

Post-conviction review of this defendant's sentencing demonstrated that his defense lawyer, untrained to recognize symptoms of trauma and their effects on behavior, believed that he had no basis for arguing for mental-health mitigation. The lawyer's misapprehension arose in part because of hospital records from the train accident in which medical notes described the young man as matter-of-fact and emotionless in the days following the loss of his leg. Had this defendant's attorney been trauma-informed, he could have hired an expert to explain that this psychic numbing is a textbook trauma symptom, as were the defendant's hypervigilance, impaired judgment, and hair-trigger response during the robbery. Trauma-informed advocacy might have helped this defendant avoid an unnecessarily lengthy prison sentence. It might have helped the court fashion penalties that sanctioned the defendant appropriately while providing him with mental health treatment, physical rehabilitation, employment training for work he could perform despite his injury, and reentry placement into safe, affordable housing with assistance for people with disabilities.

The Supreme Court has recognized that judicial consideration of traits such as “immaturity, recklessness, and impetuosity,” as well as “heedless risk-taking,” and increased vulnerability to “negative influences and outside pressures” is crucial to the imposition of proportionate punishment. Such traits are characteristic of trauma, the effects of which remain salient, impactful, and—if left untreated—perpetual well after an abused child, or one trapped in a violence-torn community, passes the age of majority. In any just sentencing system, people standing punishment should be represented by advocates skilled in explaining these truths.

As the next section describes, however, by law and in practice, courts sentence the vast majority of defendants without any consideration of trauma's demonstrable effects on their behavior.

*25 III. LIMITS ON CONSIDERATION OF TRAUMA IN NONCAPITAL SENTENCING

A. Evolution of De Jure Sentencing Exclusion of Disadvantaged Background

Many noncapital defendants have trauma histories as extensive as those of capital defendants. Yet, beginning in the 1970s, many state and federal jurisdictions jettisoned a longstanding individualized approach to noncapital sentencing. They instead substituted sentencing guidelines, determinate sentencing, and three-strikes laws that brooked
little opportunity for consideration of the defendant's life circumstances once conviction of a particular offense had attached. To this day, evidence of childhood trauma is not ordinarily relevant in determining whether a federal sentence warrants downward departure or variance from the applicable Guidelines range.

Before 1975, most American jurisdictions featured indeterminate sentencing regimes that permitted courts to consider the circumstances, backgrounds, and psychological characteristics that were believed to have contributed to defendants' criminality. Judges had the discretion to fashion penalties that enhanced defendants' prospects for rehabilitation. However, as Professor Kate Stith and her co-author Steve Y. Koh have recounted, concerns about inconsistency and judicial bias, as well as the politicization of crime policy, paved the way for the federal and state sentencing reforms of the late 1970s and early 1980s. During those years, determinate sentencing, whose stated aims were consistency, fairness, and transparency, gained momentum.

A period in which most American jurisdictions enacted some combination of mandatory minimum sentences, truth-in-sentencing, three-strikes, and other determinate sentencing laws followed. In the federal system, as well as in some states, sentencing reform thereby evolved. Modest proposals that were intended to reduce bias by implementing guidelines but that still included a wide range of factors related to the offender and the offense, and that discouraged incarceration, gave way to adoption of determinate sentencing that eliminated virtually any consideration of a defendant's life history in imposition of even the most stringent punishment.

An example from the Federal Sentencing Guidelines exemplifies the by-design exclusion of social history from noncapital sentencing during the determinate era: judges considering downward departures from the Guidelines are forbidden from considering “lack of guidance as a youth and disadvantaged upbringing” in sentencing. In other words, although the federal sentencing statute calls for regard of “the nature and circumstances of the offense and the history and characteristics of the defendant,” the Sentencing Commission affirmatively excludes consideration of social disadvantage and resultant mental and emotional conditions.

The Guidelines' ostensible effort at eliminating sentencing disparities between defendants with more advantaged and less advantaged backgrounds thereby predictably redounded to the detriment of the less fortunate and accelerated the rise in incarceration. If a sentencing policy's aim is reduction of bias favoring social advantage, then eliminating consideration of a defendant's socioeconomic status so that a wealthier defendant gains no benefit from that happenstance at sentencing may be rational. However, it defies explanation how barring consideration of the effects of poverty or other social disadvantage, factors often at the heart of why people break the law, evens the field for poor defendants. In the end, efforts at leveling sentencing have, instead, produced a body of law that diminishes consideration of background necessary for complete assessments of defendants' blameworthiness. It has also deprived courts of information about factors that might help them order penalties that rehabilitate individuals and protect public safety by addressing the conditions underlying their offenses. The net result has been exponential growth of American incarceration.

Before the Supreme Court decided United States v. Booker, making the Federal Sentencing Guidelines discretionary rather than mandatory, defendants relied on U.S.S.G. § 5K2 to argue for downward departures based on mitigating circumstances not accounted for in the Guidelines. The inclusion of § 5K2 was based on recognition that “it is difficult to prescribe a single set of guidelines that encompasses the vast range of human conduct potentially relevant to a sentencing decision.” However, the provision generally required a showing that the mitigation presented was extraordinary and outside the “heartland” of conduct the Guidelines prescribed for certain offenses. Yet, as the
following discussion shows, courts have declined to consider even extreme and brutal abuse to be mitigating in noncapital cases.

B. De Facto Exclusions of Trauma Evidence in Sentencing

This history of sentencing guidelines explains why courts considering noncapital cases involving defendants who have survived even severe and repeated traumatic experiences historically have discounted their trauma histories when considering departures from the Sentencing Guidelines. In fact, some courts affirming sentences imposed without consideration of lifetime adversity have cited the fact that too many people who stand before them convicted of crime have suffered such harms. They have reasoned that the ubiquity of disadvantage in defendants' lives provides little basis for differentiation among them. In one court's explanation:

Childhood abuse and neglect are often present in the lives of criminals. They always affect their mental and emotional condition. We simply cannot agree, therefore, that these are the kinds of considerations which warrant substantial reductions in guidelines sentences .... As this case and others demonstrate, even in noncapital sentencing in which the defendant's trauma rises to the level routinely considered centrally mitigating in capital cases, courts have declined to depart from the Guidelines sentences.

For instance, in United States v. Pullen, Pullen was convicted of armed robbery, and the district court refused to grant a downward sentencing departure based on extraordinary childhood abuse, notwithstanding the following:

The defendant's father was a drunkard and a gambler. He beat his wife and children and threatened them with guns and knives. When the defendant was five years old, his father abused him sexually over a period of several months. [Later, when the defendant was an adolescent living with his father after his parents' divorce,] the two would go out drinking together and once after a bout of drinking his father raped him. He ran away. His troubles with the law escalated.

Pullen's lawyer presented a mental health expert who opined that Pullen's history of abuse resulted in mental disorders that “[were] causative of” his criminal activity, because they “reduce[d] his impulse and behavioral controls and impair[ed] his ability to think and act clearly.” Still, the Court of Appeals affirmed the district court's exclusion of this social history and adherence to the Guidelines sentence.

Even more remarkably, the court concluded that Pullen had not demonstrated that his abuse was so exceptional that he deserved leniency among robbers. Among other reasons, the court cited: a concern that if evidence of a defendant's “miserable family history” were to become a permissible basis for leniency, this would “resurrect” the pre-Guidelines era of discretionary sentencing; “[j]ust as in capital cases ... defense lawyers in run-of-the-mill federal criminal cases would hire [experts] to comb the defendant's personal and family history for evidence of adversity,” which would in turn lead the government to counter with its own experts, which would leave judges with space to “defend any departure, upward or downward, from the sentencing guidelines[.]” The court acknowledged that such a system might be an improvement over the one required by the Guidelines, but one the Sentencing Reform Act prohibited. The court's opinion rings of the concern that exposure to trauma at the root of a great deal of serious crime implicates a fundamental reconsideration
of the means and *29 ends of criminal sentencing. Such reconsideration might gain a foothold should judges and policymakers overcome their fears of too much justice. 142

Perversely, the sacrifice of individualized sentencing has failed to yield the ideal of consistency and fairness. Instead, the exclusion of social history from sentencing consideration has hindered courts from learning the reasons that people break the law. It has prevented consideration of sound bases for proportionate punishment and opportunities for rehabilitation, while still producing disparate outcomes in numerous cases. 143 Rather than seeing the pervasiveness of trauma in case after case as an opportunity to identify and treat a factor underlying many offenses, courts, constrained by guidelines and determinate sentences, have explicitly disavowed its consideration.

A per curiam opinion from Wisconsin, a state with a “truth-in-sentencing” regime and advisory guidelines, exemplifies the point. 144 In 2009, the state Court of Appeals affirmed denial of Tocara D. McClellan's post-conviction motion. 145 McClellan, who pled guilty to one count of armed robbery by use of force, “as party to the crime,” had argued that his trial lawyer was ineffective for failing to present mitigation at his sentencing. 146 At twenty-one, McClellan and three others broke into the home of two women. 147 During the robbery, McClellan put a gun in the mouth of one woman, pistol-whipped her sixteen-year-old son, and threatened to shoot her eight-year-old niece. 148 At sentencing, the trial court expressed confusion as to why McClellan, whose record included only minor juvenile infractions, would be involved in such a violent offense. 149 McClellan's defense lawyer called the crime “very uncharacteristic” of his client, who in turn told the court that he had no explanation for his actions, that his parents had done a “dang good job” with him, and that he “just did something [he] shouldn't have done.” 150 McClellan also said that he was very sorry and that he did not plan for anyone to get hurt. 151 The court considered evidence of McClellan's having attended “special classes” in school and receiving social security benefits for a learning disability along with his lack of significant prior criminal history, and *30 sentenced him to twelve years of prison and eight years of supervised release. 152

In post-conviction, McClellan presented evidence that, beginning when he was ten years old, a family friend, George Geres, repeatedly fondled him. 153 The abuse escalated to rape when McClellan was fourteen, in exchange for which Geres provided McClellan with “drugs, alcohol, and employment.” 154 McClellan also reported that his mother, herself a heavy drug user who allowed Geres to sell drugs from her home, ignored her son's pleas for help, and refused to let his uncle intervene to protect him. 155 McClellan explained in post-conviction that he had not divulged this information to the sentencing court, his defense lawyer, or the author of his pre-sentence investigation report (PSI) because he was afraid Geres would retaliate against his mother, and because he wanted to avoid embarrassing family members attending his sentencing. 156 The trial court nevertheless denied McClellan's post-conviction motion. The court reasoned that it was McClellan's decision to withhold relevant information, rather than his attorney's failure to investigate, and that such an investigation unlikely would have been fruitful in any event, because McClellan's mother and Geres could not have been expected to corroborate his account. 157

Such judicial findings would have been in clear violation of the Constitution had McClellan's been a capital case. 158 In explicit reliance on the fact that it was not, the Court of Appeals affirmed McClellan's sentence and distinguished the Supreme Court's seminal capital mitigation case, Wiggins v. Smith, and the professional norms applicable to capital cases. 159 The court reasoned that there is no professional requirement that defense lawyers conduct “their own investigation, hire private investigators, gather records, interview family members, hire experts when necessary and ask clients difficult questions designed to elicit information.” 160 The court went on to fault McClellan for representing that
he had a good upbringing and failing to reveal, in order to avoid embarrassing his family and to protect his mother, his history of abuse to his lawyer, the trial court, or the author of the PSI. The court further concluded that even if McClellan's lawyer had erred, his mistakes would not have been prejudicial, because McClellan had failed to show that his background might have reduced his culpability for his role in the robbery. Rather, McClellan's history of sexual abuse was discounted as bearing no direct nexus to the offense. Finally, the court held against McClellan his expert's proffer of evidence that he suffered from post-traumatic stress disorder as a result of the abuse and concluded that such evidence of “untreated issues” might have instead been considered aggravating and warranted a longer prison sentence.

The courts' disregard of McClellan's evidence of sexual abuse, gross parental neglect, and resultant mental health consequences is emblematic of several problems with the state of noncapital sentencing. First, this case highlights the urgent imperative for noncapital defense lawyers to improve their own practices. They must evolve professional standards to meet the needs of traumatized clients and catch up to what social scientists and lawyers in other specialties such as juvenile representation have known for years about trauma's impact on brain and behavior. Second, it underscores how trauma-informed representation would replace the notion that clients, uneducated in the law and victims of severe adversity, are responsible for understanding the relevance of their most private and shameful experiences to their criminal cases. Third, it demonstrates the need to educate lawyers, who must in turn advocate before prosecutors, probation officers, and courts, about the specific mitigating relevance of trauma. Actors in the justice system need to learn how exposure to violence affects behaviors essential to any fair consideration of moral culpability. Finally, McClellan establishes why defense attorneys must show courts that treatment for trauma can be effective, its impacts are tractable, and just and effective penalties should include rehabilitation.

As McClellan illustrates, the causes of trauma's detrimental impacts are often the result of life circumstances over which people who subsequently break the law had no control. Defense attorneys must, therefore, in case after case, present evidence explaining how those experiences mitigate their clients' blameworthiness. They need to argue for penalties that will rehabilitate and treat the underlying reasons their clients caused harm. The following sections describe the work that quality trauma-informed defense entails. When done well, such representation will demonstrate to judges and other actors in the justice system that many of the people standing before them have been forced to organize their lives around a logic of survival. That logic governs the way they behave and explains events that bring them into contact with the law. Defense lawyers have the power to present that to courts deciding their clients' futures. The next sections describe why and how defense attorneys should go about providing trauma-informed sentencing representation.

**IV. DEFENSE LAWYERS' OBLIGATION OF TRAUMA-INFORMED SENTENCING ADVOCACY**

*United States v. Booker, Miller v. Alabama,* and other sentencing and policy reforms discussed here signal a resurgence of individualized punishment that accounts for adversity in the defendant's background. Defense attorneys must now adapt their representation to the renaissance of judicial discretion. They need to establish the role that social history mitigation, particularly the effects of trauma, ought to play in the imposition of individualized sentences.

This article urges defense lawyers to pick up this mantle for two principal reasons. First, they have the immediate power to evolve their practices. Second, they are the actors in the justice system with the primary incentive and professional obligation to ensure that their clients' sentencing proceedings are based on an accurate record of all the circumstances that ought to factor into proportionate punishment or weigh in favor of rehabilitation.
lives that support mitigated punishment. They are also required to advocate for the least restrictive penalty possible and to push for appropriate treatment programs as part of whatever sentence is imposed. 171

*33 Practitioners in other professional disciplines, as well as lawyers who represent children, adult victims of domestic violence, immigrants, and veterans, have all recognized the import of trauma-informed practices; yet, criminal defense attorneys have developed no such universal, trauma-informed professional norms or standards of representation. 172 As I suggest in earlier work, likely reasons that defense lawyers have lagged behind other professionals in this area include: some defense lawyers' misconception that the prevalence of plea bargaining renders social history mitigation irrelevant, a wrong-headed notion if ever there was one; lack of resources, time, or expertise in mitigation investigation; courts' and practitioners' narrow adherence to the Supreme Court's "death is different" jurisprudence; and atrophied defense sentencing skills that lay dormant during decades of the Guidelines and determinate sentencing era in which courts adhered to directives to exclude evidence of adversity from sentencing consideration. 173

However, given the frequency with which criminal defendants have themselves been victims of or witnesses to traumatic events, criminal defense lawyers ought to instead stand at the forefront of trauma-informed representation practices. This is particularly essential in light of the long-standing substitution, in many communities, of the criminal justice system for effective delivery of mental health services. 174 Yet, in the absence of a doctrinal imperative, noncapital defense lawyers must seize the initiative themselves to develop trauma-informed practices. Those that blaze the trail will provide models for colleagues to follow suit.

As importantly, the bench needs examples of thorough social history mitigation in order for judges to apprehend the powerful and often overlooked factors, such as abusive homes and violence-torn neighborhoods, that explain many defendants' offenses. As I have described previously, if the trajectory *34 of capital and juvenile life without parole case law is any indication, only after some attorneys evolve their practices will professional norms evolve across jurisdictions and will doctrinal imperative follow. 175

In fact, a sample of noncapital Guidelines-era federal cases demonstrates that even in a sentencing framework in which evidence of life adversity is meant to be excluded, occasional defense presentation of trauma has, at a minimum, forced consideration of a defendant's history of victimization or exposure to violence. In some cases, such defense demonstrations have provided defendants their only chance at persuading courts to depart from determinate sentences. 176 In one federal case, the court of appeals vacated the defendant, B. Roe's, Guidelines sentence for bank robbery based on evidence, including expert testimony, concerning the impact of her mother's boyfriend's abuse: beating her savagely with belts, extension cords, and coat hangers, sometimes daily; routinely raping and sodomizing her; beating her into submission if she resisted; and on at least one occasion forcing her to lie on the basement stairs naked while he urinated in her mouth. 177 At twelve, she ran away from home and lived on the streets. An acquaintance then took her to Las Vegas, where she was forced to work as a prostitute, and she was abused by a series of boyfriends and pimps for fifteen years. One expert report described her as "virtually a mindless puppet." 178 Because of the detailed presentation of Ms. Roe's social history, corroborated by expert reports, the court of appeals possessed a record on which to view her offense in the context of her whole life. On that basis, it ordered the district court to reconsider her sentence in light of the psychological impact of her history of extraordinary childhood abuse and neglect. 179

Attorneys representing veterans in federal proceedings have also in some cases persuaded courts to consider combat trauma a reason to depart downward from the Guidelines. 180 In this context, capital case advocacy in the wake of Porter v. McCollum, a death penalty case in which the defendant was a veteran, discussed in detail infra, explicitly influenced the
Sentencing Commission. After the Supreme Court decided *Porter*, the Sentencing Commission amended the Guidelines to permit consideration of military service at sentencing, when historically, such service was considered “not ordinarily relevant.”  

*35* If defense lawyers had failed in *Roe* and the other cited cases to buck the strictures on judicial consideration of their clients' trauma, their clients would have stood little chance of receiving sentences proportionate to their blameworthiness. Their sentencing judges would never have learned of circumstances that explained the defendants' misdeeds or been provided an opportunity to consider punishment effective at treating the factors underlying their offenses.

Today, there is new momentum for noncapital sentencing mitigation in the wake of *Booker*, *Miller*, and *Graham*. These precedents unquestionably permit more room for courts to consider a defendant's social history in sentencing than has been available under the mandatory and determinate sentencing era of the last forty years.  

In fact, the Supreme Court has announced in strong noncapital dicta that “possession of the fullest information possible concerning the defendant's life and characteristics” is part of a “uniform and constant” federal sentencing principle that “the punishment should fit the offender and not merely the crime,” and therefore treat “every convicted person as an individual and every case as a unique study in the human failings that sometimes mitigate, sometimes magnify, the crime and the punishment to ensue.”  

Yet, the vestiges of the determinate era's actuarial approach to sentencing practice, and decades of the “death is different” doctrine, remain abundantly evident, both in defense practices and in courts' constricted view of textbook mitigation.

The brief contextual history of guidelines and determinate sentencing in this article explains why defense lawyers may have shelved noncapital mitigation practice for several decades and why reinvigorating that practice now operationalizes the underlying moral purpose of discounting punishment for people who have suffered the sorts of trauma described herein. However, in order for defense lawyers to realize their potential to fundamentally shift the punishment paradigm, they will need to provide trauma-informed sentencing advocacy in a wide range of cases, over time and across jurisdictions. There is good reason to do so. No one should be blamed for the accident of birth that lands him in a brutal household or crime-ridden neighborhood. Defense lawyers are obligated to explain why and how those circumstances harm their clients and why sentencers should calibrate their penalties accordingly.

*36* V. WHAT TRAUMA-INFORMED SENTENCING REPRESENTATION SHOULD LOOK LIKE

A. Resources

The recommendations that follow will require resources and funding that are often scarce for attorneys who defend the indigent. For this reason, adequately funded public defender offices accustomed to delivering high-quality, holistic representation and staffed with mitigation specialists will most likely be the first to forge routine trauma-informed defense work.  

Public defender offices seeking to develop such work might borrow from the playbooks of immigration, child welfare, domestic violence, and veterans' advocates. Many face the same resource constraints that public defenders do and yet have managed to grow trauma-informed practices.

As trauma-informed sentencing representation gains traction, courts and probation departments will come to expect that a complete sentencing profile should include exploration of a defendant's trauma history. That profile should include explanation of trauma's impact on the defendant's behavior as well as recommendations for treatment that might best rehabilitate him while adequately protecting the public. As these expectations set in, judges and policymakers ought to be
more amenable to individual attorneys' and indigent defense offices' requests for additional resources to support trauma-informed sentencing mitigation work. Should defense advocacy result in a doctrinal imperative, as it has in capital and juvenile life without parole cases, mandatory provision of mitigation resources for adult noncapital sentencing will follow.  

Law school clinics also present excellent prospects for pioneering best trauma-informed defense sentencing practices because many are better resourced than typical indigent defense offices. The experienced attorneys who lead law school clinics are also dedicated to teaching future lawyers how to provide the best possible representation to their clients. Further, law schools are training grounds for future judges, prosecutors, and policymakers. This positions them well to develop and disseminate training materials and convene gatherings to share their research and practical knowledge of cutting-edge sentencing practice with members of the bench and bar. Finally, universities are home to social scientists, mental health experts, social workers, and cultural historians. This milieu uniquely situates law school clinics to assemble the interdisciplinary teams essential to quality mitigation *37 practices and to build a knowledge bank that will encourage the ongoing study of lives behind America's prison swell.  

B. Practice Primer  

Defense lawyers preparing to investigate their clients' trauma histories will in most cases need to pursue the “holy trinity” of mitigation: collection of records; in-person, one-on-one witness interviews with a range of people familiar with their clients' life experiences; and expert assistance. Witness interviews and life history records should reinforce and corroborate the information garnered from one another. Experts should tie the details together into a cohesive explanation for the impact of traumatic adversity on a client's functioning and behavior. By the same token, mental health evaluations are only as good as the social history undergirding them. For this reason, teams that include mitigation specialists working alongside attorneys are best equipped to gather as complete a social history as possible. Defense advocates must also recognize that trauma symptoms and related behavioral impairments often defy tidy diagnoses. Rather, they are a complex, dynamic group of factors that distort people's reactions and impair their judgment.

Defense attorneys and law students learning to provide trauma-informed sentencing representation will also need to gain and marshal specialized expertise in communicating effectively with traumatized clients. In many cases, trauma symptoms seriously hamper clients' abilities to assist with their own defenses. For example, common trauma symptoms may lead some defendants to be less than forthcoming about their backgrounds or might impair their memories. Their attorneys will need to be trained in how to elicit relevant information while minimizing the risks of re-traumatizing them. This is all the more reason that gathering social history from a diverse set of sources, rather than relying exclusively on the client's own account, is critically important to competent sentencing representation.

In addition, defense lawyers must become aware of the ways in which trauma impacts defendants' experiences of the justice system: their clients may be mistrustful of them; they may encounter difficulty assessing risks and benefits of case-related decisions; they may be disengaged and dissociative; they may have trouble staying focused or accurately recalling events. All of these are textbook symptoms of trauma. Moreover, the imbalance of power inherent in attorney-client relationships may trigger clients who have survived particular types of trauma, such as domestic partner or childhood abuse. For these reasons and others, lawyers seeking to gain the experience necessary to improve their representation of traumatized clients will need to learn what mental health and social service providers can teach them about effective communication with traumatized people. This includes, whenever possible, working on teams with
mitigation specialists and mental health experts capable of gathering clients' life stories while meeting their legal and interpersonal needs. 197

Attorneys, law students, mitigation specialists, and other defense team members committing themselves to presenting their clients' adversities will also need to learn how to protect themselves from the effects of vicarious trauma, or “burnout.” This self-protection is essential to maintaining the stamina and capacity necessary to work effectively on behalf of traumatized clients. 198 Clinical professors teaching law students to investigate and describe clients' trauma histories must, in addition, remain mindful that students themselves may carry backgrounds of serious adversity. They should teach their students to consider ways in which their own histories might impact their work on behalf of clients with similar experiences. 199 Scholars and practitioners have written a good deal about the signs and symptoms of vicarious trauma and prescribed concrete strategies for combatting it, crucial information that any attorney intending to deliver trauma-informed representation should heed. 200

Moreover, judges have well-founded concern about protecting public safety. This means that effective noncapital sentencing representation of traumatized clients will need to persuade courts that the people awaiting sentencing are amenable to treatment, that treatment ameliorates the adverse behavioral manifestations of trauma, and that mental health or rehabilitation *39 programs may in many cases present viable alternatives to incarceration. At the very least, treatment programs ought to be part of any punishment, including prison or jail time, aimed at reducing a traumatized person's risk of recidivism. 201 Otherwise, penal institutions are likely only to compound trauma. 202 Prisons and juvenile detention centers are, after all, all too often their own hotbeds of violence, and in the absence of meaningful educational programs and mental health treatment, it is not unusual for confined people to fill their time with less constructive pursuits. Yet, treatment is demonstrably effective in alleviating the behavioral and mental health consequences of trauma, and the earlier the interventions are deployed, the better the chances that people who have survived harrowing life experiences will escape the cycle of harm. 203

Finally, effective noncapital sentencing mitigation work must demonstrate prospects for rehabilitation. For this reason, capital mitigation, with its emphasis on why a defendant should spend his life in prison as opposed to being executed, will by definition serve as an incomplete model. This implicates the tension between proportionate retributive sentencing and rehabilitative sentencing discussed, supra. In other words, in capital sentencing, the more severely traumatized a client is, the more likely a skilled attorney can persuade a jury to spare his life, because the alternative is usually life behind bars. In noncapital sentencing, evidence of trauma will need to be tempered with realistic treatment prospects that convince a judge that a person can be sentenced proportionally to his culpability without endangering public safety. With that said, the past thirty years of capital defense practice has evolved a sophisticated factual and doctrinal record on which noncapital lawyers may build, as their trauma-informed advocacy begins to shape a new sentencing era. The ensuing section describes that record.

VI. SUPREME COURT PRECEDENT CONCERNING CHILDHOOD ADVERSITY'S RELEVANCE TO SENTENCING

The following case summaries demonstrate the power of detailed individual stories in mitigating even the most serious offenses. The case summaries also illustrate the evolution of the Supreme Court's understanding of trauma. The Court's opinions have become more textured with detail and interwoven with social science as the body of precedent has built over time, providing a powerful roadmap showing how thorough defense advocacy progresses law. Finally, the capital cases stand as formidable precedent for *40 advocates seeking to expand the consideration of trauma histories in other criminal cases, as they have successfully done in the juvenile life without parole context, also briefly summarized below.
A. Case Examples

Beginning with *Eddings v. Oklahoma* in 1982, and later in a trio of watershed cases in the 2000s, *Williams v. Taylor*, *Wiggins v. Smith*, and *Rompilla v. Beard*, the Supreme Court held that death-sentenced petitioners' traumatic backgrounds were bases for mercy that their sentencers were constitutionally obligated to consider. In each case, skilled defense teams assembled the detailed record of adversity each petitioner suffered.

In *Eddings v. Oklahoma*, the Court solidified the principle that, in capital cases, courts must consider any relevant mitigating evidence. Monty Lee Eddings had been convicted of a murder committed when he was sixteen years old. The Court considered evidence of Eddings's “troubled youth” relevant, specifically that: Eddings had “been raised without proper guidance”; his parents had divorced when he was five years old; and he had lived with his mother until he was fourteen “without rules or supervision.” There was “suggestion that Eddings' mother was an alcoholic and possibly a prostitute.” By the time Eddings was fourteen and could “no longer be controlled,” his mother sent him to live with his father whose attempts at discipline “gave way to physical punishment” described as “excessive,” including striking him with a strap or something like it. Testimony showed that Eddings was emotionally disturbed generally, as well as at the time of the crime, and that his mental and emotional development was “at a level several years below his age.” A psychiatrist also testified that Eddings could be rehabilitated by intensive therapy over 15-20 years, and, if treated, “would no longer pose a serious threat to society.”

The Court held that “the background and mental and emotional development of a youthful defendant [must] be duly considered in sentencing.” The Court noted, in particular, the relevance of child abuse and its mental and emotional impact: “[T]here can be no doubt that evidence of a turbulent family history, of beatings by a harsh father, and of severe emotional disturbance is particularly relevant.” Eddings had been “deprived of the care, concern, and paternal attention that children deserve ... raised in a neglectful, sometimes even violent, family background.” As a result, Eddings' “mental and emotional development were at a level several years below his chronological age,” and he suffered from “severe emotional disturbance.” The Court's engagement with Monty Lee Eddings's traumatic social history and related psychological evidence in judgment of his moral culpability laid the foundation for scores of capital and juvenile cases hence.

In the early 2000s, a trio of Supreme Court capital cases dove more deeply into the relevance of childhood maltreatment to moral culpability: *Williams v. Taylor*, *Wiggins v. Smith*, and *Rompilla v. Beard*. In each, the Court overturned the petitioner's death sentence for his trial lawyer's failure, in violation of the Sixth Amendment, to present evidence of brutal childhood abuse. The indelible details with which the Court recounted these petitioners' early years marked an explication of the injuries that was deeper than that of the foundational capital mitigation cases' general descriptions of “troubled youth.”

In the first of the three Sixth Amendment cases, *Williams v. Taylor*, social service records documented that Terry Williams's life began with parents who had been imprisoned for criminally neglecting him and his siblings. His father severely and repeatedly beat him. He had lived in a child welfare bureau's custody while his parents were in prison, including a stint in an abusive foster home. The Court's opinion included a notorious footnote citing Williams's social services records' describing the following:
The home was a complete wreck .... There were several places on the floor where someone had had a bowel movement. Urine was standing in several places in the bedrooms. There were dirty dishes scattered over the kitchen, and it was impossible to step any place on the kitchen floor where there was no trash .... The children were all dirty and none of them had on under-pants. Noah and Lula were so intoxicated, they could not find any clothes for the children, nor were they able to put the clothes on them .... The children had to be put in Winslow Hospital, as four of them, by that time, were definitely under the influence of whiskey. 222

Williams was later found to be borderline intellectually disabled and failed to advance in school past a sixth-grade level. 223

*42 In the second of the three cases, Wiggins v. Smith, Kevin Wiggins's “excruciating life history” 224 began with his mother, a “chronic alcoholic” who “frequently left [him] and his siblings home alone for days, forcing them to beg for food and to eat paint chips and garbage.” 225 Mrs. Wiggins “beat[] the children for breaking into the kitchen, which she often kept locked.” 226 She also had sex “while her children slept in the same bed,” and once forced Wiggins's hand against a hot stove, an injury requiring hospitalization. 227 When Wiggins was six, the state placed him in foster care. There, his first and second foster mothers abused him physically, and his second foster father repeatedly molested and raped him. 228 In another home, his foster mother's sons gang-raped him on more than one occasion. 229 At sixteen, Kevin Wiggins ran away from foster care, and was at times homeless. 230 He was also later sexually abused by his Job Corps supervisor. 231

And in the third of the cases, Rompilla v. Beard, Ronald Rompilla's parents were “both severe alcoholics who drank constantly,” including while his mother was pregnant with him. 232 His father had a “vicious temper” and frequently beat Rompilla's mother, “leaving her bruised and black-eyed.” 233 His parents “fought violently,” and his mother stabbed his father on at least one occasion. 234 Rompilla's father also beat him “with his hands, fists, leather straps, belts and sticks.” 235 Yelling and verbal abuse replaced “expressions of parental love, affection or approval,” 236 and “[a]ll of the children lived in terror.” 237 Rompilla's father locked him and his brother in a “small wire mesh dog pen that was filthy and excrement filled.” 238 The children were isolated, forbidden from visiting other children or speaking to anyone on the phone. 239 The Rompillas lived in a house with no indoor plumbing; Ronald slept in an attic with no heat; and “the children were not given clothes and attended school in rags.” 240 Later testing found that Rompilla suffered from organic brain damage and “an extreme mental disturbance” that impaired several of his cognitive functions. 241

Additional Supreme Court cases illustrate the salience of traumatic life history in capital sentencing. Porter v. McCollum (2009) established an important guideline for consideration of trauma at sentencing in that it faulted  *43 the lower courts for discounting that evidence because Porter was 54 years old by the time of the offense. In doing so, the Court recognized that the effects of trauma reverberate throughout a lifetime. 242 In addition, the Court concluded that even the potentially unhelpful fact that Porter went AWOL more than once during his military service in no way diminished his mitigation, and was, in fact, consistent with the “intense stress and mental and emotional toll” of combat. 243 This recognition, too, evinces a nuanced view of mitigation as complicated, imperfect, and requiring careful engagement with the details of personal adversity. 244
Porter had suffered a “horrible family life,” as well as military trauma including active combat in two “of the most critical ... and horrific” battles of the Korean War, in which his company “sustained the heaviest losses of any troops in the battle, with more than 50% casualties” as well as “mortar, artillery, machine gun, and every other kind of fire you can imagine.” 245 Porter himself was wounded twice. 246 Evidence also showed that he suffered from mental impairment. 247

One more Supreme Court capital case opinion is noteworthy for its painstaking catalogue of a capital defendant's depraved upbringing and its explicit consideration of trauma's psychic and behavioral toll: Justice Sotomayor's ten-page dissent from denial of certiorari in Hodge v. Kentucky. 248 Benny Lee Hodge suffered what the Kentucky Supreme Court called a “most severe and unimaginable level of physical and mental abuse.” 249 The beatings began in utero when Hodge's father beat his mother while she was pregnant with him; he later continued to beat her when Hodge was born, even while she held him, an infant, in her arms. 248 As a youngster, Hodge escaped his mother's next husband by living with step-relatives, “bootleggers who ran a brothel.” 251 His stepfather, Billy Joe, controlled what little money the family had and left them in abject poverty. He beat and raped Hodge's mother, once so severely that she miscarried. He pointed a gun at her and threatened to kill her. “All of this abuse occurred while Hodge and his sisters could see or hear ... [and] following many beatings, [the children] thought their mother was dead.” 252 Billy Joe also molested at least one of Hodge's sisters and often beat Hodge with a belt, leaving imprints of the buckle on his body. 253 Hodge was “kicked, thrown against walls, and punched. Billy Joe once made Hodge watch while he brutally killed Hodge's *44 dog. Another time, Billy Joe rubbed Hodge's nose in his own feces.” 254 Hodge, who had been an average student before Billy Joe entered his family, began stealing around age twelve, commencing years in and out of detention, where he was further subjected to routine physical and verbal abuse. 255 Psychologists who testified in Hodge's post-conviction hearing, and whose opinions the state court credited, explained the damage with which Hodge's extraordinarily violent upbringing stained his development: it left him hypervigilant, in a “constant state of anxiety”; it “taught him that the world was a hostile place,” where he could count on no one else to protect him, “not his family and not society.” He suffered from PTSD and “turned to drugs and alcohol to numb his feelings.” 256

Williams, Wiggins, Rompilla, Porter, and Hodge, all brutalized children, each grew into men who committed horrific murders. 257 Yet the Supreme Court recognized the inescapable salience of their troubled histories to their sentencers' assessments of their moral culpability. The relevance of trauma to sentencing is ripe for extension to noncapital cases, beyond juvenile life without parole, where attorneys have already skillfully demonstrated the applicability of the capital doctrine's logic to juvenile sentences. In Graham v. Florida 258 and Miller v. Alabama, 259 each petitioner's social history and particular life circumstances, including trauma, played a central role in the Court's assessment of his blameworthiness. 260 For example, Evan Miller's “stepfather physically abused him; his alcoholic and drug-addicted mother neglected him; he had been in and out of foster care as a result and had tried to kill himself four times, the first of which when he should have been in kindergarten.” 261 In considering the petitioners' life circumstances in these cases, the Court was clear that children's lack of control over their home environments, combined with their immaturity, require individualized *45 sentencing hearings and consideration of social history before life without parole may be imposed on a juvenile defendant. 262

The opinions in these cases and others actualize Justice O'Connor's principle that people maltreated as children who break the law are not to be judged by the same standards as defendants whose lives are unmarred by such adversity. The cases recognize that childhood trauma may produce lasting developmental and behavioral deficits central to culpability, even where crimes involve the most serious offenses. The capital and juvenile life without parole case law also stands as a
beacon of how defense practice changes sentencing doctrine. They serve as a model for skilled defense lawyers to adopt trauma-informed practice on behalf of clients convicted of less serious crimes.

VII. CONSEQUENCES, RECOMMENDATIONS, AND THE FUTURE OF PUNISHMENT

Defense lawyers are in the best positions to drive sentencing change at this pivotal moment reconsidering the morality and efficacy of American punishment. In addition to developing a robust, accurate account of a client's social history and putting that history into consideration in individual cases, defense lawyers presenting sentencing evidence of their clients' exposure to trauma will achieve several other aims. They will explain how trauma tangibly and empirically damages behavioral domains relevant to culpability and just punishment.\textsuperscript{263} They will show courts that dismissing defendants' exposure to violence as ubiquitous or not extraordinary is unscientific and unjustifiable under any valid penal theory.\textsuperscript{264} They will expose actors in the criminal justice system to a principle that social scientists have accepted for decades: that in order to stem the tide of violent crime, policymakers will need to strengthen social services and bolster institutions meeting the needs of people who have suffered, and are at risk of suffering, the ravages of home and community violence.\textsuperscript{265} They will establish that clients' injuries can be treated to prevent recidivism. Trauma-informed representation will demonstrate the need to redistribute resources toward institutions and methods that prevent and heal, rather than compound, the long-term injuries \textsuperscript{*46} and harmful behaviors that often result from traumatic exposure to violence.\textsuperscript{266}

A number of good-faith objections to trauma-informed defense advocacy deserve consideration, and I propose counters to them in the following paragraph. They include concerns such as that of the McClellan court that noncapital cases will require the resources heretofore reserved for capital proceedings.\textsuperscript{267} Another criticism is that fact-finding in noncapital sentencing will require intensive examination of facts and scientific principles with which courts are not ordinarily familiar. Moreover, how will judges be able to tell whether offenses are really the results of trauma warranting mitigated sentences, or simply bad acts requiring harsher punishment? Finally, even if someone deserves an ameliorated penalty because trauma-induced impairments conditioned his criminal behavior, how will courts ensure public safety?

There can be no question that defense advocacy that forces examination of trauma's role in culpability will be resource-intensive. However, criminal sentencing already exacts high fiscal and human tolls. Except, as it is practiced today, it is also bereft of the moral basis for legitimate punishment. Criminal sentencing is often grossly disproportionate to a defendant's true culpability, lacking as it is routine examination of the defendant's life circumstances.\textsuperscript{268} Given the bipartisan recognition that sentencing reform is overdue, trauma-informed representation is one approach to redistributing resources away from long prison terms and toward prevention and treatment of social conditions that are empirically proven to cause crime.

In addition, until this point, widespread criminal prosecution and lopsided defense advocacy has resulted in cheap, easy conviction and too-often uncontested sentencing.\textsuperscript{269} More robust adversarial sentencing defense will slow the conveyor belt of justice by reducing arrests, diverting more cases to non-criminal disposition, and mitigating plea agreements. Moreover, as courts are repeatedly confronted with evidence of defendants' trauma histories, judges will learn more about trauma's impacts. Over time, they will require less intensive training and education as they develop their own relevant expertise. In addition, testifying experts need not be deployed in every case. Rather, the interdisciplinary team defense approach requires only that defense attorneys consult mental health experts to ensure that they are able to present a persuasive argument in each case. Testifying experts or written reports may be reserved for cases in which they are necessary to explain the complex behavioral impacts of trauma--ones that are not always proximately "causal"--in the context of a criminal offense. I address public-safety concerns in the following sections.
Of course, explanation of the need for trauma-informed defense work provokes the question, “What next?” The following recommendations for change are within immediate reach, but also look ahead, with the expectation that if the modest reforms take hold, a fundamental paradigmatic shift in sentencing will develop.

### A. Recommendations

First, defense lawyers should develop and implement training programs on how to recognize the signs and symptoms of trauma and how to interview their clients and social history witnesses about the sources of trauma and its impact on their clients' lives.

Second, all defense lawyers need to learn the tools that capital defense teams have developed to perform well-documented, scientifically corroborated mitigation. In order to perform this work effectively, public defender offices and court-appointed attorney programs should employ mitigation specialists and provide resources to hire trauma experts and other mental health experts when necessary. Relatedly, departments of public health, social work, psychology, and related disciplines should create and expand education and training of students on how to assist legal teams in integrating trauma-based symptoms into their work. Such programs will broaden the pool of experts trained to work on interdisciplinary teams providing trauma-informed representation to people charged with crimes.

Third, state and local criminal justice agencies should dedicate resources to training police and correctional officers in how to respond to crime with sensitivity to the effects of trauma on both victims and alleged perpetrators. 270

Fourth, legislators should foster the establishment of trauma-informed law enforcement agencies, schools, and detention centers. They should expand funding for mental health centers and community-based rehabilitation programs designed to provide trauma survivors with evidence-based treatments to alleviate their symptoms and help them live law-abiding lives.

Fifth, local, state, and federal prisons should implement trauma assessment and treatment of prisoners in their custody throughout their time in confinement and should provide necessary training for correctional staff and mental health care providers.

Last, judges, prosecutors, and probation officers should also receive training in recognizing the myriad sources of trauma and its impact on physiology and behavior. They then ought to begin accounting for it meaningfully in charging decisions, plea negotiations, sentencing recommendations, and judgments imposed.

### B. Implications for Sentencing Reform

Beyond these immediate interventions, defense lawyers' well-supported arguments about what resources would benefit their clients while enhancing public safety can serve as a catalyst for more fundamental social change. 271

For example, for decades, policies have turned away from rehabilitative programs in favor of penalties emphasizing "just deserts." This has caused courts to prioritize punishment over treatment that might heal criminogenic social problems. Even when judges do seek community institutions to assist defendants with supportive transitions to law-abiding behavior, they are often frustrated by a lack of available options to assist defendants with education, employment, mentoring, or counseling. 272 In addition, a national survey of crime victims' views on crime and punishment shows that they prefer, by a margin of two-to-one, that the criminal justice system focus more on
rehabilitation than on punishment. They also prefer increased investment in mental health treatment over increased investment in prisons and jails, by a margin of seven-to-one. Yet, for the past forty years, prisons have been default repositories for injured people who hurt others. They are ill-equipped to either ameliorate the underlying social conditions that breed violence or to treat its individual consequences effectively. Investing resources into mental health and social interventions for people in the criminal justice system has transformative potential to present courts with viable alternatives to incarceration that will both rehabilitate people and enhance public safety. Moreover, there can be no end to mass incarceration without effective community treatment resources for people who are currently being sent to prison.

Defense lawyering that includes detailed social history will also provide a record of insight into missed opportunities for interventions that might have provided support to traumatized defendants well before they broke the law. For example, the experiences of many defendants will demonstrate that schools, which should be mainstays for traumatized children, have become punitive institutions that too often exacerbate injury and truncate opportunity. The same can be said for community centers that either exclude young people with criminal records or are so closely linked to law enforcement that they serve as extensions of the carceral state. Defense teams can point out the need for refashioning schools and community centers as places where vulnerable youth can learn crucial life skills, including how to manage conflict or how to navigate their lives productively while living with symptoms of trauma. Investing funds in programs such as community schools that provide health care, nutritional, academic, and other social resources to families of school-aged children will also go a long way toward providing the economic and family support that many traumatized people need to lead successful, law-abiding lives.

Finally, competent sentencing representation that identifies the sources of injury to traumatized clients will bring into view widely-tolerated social factors that breed crime and counsel resolution of cases that heals rather than compounds harm. In other words, trauma-informed defense representation has the power to widen the lens of culpability and at the same time encourage courts to stigmatize less and empathize more with people who break the law. This could be the paradigmatic foundation of refashioning punishment.

C. Innovative Models

Criminal justice programs aimed at stemming the cycle of trauma are beginning to gain traction. Organizations such as Common Justice and Crime Survivors for Safety and Justice explicitly base their work on the premise that survivors of trauma are at greater risk of being violent themselves. They offer and advocate for alternatives to incarceration for victims who later commit acts of violence. Crime Survivors for Safety and Justice, for example, has created networks of crime survivors in states and local communities that advocate for legislative reforms to redirect money from prisons into mental health programs, drug treatment, and victims' services. The organization also advocates the creation of trauma centers in neighborhoods with high crime rates. Common Justice offers an alternative to incarceration and a victim service program for both perpetrators and victims of serious violent felonies. This initiative is modeling ways to heal trauma in the criminal justice context by providing intensive treatment to both crime survivors and offenders. These examples of criminal justice reform are replicable and are based on an implicit understanding among many who themselves or whose loved ones have broken the law: the line between victim and perpetrator is all too often fluid, ever-changing, and cyclical.
In addition, around the country, veterans' courts are establishing a trauma-treatment paradigm in criminal proceedings. In veterans' courts, defendants with a history of military service are provided integrated alcohol, drug, and mental health treatment as well as access to primary health care, housing, education, employment, and family counseling programs. Veteran-defendants are also paired with volunteer peer mentors who assist them with life skills, accessing social services, and maintaining sobriety while helping them remain accountable to the treatment court. However, most veterans' courts are limited to non-violent defendants and therefore serve as an imperfect model for meaningful trauma-based criminal justice interventions. Nevertheless, their emphasis on wraparound social services and intensive interpersonal support are worth examining closely as regular criminal courts begin to consider trauma-informed approaches to sentencing.

Adopting nuanced, empirically-based models of how to prevent harm through programs such as those described here offers hope for more effective and just sentencing than the revolving prison doors that have dominated the last forty years of American punishment.

D. Conclusion

In an ode to urban trauma, the poet and lyricist Tupac Shakur, rhymed the following:

... I'm tryin' to make a dollar out of fifteen cents

It's hard to be legit and still pay your rent

And in the end it seems I'm headin' for tha pen

I try and find my friends, but they're blowin' in the wind

Last night my buddy lost his whole family

It's gonna take the man in me to conquer this insanity

It seems tha rain'll never let up

I try to keep my head up, and still keep from getting' wet up
You know it's funny when it rains it pours

They got money for wars, but can't feed the poor

Said it ain't no hope for the youth and the truth is

It ain't no hope for tha future

And then they wonder why we crazy

I blame my mother, for turning my brother into a crack baby

We ain't meant to survive, 'cause it's a setup

*52 And even though you're fed up

Huh, ya got to keep your head up .... 292

These lyrics reflect the foreboding and hopelessness that many of the young people of color who disproportionately populate our prisons and jails lived with in 1993 when the song was written and continue to live with today. The poetry evokes poverty, fatalism, and loss of loved ones--to murder, mental illness, and addiction. The verse captures a fundamental belief that, at bottom, these young people are "not meant to survive." 293 It is about conditions allowed to flourish in poor black and brown neighborhoods that would be unthinkable anywhere else, and the devastation those conditions visit on individual men and women, girls, and boys. It is about the havoc violence wreaks in their communities.

Shakur's poem might have rung hollow to his audience absent his mention of another all-too-common experience of many poor black and Latino men: the intuition that he was "headin' for tha pen." 294 Shakur gave voice to what so many know all too well: poverty, lack of opportunity, and violent loss pave the way to prison. A majority of locked-up people have experienced this potpourri of harms, intensified by the pernicious overlay of deprivation, disenfranchisement, and racial discrimination. 295 The song suggests that the link between trauma and incarceration is obvious to the people who live with both. Yet, the actors in the justice system responsible for defending and judging those people when they transgress the law have mostly been blind to it. This article is about noncapital defense lawyers' responsibility to make
that link clear, to explain to courts how their clients’ adversities have narrowed their opportunities and distorted their choices, how their trauma has fundamentally altered their wiring and impacted their behavior, and to urge sentencers to reshape punishment in its light.

Capital defense lawyers are constitutionally obligated to perform this work. Their noncapital counterparts are not, which means that absent an individual defense attorney's own instinct and initiative, the vast majority of people behind bars are locked up without anyone in the justice system knowing a thing about the context in which they broke the law, a backdrop all too often marked by their own victimization at home or on the streets.

*53 Dr. John Rich has eloquently described the mutual benefits of a treatment and service-based approach to the root causes of violence:

> [W]e must focus on their safety: the very people we have blamed for making the community unsafe. We are only as safe as they are. The same safety that we desire, they desire. If we believe that locking them up, brutalizing them in the homes where they live, in the streets where they walk, in hospitals where they seek care, will make us safer, we are sorely mistaken. But if we see our fates and our community as directly tied to them, then we will fight the free flow of firearms, oppose more brutal policing, advocate for greater opportunities for meaningful work, and engage them as full partners in both understanding and addressing the problems that grip the communities in which they live. 296

Put simply, for both just and pragmatic reasons, when a person stands punished, by a legal system over which he has no influence, the fact that he experienced overwhelming adversity arising from social conditions over which he had no control should affect the way that he is judged. Defense attorneys are in the best position to amplify this principle and bring it to the fore by learning about and persuading courts of the powerful salience of trauma in their clients' lives.

In case after case, defense lawyers can and ought to advocate for sentences that heal their injured clients. They must make persuasive arguments locating their clients' actions in the cipher of impoverished, brutal homes and neighborhoods over which they had no choice of occupation, mitigating their blameworthiness, and explaining what treatments they need to heal. Then, the urgent imperative for social investment will become clear, and a new dawn of rehabilitation, compassion, and mutual safety will gain a chance to take hold. 297

Footnotes

1 The title of this article is inspired by Dr. John Rich's adoption of psychiatrist Dr. Sandra Bloom's observation that many of the young African-American men that their medical practice in Philadelphia treats for physical and emotional effects of violence have been pathologized and punished, but never recognized as wounded and in need of healing. Doctors Rich and Bloom invite a reconsideration of these young men as being neither sick nor bad, but injured. See JOHN A. RICH, WRONG PLACE, WRONG TIME: TRAUMA AND VIOLENCE IN THE LIVES OF YOUNG BLACK MEN 66 (2009). Dr. Rich writes that regarding the young men as injured “does not relieve them of their responsibility [for their own perpetuation of violence]; we merely recognize all the poverty and loss and violence and hopelessness that made them see the world as they do. It implies that all of us bear responsibility for understanding why they got injured and how to prevent it from happening again.” Id. (emphasis added).

2 Clinical Associate Professor of Law, Yale Law School. Many thanks to Taylor Henley for her substantial research assistance with this piece and to Jean-Paul Jacquet, Miriam Becker-Cohen, Kate Logue, Mark Birhanu, and Bertolain Elysee, for their
research assistance as well. I am also indebted to my colleagues at Yale Law School who provided me with insightful feedback, especially Fiona Doherty, James Forman, Jr., Heather Gerken, Douglas Kysar, Tracey Meares, Jean Koh Peters, Claire Priest, Judith Resnik, Kate Stith, Michael Wishnie, and Gideon Yaffe.


7 Relatedly, why not advocate an across-the-board discount instead of individualized consideration of mitigation? One reason is that individual circumstances may warrant varying degrees of leniency, even if advocacy succeeds in lowering baseline minimum sentences. In other words, even if legislation requires a five-year discount for sexual abuse, that might not fully account for the mitigating force of an individual defendant’s history. In addition, depersonalized noncapital sentencing is the current norm, one that has fueled unprecedented incarceration rates. Robust mitigation presentations, as opposed to parole-style checklists identifying factors in a person’s background, at a minimum provide a sentencer the opportunity to consider a nuanced explication of the interrelated factors shaping the defendant’s behavior and why the mitigation is relevant to proportionate punishment. Finally, sentencing reforms hewed toward uniformity have not historically benefitted the disadvantaged, whose improved sentencing outcomes are a primary goal of the proposals here. See Kate Stith & Steve Y. Koh, The Politics of Sentencing Reform: The Legislative History of the Federal Sentencing Guidelines, 28 WAKE FOREST L. REV. 223, 266-67, 287 (1993); see id. n. 398 (citing sources); MICHAEL TONRY, SENTENCING FRAGMENTS 137 (2016); see id. at 153-54.


9 See id. at 21-22.

10 Innocence and racial profiling litigation, for example, have been the driving forces behind policy changes in those areas. See, e.g., 34 U.S.C. § 40727 (West 2017), the Kirk Bloodsworth Post-Conviction DNA Testing Grant Program (passed after high-profile DNA exoneration of Mr. Bloodsworth); FLA. STAT. ANN. §§ 961.01-961.07 (2008), passed in response to litigation by an exoneree and permitting compensation to the wrongfully convicted; Annie Cheng, The Importance of Recognizing Trauma Throughout Capital Mitigation Investigations and Presentations, 36 HOFSTRA L. REV. 923, 930-31 (2008); see id. at 927; Craig Haney, The Social Context of Capital Murder: Social Histories and the Logic of Mitigation, 35 SANTA CLARA L. REV. 547, 573 (1995); James E. Reavis, Adverse Childhood


15 See Whitten, supra note 14; Samantha Buckingham, Trauma Informed Juvenile Justice, 53 AM. CRIM. L. REV. 654 (2016); Listenbee, Jr., supra note 14, at 141 A poignant example of the excruciating toll that neighborhood gun violence takes on families can be found in a recent article describing a project in which parents of young people killed by firearms have compiled an online yearbook, akin to a school yearbook, with photos and stories describing their lost children. See Noah Remnick, Yearbook Project Collects Stories of Children Killed in Shootings, N.Y. TIMES (June 19, 2016), https://www.nytimes.com/2016/06/20/nyregion/yearbook-project-collects-stories-of-children-killed-in-shootings.html.


17 Listenbee, Jr., et al., supra note 14, at 141-42.


19 See Reavis, supra note 13, at 44-48; see JILL LEOVY, GHETTOSIDE: A TRUE STORY OF MURDER IN AMERICA 35 (2015) (reporting some survivors of homicide victims as describing their “worst spells of grief [taking place] two, or five, or twenty years after the murder”).


21 See TONRY, supra note 7, at 208; see also Kate Stith & Jose Cabranes, Judging Under the Federal Sentencing Guidelines, 91 NW. U. L. REV. 1247, 1252 (1997) (“We take as an established truth of our constitutional order that the criminal justice system exists not only to protect society in a reasonably efficient and humane way, but also to defend, affirm, and, when necessary, clarify the moral principles embodied in our laws.”).

22 See ALLIANCE FOR SAFETY & JUSTICE, CRIME SURVIVORS SPEAK: THE FIRST-EVER NATIONAL SURVEY OF CRIME VICTIMS’ VIEWS ON SAFETY AND JUSTICE 21, 28 (2016) (reporting that 52% of over 800 crime victims surveyed believe that prison makes people more likely to commit crimes and prefer, by a margin of seven-to-one, investment in social services and programs that prevent crime).

23 Another concern is that more individualized sentencing will encourage the proliferation of victim impact statements at routine sentencings. However, even absent robust mitigation presentations, victims are permitted and even encouraged to make impact statements in noncapital cases. They do so daily in state and federal courts around the country. Douglas E. Beloo, Constitutional Implications of Crime Victims As Participants, 88 CORNELL L. REV. 282, 286, 299 (2003); Paul G. Cassell, In Defense of Victim Impact Statements, 6 OHIO ST. J. CRIM. L. 611, 615 (2009); Kevin T. Wolff & Monica K. Miller, Victim and Execution Impact Statements What Judges Should Know About Case Law and Psychological Research?, 92 JUDICATURE 148, 150 (2009).

24 See Stith & Cabranes, supra note 21, at 78-79; Richard S. Frase, Punishment Purposes, 58 STAN. L. REV. 67, 73 (2005); see also H.L.A. HART, PUNISHMENT AND RESPONSIBILITY: ESSAYS IN THE PHILOSOPHY OF THE LAW 25
For example, quality educational opportunities and access to the political process are both essential to exerting control over one's community and environment. Yet, throughout the United States, pockets of multilayered disenfranchisement persist and deprive their residents of basic social entitlements crucial to living a minimally successful life. See, e.g., Nikole Hannah-Jones, The Problem We All Live With, THIS AMERICAN LIFE (Jul. 31, 2015), https://www.thisamericanlife.org/radio-archives/episode/562/the-problem-we-all-live-with (describing the recalcitrance of school segregation in Missouri); Anthony V. Alfieri, Inner-City Anti-Poverty Campaigns, 18 (Univ. Miami Legal Studies Research Paper No. 17-16, 2017), https://ssrn.com/abstract=2962041 (describing interlocking banking and federal housing policies that shut African Americans out of prosperous residential housing and skilled labor markets); David Dante Troutt, Trapped in Tragedies: Childhood Trauma, Spatial Inequality and Law, 5, 6, http://ssrn.com/abstract=2948001.

25 See Frase, supra note 24, at 75-76.


28 See Frase, supra note 24, at 81.


32 See E. Ann Carson, Prisoners in 2014, U.S. DEPARTMENT OF JUSTICE OFFICE OF JUSTICE PROGRAMS: BUREAU OF JUSTICE STATISTICS 1 (Sept. 2015), http://www.bjs.gov/content/pub/pdf/p14.pdf (“Violent offenders made up 54% of the state male prison population at yearend 2013[.]”); James Forman, Jr., Racial Critiques of Mass Incarceration: Beyond the New Jim Crow, 87 N.Y.U. L. REV. 21, 46-49 (2012); TONRY, supra note 7, at 206; JOHN F. PFAFF, LOCKED IN: THE TRUE CAUSES OF MASS INCARCERATION AND HOW TO ACHIEVE REAL REFORM 3, 5-6 (2017) (“In reality, only about 16 percent of state prisoners are serving time on drug charges--and very few of them, perhaps only around 5 or 6 percent of that group, are both low level and nonviolent. At the same time, more than half of all people in state prisons have been convicted of a violent crime. A strategy based on decriminalizing drugs will thus disappoint--and disappoint significantly. Yet we see little to no efforts to reform the treatment of people convicted of violent crimes.”); see also id. at 11-12 (“[A]lmost all the people who actually serve long sentences have been convicted of serious violent crimes. To make significant cuts to state prisons, states need to be willing to move past reforms aimed at the minor offender and focus much more on the (far more politically tricky) people convicted of violent offenses.”).
34. cf. THE WHITE HOUSE, OFFICE OF THE PRESS SECRETARY, REMARKS BY THE PRESIDENT AT THE NAACP CONFERENCE, July 14, 2015 (noting the human and fiscal cost of America’s high incarceration rate and describing bipartisan efforts to reduce prison populations in state and federal prisons, yet asserting that violent criminals belong behind bars, even though “they may have had terrible things happen to them in their lives”).

35. See RICH, supra note 1, at 200 (endorsing an approach to trauma treatment that addresses the underlying causes of entrenched social problems).

36. See TONRY, supra note 7, at 202.


39. 132 S. Ct. 2455, 2468 (2012). Individuals of course experience the effects of traumatic exposure differently, and many are resilient or fortunate enough to have protective caregivers, community institutions, or resources that help counterbalance trauma’s harms. Nevertheless, these symptoms are well-documented and common responses to traumatic stress that warrant consideration when a person is being criminally punished.


43. See Wayland, supra note 13, at 927 (“There is an enormous body of literature from multiple fields--epidemiology, psychology, psychiatry, developmental psychopathology, and neuroscience--that clarifies the process by which exposure to psychological trauma leads to a host of devastating psychological and behavioral consequences--including violence--through multiple common pathways.”).

44. See Nancy Wolff & Jing Shi, Childhood and Adult Trauma Experiences of Incarcerated Persons and Their Relationship to Adult Behavioral Health Problems and Treatment, INT. J. ENVIRON. RES. MENTAL HEALTH, 1909 (May 2012), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3386595/.

45. Haney, supra note 38, at 881.


47. For many, disenfranchisement arises directly from criminal justice involvement: 5.8 million Americans and one in thirteen African Americans are barred from voting because of a felony conviction. Jean Chung, Felony Disenfranchisement: A Primer, THE SENTENCING PROJECT (2016), http://www.sentencingproject.org/publications/felony-disenfranchisement-a-primer/.
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49 See Troutt, supra note 25, at 11 (describing how poverty elevates the risk of childhood exposure to events like sexual abuse or death of a loved one and how lack of access to therapeutic services means fewer resources to cope with post-traumatic behavioral consequences).

50 See Atiq & Miller, supra note 8, at 180 (citing Victor Tadros, Poverty and Criminal Responsibility, 43 J. VALUE INQUIRY 391, 393 (2009)).


53 See VAN DER KOLK, supra note 32, at 21.

54 For a comprehensive history of traumatology, see id. at 145-49, 179, 183-91.


58 VAN DER KOLK, supra note 32, at 147, 150.


60 See COURTOIS & FORD, supra note 27, at ix.
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See Buckingham, supra note 15, at 654, n.75.

GARBARINO, ET AL., supra note 18, at 83.

Miller v. Alabama, 132 S. Ct. 2455, 2468 (2012). The ACE study showed that “the impact of trauma pervaded these patients’ adult lives.” VAN DER KOLK, supra note 32, at 148.

See GARBARINO, ET AL., supra note 18, at 49 (“In dangerous inner-city neighborhoods, violence is an almost daily occurrence ... [T]he longer the violence continues, the fewer sources of support children [living in those neighborhoods] have to draw on. All this is compounded in inner-city environments by poverty, family disruption, and community disintegration.”); see id. at 50.


See Troutt, supra note 25, at 6, 11-12; Alfieri, supra note 23, at 23-24.

See Haney, supra note 38, at 863.

GARBARINO, ET AL., supra note 18, at 51.


See Claudia Rankine, The Black Condition Is One of Mourning, N.Y. TIMES MAG., June 22, 2015 (“I asked another friend what it's like being the mother of a black son. ‘The condition of black life is one of mourning,’ she said bluntly .... [T]here really is no mode of empathy that can replicate the daily strain of knowing that as a black person you can be killed for simply being black: no hands in your pockets, no playing music, no sudden movements, no driving your car, no walking at night, no walking in the day, no turning onto this street, no entering this building, no standing your ground, no standing here, no standing there, no talking back, no playing with toy guns, no living while black.”).


VICTOR M. RIOS, PUNISHED: POLICING THE LIVES OF BLACK AND LATINO BOYS 57 (2011); id. at 76-78 (describing a young man's near-fatal stabbing and subsequent police interrogation and branding him a gang member after the assault, despite the lack of any evidence before he became a stabbing victim that he was affiliated with a gang); see id. at 121.

See ELIZABETH HINTON, FROM THE WAR ON POVERTY TO THE WAR ON CRIME: THE MAKING OF MASS INCARCERATION IN AMERICA 9 (2016); see also LEOVY, supra note 19, at 41; Paul Schwartzman, In a City Poisoned...
The relationship between family disruption and community violence is complicated. As Dr. John Rich has observed, “Fragmentation of urban families, while often attributed to lack of responsibility on the part of the father, may have significant roots in trauma itself. We know that traumatized people can find it difficult to connect to loved ones and to feel. We also know that in the setting of poverty and lack of opportunity young men may find it difficult to fulfill their responsibilities, even if they desire to do so.” RICH, supra note 1, at xiv. Moreover, parents’ concerns about neighborhood violence can contribute to punitive parenting; anxious parents impose harsh discipline on their own children in desperate attempts to keep them safe. See TA-NEHISI COATES, BETWEEN THE WORLD AND ME 16-17 (2015).

See LEOVY, supra note 19, at 252 (“Take a bunch of teenage boys from the whitest, safest suburb in America and plunk them down in a place where their friends are murdered and they are constantly attacked and threatened. Signal that no one cares, and fail to solve murders. Limit their options for escape. Then see what happens.”); COATES, supra note 77, at 84-85.

See Feierman & Fine, supra note 71, at 5.

LEOVY, supra note 19, at 37.


LEOVY, supra note 19, at 49.

RIOS, supra note 75, at xv, 39, 59, 104.

GARBARINO, ET AL., supra note 18, at 125; see also RICH, supra note 1, at 7 (“Unless a group of black men had been shot or violence had spilled out into the street and injured someone else (generally assumed to be innocent), the shooting of a young black male was not news.”).

See GARBARINO, ET AL., supra note 18, at 44, 47 (reporting Chicago statistics of school-aged children who had witnessed or been victims of violence). Violent crime in certain Chicago neighborhoods continues to dominate daily experience, some twenty-four years after Garbarino, et al. analogized it to a combat zone. See Monica Davey, A Weekend In Chicago, N.Y. TIMES, June 4, 2016 (describing “a level of violence that has become the terrifying norm” in primarily black and Latino neighborhoods in Chicago's South and West sides); see also Ford Fessenden & Haeyoun Park, Chicago's Murder Problem, N.Y. TIMES, May 27, 2016; LEOVY, supra note 19, at 90 (describing residents of Watts as perceiving themselves to be in a war zone, gang members calling themselves “soldiers,” and a protest banner labeling the neighborhood “Little Baghdad”). Of course, a great deal of violence never comes to the attention of law enforcement, the press, or health care providers at all. Therefore, violence in any community is bound to be underreported.

Haney, supra note 38, at 856-57.


See VAN DER KOLK, supra note 32, at 329.


See GARBARINO, ET AL., supra note 18, at 65, 66; RIOS, supra note 75, at 54-55.

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92 RICH, supra note 1, at 66; see id. at 203; see also RIOS, supra note 75, at 1.

93 See LEOVY, supra note 19, at 96; see id. at 181-82.

94 See GARBARINO, ET AL., supra note 18, at 56.

95 See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 2000); RICH, supra note 1, at 67.


97 See VAN DER KOLK, supra note 32, at 58-63, 68-70.


99 See id.


102 See Effects of Complex Trauma, supra note 100.


104 Listenbee, Jr., supra note 14, at 171.

105 See Buckingham, supra note 15, at 675; see also RICH, supra note 1, at 92-97, 101 (describing the numbness of a young man whose cousin was murdered as suffering “broken” emotions akin to a broken leg, such that love and fear were replaced by emptiness and anger).

106 See ALLIANCE FOR SAFETY & JUSTICE, supra note 22, at 7; see also COURTOIS & FORD, supra note 27, at 4.

107 See VAN DER KOLK, supra note 32, at 70.

108 See Effects of Complex Trauma, supra note 100.

109 Listenbee, Jr., supra note 14, at 172.


111 Richard G. Dudley, Jr., Childhood Trauma and Its Effects: Implications for Police, NEW PERSP. POLICING BULL. (U.S. Dep't of Just., Nat'l Inst. of Just.), 2015, at 8.
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112 See Feierman & Fine, supra note 71, at 9.

113 See Wayland, supra note 13, at 947.

114 See Epstein & Gonzalez, supra note 14, at 18; Feierman & Fine, supra note 71, at 5.

115 See Bremmer, supra note 101.


117 The first vignette is hypothetical; the second is based on an actual case in which I have changed some facts.

118 See Wayland, supra note 13, at 947; see also Stuart L. Lustig, Symptoms of Trauma Among Asylum Applicants: Don't Be Fooled, 31 HASTINGS INT’L & COMP. L. REV. 725, 729-30 (2008).


122 TONRY, supra note 7, at 51.

123 See Stith & Cabranes, supra note 21, at 1253-54, 1265. Without a doubt, the American approach to indeterminate sentencing included features that posed significant risk to defendants, principally virtually unchecked judicial and correctional discretion and nearly non-existent burdens of proving evidence relied on for imposition of a particular sentence, such that “sentences [were] often based at least in part on inaccurate information.” TONRY, supra note 7, at 55. Reliance on offenders' criminal histories, including conduct for which they have never been convicted, in calculating sentences is also a vestige of the indeterminate era that persisted under the Guidelines and tends to result in longer sentences. See id. at 57-58, 62-63, 70, 73.

124 TONRY, supra note 7, at 73.

125 See Stith & Koh, supra note 7, at 250-51. “Tough on crime” politics were by no means the exclusive province of conservatives. Liberal politicians dating back to the 1960s conflated anti-poverty programs with carceral ones as a reaction to the civil rights movement and related urban unrest. See HINTON, supra note 76, at 8, 11.

126 TONRY, supra note 7, at 155; Stith & Cabranes, supra note 21, at 1258 (“[E]ven in the extraordinary case, personal background information about the defendant is never required for the sentencing decision, because departure from the Guidelines is itself never required.”); see id. at 1263; see also id. at n. 141 and accompanying text; U.S. SENTENCING GUIDELINES MANUAL § 5H1.12 (U.S. SENTENCING COMM’N 1995).


See Stith & Koh, supra note 7, at 266-67, 287; id. at n. 398 (citing sources); Stith & Cabranes, supra note 21, at 1276; id. at n. 141 and accompanying text; TONRY, supra note 7, at 137, 153-54.


543 U.S. 320 (2003) (“In extreme circumstances, a court may depart downward where extreme childhood abuse caused mental and emotional conditions that contributed to the commission of the offense.”).

U.S. SENTENCING GUIDELINES MANUAL § 5K2.0  background (U.S. SENTENCING COMM’N 2012) (internal citations omitted); see also Brian Porto, Construction and Application of U.S.S.G. § 5H1.3, Concerning Mental and Emotional Conditions as Ground for Sentencing Departure, 34 A.L.R. Fed.2d 457, at *2 (2009); see also Stith & Cabranes, supra note 21, at 1277-78.

See U.S. SENTENCING GUIDELINES MANUAL ch. 1, pt. A, introductory cmt. (2002) (describing the Commission's intent that the sentencing courts treat each guideline as carving out a “heartland” or typical cases embodying the conduct that each guideline prescribes); U.S. SENTENCING GUIDELINES MANUAL § 5K2.0 background (U.S. SENTENCING COMM’N 2012).

As discussed, infra, in cases where defense lawyers have challenged the Guidelines' exclusion of evidence of trauma and made a strong record of “extraordinary” abuse, courts have considered evidence of trauma in downward departures. Moreover, selection bias in the sampling of cases is inevitable because, by definition, the only cases that will be appealed are those in which defense lawyers have made a record challenging sentencing guidelines' application. There is no way to document the untold hundreds of cases in which no such defense advocacy accompanied sentencing, as has been the norm.

See United States v. Deigert, 916 F.2d 916, 918-19 (4th Cir. 1990); United States v. Vela, 927 F.2d 197, 200 (5th Cir. 1991).

Vela, 927 F.2d at 199 (internal quotation marks and citations omitted).


See United States v. Pullen, 89 F.3d 368, 371-72 (7th Cir. 1996).

See id. at 369.

See id. at 369-70.

See id.

See id. at 371-372.


See Wis. Stat. § 973.01.

See State v. McClellan, 2009 WI App 56, ¶ 21, 317 Wis. 2d 732, 768 N.W.2d 63.

See id. at ¶ 2.

See Offender Detail, Tocara D McClellan, WIS. DEPT OF CORRECTIONS, http://offender.doc.state.wi.us/lop/searchbasic.do (search last name field McClellan, first name field Tocara) (listing Tocara McClellan's birth year as 1982).

McClellan, 2009 WI App at ¶ 2.

Id. at ¶ 3.

Id.

Id.

Id.

Id. at ¶ 5

Id.

Id. at ¶ 6.

Id.

Id. at ¶ 7.


See Smith, 539 U.S. 510; McClellan, 2009 WI App at ¶ 13-14, 21.

See McClellan, 2009 WI App 56 at ¶ 713. The court also declined to establish such a professional obligation. See id. Under Strickland v. Washington, 466 U.S. 668 (1984), a post-conviction petitioner alleging ineffective assistance of prior counsel must establish his previous lawyers' deficient performance as well as prejudice, or a reasonable probability of a different result had trial counsel not committed the claimed errors.

See McClellan, 2009 WI App at ¶ 15.

See id. at ¶ 18.

See id. at ¶ 19.

See COURTOIS & FORD, supra note 27, at 23; see also Jessica Chaudhary, Memory and Its Implications for Asylum Decisions, 6 J. HEALTH & BIOMEDICAL L. 37, 40 (2010).

See VAN DER KOLK, supra note 32, at 38 (discussing the rehabilitative potential of people who have suffered the symptoms of trauma).

Of course, nearly everyone experiences serious emotional distress as a result of unexpected events at some point in life. Research shows, however, that harms inflicted intentionally by other people, particularly caretakers, are more psychologically complex than trauma resulting from natural disasters or accidents. Exposure to trauma resulting from abuse and neglect produces long-lasting, but treatable, effects that often explain why people later violate the law. See COURTOIS & FORD, supra note 27, at 3.

168 RICH, supra note 1, at 201.


170 In federal sentencing, probation officers have also played a substantial role in determining terms of punishment. See Stith & Cabranes, supra note 21, at 1249. Before the Guidelines, probation reports included personal history and circumstances of the defendant. See id. Post-Booker, that information is again salient to probation departments' sentencing recommendations. However, as the professional guidelines for defense lawyers make clear, the defense remains obligated to ensure that probation reports are accurate and complete, which means providing social history mitigation to probation officers. See AMERICAN BAR ASSOCIATION, CRIMINAL JUSTICE SECTION STANDARDS: DEFENSE FUNCTION Standard 4-8.3(a), (d), (e), (g) (February 2015), http://www.americanbar.org/groups/criminal_justice/standards/DefenseFunctionFourthEdition.html.

171 The relevant ABA standards establish a duty to investigate all relevant facts, to present all reasonably available mitigation, and to suggest alternatives to incarceration after exploring employment, educational, and other community programs; if a prison sentence is imposed, defense counsel has a duty to seek the court's recommendation of a place of confinement that includes appropriate treatment and counseling. See American Bar Association, Criminal Justice Section Standards, supra note 170.


173 See Gohara, supra note 6, at 70-81, 83.

174 See KiDeuk Kim, et al., *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System*, URBAN INSTITUTE 1 (2015), file:///C:/Users/msg52/Article/Sources/Taylor%20Sources/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf (noting that severe mental illness affects nearly one-quarter of the United States correctional population, including people in prisons, jails, and on probation); see also Sarah Varney, *By the Numbers: Mental Illness Behind Bars*, PBS (2014), http://www.pbs.org/newshour/updates/numbers-mental-illness-behind-bars/ (reporting that in state prisons, 73 percent of women and 55 percent of men have at least one mental health problem; in federal prisons, 61 percent of women and 44 percent of men do; and in local jails, 75 percent of women and 63 percent of men do).
In both the capital and juvenile life without parole context, litigation of individual cases has forced courts to address the sentencing standards and inclusion of relevant information that will satisfy the Eighth Amendment. See Gohara, supra note 6, at 51-52, 54 (describing the evolution of capital mitigation practice in the wake of Supreme Court Eighth Amendment decisions and citing sources); see also, e.g., Miller v. Alabama, 132 S. Ct. 2455, 2465 (2013); Graham v. Florida 560 U.S. 48, 53 (2010).


United States v. Roe, 976 F.2d 1216, 1218 (9th Cir. 1992).

Id.

Id

See Wieand, supra note 55, at 251-52.

Id. at 255-56, 262-63.


Gohara, supra note 6, at 81-84.

Social history mitigation, including documenting and describing the effects of trauma, can provide a powerful explanation but never an excuse for criminal conduct. See RICH, supra note 1, at 198, 199.

See Gohara, supra note 6, at 72-73.

See, e.g., Ake v. Oklahoma, 470 U.S. 68 (1985) (holding that capital defendants are entitled to funding for expert assistance in sentencing proceedings).

See Mundy, supra note 169, at 62-70 (describing opportunities to discover social justice and develop cross-cultural awareness); Katz & Haldar, supra note 51, at 373-81 (describing benefits of teaching social justice principles and client-centered lawyering).

See Gohara, supra note 6, at 73 (citing sources). In fact, Yale School of Medicine's Child Study Center has pioneered a program to increase police awareness of children exposed to violence and other trauma and to increase clinical services available to families that have survived traumatic events. See Dudley, supra note 108, at 14 (with these new programs, “they will be more invested in and better able to develop and institute police practices that take this serious mental health problem into consideration.”).

Wayland, supra note 13, at 939.

See Richard G. Dudley, Jr. & Pamela Blume Leonard, Getting It Right: Life History Investigation as the Foundation for a Reliable Mental Health Assessment, 36 HOFSTRA L. REV. 964, 974-75 (2008) (explaining that “it is never appropriate to expect a mental health expert to deliver a comprehensive mental health assessment of the client until the life history investigation is complete”).

See VAN DER KOLK, supra note 32, at 144-45.

See Chaudhary, supra note 164, at 61.
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194 See Lustig, supra note 118, at 729-30; Chaudhary, supra note 164, at 40-41, 44; Wieand, supra note 55, at 270-71.

195 See Katz & Haldar, supra note 51, at 385-87; see id. at 387 (discussing symptoms of trauma).

196 See Wayland, supra note 13, at 949 (explaining that the imbalance of power “can trigger profound emotional responses that often reflect the devastating interpersonal sequelae of chronic and untreated child maltreatment”).

197 See VAN DER KOLK, supra note 32, at 140-41.

198 See JEAN KOH PETERS, REPRESENTING CHILDREN IN CHILD PROTECTIVE PROCEEDINGS: ETHICAL AND PRACTICAL DIMENSIONS 468 (3d ed. 2007) (describing addressing vicarious trauma as “an ethical imperative” and warning that “lawyers owe it to their clients to contain and address the damage that may be caused by intimate connection with their clients' lives”).

199 See Katz & Haldar, supra note 51, at 392-93.

200 See Peters, supra note 198, at §§ 9-3, 9-4; Katz & Haldar, supra note 51, at 392-93; see, e.g., Lynette M. Parker, Increasing Law Students' Effectiveness When Representing Traumatized Clients: A Case Study of the Katharine & George Alexander Community Law Center, 21 GEO. IMMIGR. L. J. 163 (2007). Unfortunately, recognizing the impact of vicarious trauma is another area in which attorneys lag behind professionals in other disciplines such as mental health, social work, and education. See, e.g., Jason M. Newell & Gordon A. MacNeil, Professional Burnout, Vicarious Trauma, Secondary Traumatic Stress, and Compassion Fatigue: A Review of Theoretical Terms, Risk Factors, and Preventive Methods for Clinicians and Researchers, 6 Best Practices in Mental Health (July 2010). As a result, little scholarship aimed at lawyers addresses the issue.


203 See, e.g., VAN DER KOLK, supra note 32, at Part V: Paths to Recovery (several chapters describing various treatments and modalities for ameliorating the effects of trauma in adults and youth); id. at 356-58 (describing interventions that work to heal the effects of trauma); RICH, supra note 1, at 199-201 (describing trauma interventions based on the injury paradigm and grounded in social justice).

204 Eddings v. Oklahoma, 455 U.S. 104 (1982); see, e.g., Lockett v. Ohio, 438 U.S. 586 (1978) (establishing that all mitigation must be admissible at capital sentencing).

205 Eddings, 455 U.S. at 115.

206 Id. at 107.

207 Id.

208 Id.

209 Id.

210 Id. at 107-08.

211 Id. at 116.

212 Id. at 115.
213  Id. at 116.

214  Id. at 115-16.


218  See Gohara, supra note 6, at 52.

219  Williams, 529 U.S. at 395.

220  Id.

221  Id.

222  Id. at 395 n. 19.

223  Id. at 396.


225  Id. at 516-517.

226  Id. at 517.

227  Id.

228  Id.

229  Id.

230  Id.

231  Id.


233  Id. at 392 (internal quotation marks omitted).

234  Id.

235  Id.

236  Id.

237  Id.

238  Id.

239  Id.

240  Id.

241  Id.

Id. at 43-44.

Id. at 44.

Id. at 30, 31, 35, 34, 41 (internal quotation marks omitted).

Id. at 34-35.

Id. at 40-41.


Id. at 507.

Id.

Id.

Id.

Id.

Id.

Id.

See Williams v. Taylor, 529 U.S. 362, 367-68 (2000) (describing Williams as having murdered a man with a mattock and robbing him of three dollars; he had previously confessed to beating an elderly woman into a vegetative state and had been implicated in a number of other robberies, arsons, and assaults); see also Wiggins v. Smith, 539 U.S. 510, 514 (2003) (describing Wiggins’s offense as drowning a seventy-seven-year-old woman in her bathtub and ransacking her apartment); Rompilla v. Beard, 545 U.S. 374, 397 (2005) (Kennedy, J., dissenting) (describing Rompilla’s victim as having been stabbed sixteen times around the neck and head, beaten with a blunt object, and his face gashed, possibly with broken bottles, and then having his body set on fire); Porter v. McCollum, 558 U.S. 30, 31 (2009) (describing Porter’s conviction for two counts of first-degree murder of his former girlfriend and her boyfriend after threatening and stalking her); Hodge v. Commonwealth, No. 2009-SC-000791-MR, 2011 WL 3805960, at *14 (Ky. Aug. 25, 2011) (describing Hodge and his accomplices’ “not just brutal and vicious but calculated and exceedingly cold-hearted” crime in which they gained entry to the home of a doctor using the ruse that they were FBI investigating fraud by a business partner, stealing $2 million dollars from a safe, strangling the doctor with an electrical cord until he lost consciousness while his college-age daughter was stabbed repeatedly and with such force that the final knife-thrust went all the way through her body).

560 U.S. 48 (2010) (holding that mandatory life without parole sentences for juvenile crimes other than homicide violate the Eighth Amendment).


Miller, 132 S. Ct. at 2469.

See id. at 2468.
See James Tibensky, Feature: Interviewing for Noncapital Mitigation, 38 CHAMPION 30 (2014) (describing lack of self-control, difficulty dealing with adversity, dissociation, “fight or flight” response, and inability to express normal emotions as hallmarks of trauma).

See Miller, 132 S. Ct. at 2465 (discussing various rationales of punishment and outlawing mandatory life without parole for juveniles in part because it fails to account for disadvantaged upbringing); Betsy J. Grey, Neuroscience, PTSD, and Sentencing Mitigation, 34 CARDOZO L. REV. 53, 77-82 (2012) (discussing retributive and consequentialist theories of punishment and explaining why the effects of abuse and violence is relevant to both).

Haney, supra note 38, at 869 (“[T]he relationship between childhood physical abuse and subsequent adult violent behavior has been extremely well-documented, and has given rise to the phrase ‘cycle of violence’ in the academic literature.”).

See Wieand, supra note 55, at 255-56.

See State v. McClellan, 2009 WI App 56, ¶13-14, 21, 317 Wis.2d 732, 768 N.W.2d 63.

See Ta-Nehisi Coates, The Black Family in the Age of Mass Incarceration, THE ATLANTIC, Parts II and VI (October 2015).


See Dudley, supra note 111, at 10-14.


ALLIANCE FOR SAFETY & JUSTICE, supra note 22, at 15.

Id. at 19.

See Tonry, supra note 271, at 2 (“The United States cannot avoid continued mass incarceration unless use of community punishments increases enormously for people who otherwise would be (and now are) sentenced to confinement.”).

See HINTON, supra note 76, at 238-40 (describing the ascent of zero-tolerance school policies and rise in expulsions in urban public schools and surveillance of school-age black youth as a “gateway to surveillance of their families as police departments increasingly partnered with social services”).

See id. at 99 (describing the creation of Youth Service Bureaus under the Johnson administration's “War on Crime,” which channeled “youth who had not committed any crime at all but were seen as susceptible to delinquency into community-based crime control agencies” staffed largely by law enforcement officers).

See Feierman & Fine, supra note 71, at 5 (highlighting racial disparities in the types of places that provide trauma-informed treatment to youth, and recommending that treatment and skills-building take place in private or community settings outside of the juvenile justice system, which often does more harm than good); see also id. (explaining how police officers, not community action workers, emerged as the government's chief representatives in low-income black urban communities as the “War on Poverty” and “War on Crime” merged).

informed school programs' efficacy in reducing the number of serious disciplinary issues and in-school violence; one school that had adopted "trauma-informed practices ... saw a fivefold increase in graduation rates, a threefold increase in students headed to college, 75 percent fewer fights, and 90 percent fewer suspensions"; a study of a different school system's trauma-informed school programs showed "a 49 percent decline in suspensions, and a 42 percent decline in serious behavioral incidents ... [and] 98 percent of students with significant behavioral and emotional challenges now have a plan in place for services and supports"; see also HINTON, supra note 76, at 99 (2016) (describing the advent of entwinement between social service agencies and crime control); id. at 101, 103 (tracing the history of evolution of anti-poverty programs of the 1960s into community centers often directed by law enforcement officials and charged with “operate[ing] as an umbrella for Great Society programs ... to provide a range of services for black urban youth”).

Hinton writes that creation of the federal Office of Juvenile Justice and Delinquency Prevention provided the federal government an opportunity to address crime and violence among young people by “confronting related problems in urban public school systems, public housing, and low-income neighborhoods,” but the federal government instead shifted its approach to delinquency in a punitive direction by “empowering law enforcement authorities to intervene in public institutions serving youth in segregated urban communities.” HINTON, supra note 76, at 227. See also id. at 244-46 (describing a successful alternative to incarceration program in Denver that remained independent of the formal criminal justice system and provided job training and classroom instruction to “hardcore delinquent[ ]” youth and “chronic offenders” who were allowed to live at home while receiving services designed to prevent recidivism).

280 See RICH, supra note 1, at 66 (explaining that seeing young men who might have acted violently after themselves witnessing or falling victim to violence requires “that all of us bear responsibility for understanding why they got injured and how to prevent it from happening again”); see also VAN DER KOLK, supra note 32, at 350 (“[A]s long as we continue to live in denial and treat only trauma while ignoring its origins, we are bound to fail ... Poverty, unemployment, inferior schools, social isolation, widespread availability of guns, and substandard housing all are breeding grounds for trauma.”).


282 Id. (“[W]e must adjust our shared understanding of crime demographics to account for the fact that those most routinely portrayed as perpetrators are often at equal or greater risk of being victims.”).


284 Funding is available to support this work. See id. (describing Congressional allotment of $1.6 billion in new funds to be deployed to local organizations serving survivors of crime).

285 See Common Justice, VERA INSTITUTE OF JUSTICE (last visited Feb. 5, 2018), https://www.vera.org/research/steve-aos-presentation-using-evidence-based-public-policy-to-reduce-incarceration-crime-and-criminal-justice-costs (explaining that the Common Justice program provides the harmed and responsible parties with an opportunity to engage in a facilitated dialogue and to agree upon appropriate sanctions, such as apologies and commitments to attend rehabilitative programming).

286 See Danielle Sered, Young Men of Color and the Other Side of Harm, VERA INSTITUTE OF JUSTICE 1-2, 4 (Dec. 2014), http://www.vera.org/sites/default/files/resources/downloads/young-men-color-disparities-responses-violence.pdf (“There is no evidence suggesting that the same disparities that exist when young men of color are defendants disappear when they are victims.”).


288 Id. at 307 (noting that this “continuum of rehabilitation services” plays an essential role in the success of a veterans' treatment court by enabling veteran-defendants to be diverted from traditional adjudication and sentencing paradigms and into treatment programs).
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289  Id. at 304 (“[M]ost veterans courts have a mentoring program that pairs each participant with a volunteer mentor who comes from a similar background. The mentoring program is the most direct response to the observation that veterans respond better to treatment when they work with other veterans.”).

290  Id. at 309 (describing veterans’ courts’ general limitation to non-violent defendants).

291  National statistics on recidivism show that over 75% of people who leave prison are rearrested within five years of their release. See Recidivism, NAT’L INSTITUTE OF JUSTICE, http://www.nij.gov/topics/corrections/recidivism/pages/welcome.aspx (last visited Feb. 5, 2018) (citing a Bureau of Justice Statistics study, which tracked 404,638 prisoners in 30 states after their release in 2005, and found that about three-fourths of the released prisoners were rearrested by 2010).


294  See HINTON, supra note 76, at 5 (“Black Americans and Latinos together constitute 59 percent of the nation’s prisoners, even though they make up roughly a quarter of the entire U.S. population .... Odds are 50-50 that young, black urban males are in jail, in a cell in one of the 1,821 state and federal prisons across the United States, or on probation or parole.”).

295  See Wayland, supra note 13, at 961 (“The trauma literature demonstrates that men, young people, minorities, and people of lower socioeconomic status are among those at highest risk for exposure to traumatic experiences. People who are at risk for cumulative traumatic exposure include people traumatized as children and people who are disenfranchised by virtue of race and class.”).

296  RICH, supra note 1, at 201.

297  See HINTON, supra note 76, at 340 (“Barring fundamental redistributive changes at the national level, the cycle of racial marginalization, socioeconomic isolation, and imprisonment is ever more likely to repeat itself.”); Sered, supra note 282, at 4 (“Attention is increasingly being paid to the disparities [young men of color] experience, as well as to a variety of barriers to economic advancement, educational attainment, and positive health outcomes. Woven throughout this attention is a concern about the disproportionate involvement of young men of color in the criminal justice system as those responsible for crime. Still missing, however, is recognition that these young men are also disproportionately victims of crime and violence.”); Listenbee, Jr., supra note 14, at 174 (“The system must recognize the heavy burdens that most young offenders carry and help them move into a healthy and productive adulthood by providing services that address the damage done by exposure to violence.”).

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TRAUMA: WHAT LURKS BENEATH THE SURFACE

SARA E. GOLD*

Scholarship in the behavioral health field demonstrates that an overwhelming majority of clients experiencing urban poverty, and particularly low-income clients living with chronic medical and mental health issues, have endured trauma as children and adults. While legal scholars and service providers have begun to discuss the role that trauma plays in the client's interactions with the lawyer, the dialogue has largely focused on trauma relevant to the subject matter of the legal representation. This article expands current scholarship by asserting that given the prevalence of trauma, the lawyer serving the urban poor should presumptively adopt a trauma-informed practice approach regardless of the subject matter of the representation. The lawyer engaging in a trauma-informed practice can enrich the client experience generally and enrich it significantly for the many clients who come to the lawyer-client relationship with a history of trauma.

I. INTRODUCTION

When we first met Ms. A.,¹ she was thirty years old and raising

* Clinical Law Instructor, University of Maryland Francis King Carey School of Law. I would like to thank Robert Dinerstein, Naomi Mann, Kate Mitchell, and Jennifer Rosen Valverde who provided invaluable feedback at the 2016 NYU Clinical Law Writers' Workshop. I would also like to thank the participants in the 2016 American Association of Law Schools (AALS) Clinical Conference Scholarship Working Group, and the Fall 2016 University of Maryland Carey School of Law and University of Baltimore Law School Junior Faculty Workshop for their thoughtful comments and support. Finally, I would like to thank my colleagues Leigh Goodmark and Maureen Sweeney for their encouragement and guidance throughout my writing process, and Kay Connors, Project Director of the Family Informed Trauma Treatment (FITT) Center at the University of Maryland Baltimore, for introducing me to the prevalence and effects of trauma, and stimulating my thinking about trauma's influence on the lawyer-client relationship.

¹ To preserve the client’s anonymity and privacy, I do not use the client’s name or real initial. In addition, the narrative, while inspired by the experiences of one client, combines the experiences of several different clients with some facts that are fictitious. While clinical scholarship commonly uses clients’ stories to enrich the dialogue about theoretical concepts, some scholars have rightly questioned whether the client should have a role in deciding whether, and how, their narrative should be told. See, e.g., Binny Miller, Telling Stories about Cases and Clients: The Ethics of Narrative, 14 GEO. J. LEGAL ETHICS 1 (2000); Nina Tarr, Clients' and Students' Stories: Avoiding Exploitation and Complying with the Law to Produce Scholarship with Integrity, 5 CLINICAL L. REV. 271, 273-75, 306-08 (1998) (questioning whether it is exploitative for clinicians to use client stories to advance their scholarship, and balancing respect for client dignity, autonomy, and privacy with maintaining ability to produce scholarship that has integrity). I chose not to seek the client’s consent to
four children on her own. She worked the night shift preparing and serving food in the student center at a local university. When she wasn’t working, Ms. A.’s priority was to take care of her children. Her two youngest children, who were 13 months and three years old at the time, were not yet in school and Ms. A. cared for them during the day. Ms. A.’s son, who was ten, had severe asthma and HIV. Ms. A.’s oldest daughter was fifteen and struggling to keep up in the ninth grade. She was frequently late to or absent from school, and was involved in fights with classmates. Ms. A. had her own health issues, including acute pancreatitis and HIV, which generally took a back burner to the more immediate needs of her children.

Ms. A. had a contentious relationship with the father of her oldest daughter, and based on her concerns about his drug use, tried to minimize the time her daughter spent with her father. For the year leading up to our lawyer-client relationship with Ms. A., the fifteen-year-old had been spending increasingly more time at her father’s home, in an environment that Ms. A. did not think offered proper supervision. The father had recently threatened to seek custody of his daughter. The father of Ms. A.’s son, whom she described as the love of her life and to whom she had been married, was killed in a tractor trailer accident when her son was a toddler. Shortly after his death, Ms. A. began experiencing repeated flare-ups of her acute pancreatitis causing her to miss a lot of work. Ms. A. was ultimately terminated from her dining services job for excessive absenteeism and, as a result, she lost her family’s employer-funded health insurance. For the next couple of years, Ms. A. relied on the emergency room to treat her medical needs as well as her son’s asthma. Ms. A. began receiving Social Security disability benefits and did her best to financially support her family.

In the years following the death of her husband, Ms. A. began a relationship with a man who was physically and emotionally abusive towards her. This man became the father of Ms. A.’s two youngest children.

Before we met Ms. A., she and her children experienced a period of homelessness. With the support of a psychiatrist and social worker at the HIV medical clinic where Ms. A. received her primary care, Ms. A. slowly regained her health and was eventually able to return to the workforce. Once receiving a paycheck again, Ms. A. was able to separate from the man who abused her and move into her own apartment
tell any of the client-inspired stories in this article because I did not want to risk causing the client psychological harm by initiating a conversation about personal experiences they may not want to discuss, and which they never referred to as “traumatic” to me. I try to maintain the integrity of the experiences as much as possible while changing enough of the facts to not tell the “real” story of any client.
with her children.

Further complicating Ms. A.'s life, within weeks of Ms. A.'s return to work, Ms. A.'s mother died. Ms. A.'s mother was her self-described "best friend" and sole source of emotional support. The loss hit Ms. A. extremely hard.

Ms. A. did not share with the student attorneys representing her any of these experiences at the time she sought legal representation, nor did the student attorneys ask questions that might have elicited some of this history. Ms. A.'s experiences were deeply personal and they were not relevant to the legal matter for which she sought legal representation. Indeed, Ms. A. sought legal help after receiving a notice from the Social Security Administration terminating her disability benefits, and directing her to repay within thirty days approximately $35,000 that Social Security claimed it had overpaid her. Ms. A. sought legal assistance because she had no financial ability to repay any of the overpayment. Slowly, over the course of the student attorneys' almost two-year relationship with Ms. A., she shared some of her difficult and personal experiences.

Although Ms. A.’s experiences were not substantively relevant to the Social Security overpayment matter for which Ms. A. initially sought the legal clinic's assistance, would the student attorneys' knowledge of them earlier in their relationship have changed their lawyering approach? Did Ms. A.’s experiences affect the way she communicated with the student attorneys? Did they affect how much, and how soon, she trusted the student attorneys? Did they affect the credibility of the information Ms. A. shared with the student attorneys? Would the student attorneys have engaged with, or understood, Ms. A. differently had they known that Ms. A. had experienced homelessness, domestic violence, the death of her husband, financial instability, raising a son with chronic health conditions, and her own chronic health conditions? Should they have?

The answers to these questions highlight the role that trauma plays in the relationship between the lawyer and the client. Legal scholars and practitioners know that establishing a trusting relationship in which the client is able to share information relevant to the case, including not only relevant factual details about the substantive legal matter, but also the ethical, moral, and personal considerations that are relevant to client decision-making, is critical to good representation. Just as world view, 

2 Md. Atty’s Rules of Prof’l Conduct r. 2.1 (Md. Bar Ass’n 2016).
disability, religion, ethnicity, socio-economic status, and culture influence client behavior and decision-making, so, too, does trauma.

Scholarship in the behavioral health field demonstrates that an overwhelming majority of clients experiencing urban poverty, and particularly low-income clients living with mental health issues and chronic physical conditions including HIV, have endured trauma during their lifetime. Experiences such as those endured by Ms. A. as well as others including witnessing or experiencing violence in the client’s home and community, difficulty paying rent, eviction, homelessness, substance abuse, mental health challenges, discrimination, and loss of a loved one constitute trauma.

Equipped with a developing understanding of trauma, the student attorneys representing Ms. A. presumptively engaged in a trauma-informed lawyering approach. While this approach mirrors much of client-centered lawyering generally, it extends the practice through its acute awareness of trauma and places specific emphasis on ensuring the client’s physical and emotional safety in which trust plays a large role, and on intentionally creating opportunities for the client to rebuild control over their life in large part through empowering client decision-making. While client-centered lawyering is a trauma-informed practice approach, the lawyer’s heightened awareness of the prevalence and influence of trauma allows the lawyer to be more deliberate about taking steps to provide better representation to the client who has experienced trauma.

While legal scholars and legal service providers have begun to discuss the role that traumatic experiences play in the client’s interaction with the lawyer, the dialogue has largely focused on trauma rele-

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4 Id. at 294; Michelle S. Jacobs, People from the Footnotes: The Missing Element in Client-Centered Counseling, 27 GOLDEN GATE U.L. REV. 345, 354 n.29 (1997). As much as the client’s views are influenced by many factors, so, too, are the lawyer’s views. Much has been written about the need for lawyers to be aware and critical of their own values that they bring to the lawyer-client relationship, as well as about the assumptions they hold about their clients’ views, values, and influences. See id. at 361 n.73; Dinerstein et al., supra note 3, at 301.

5 Most individuals seeking public behavioral health and other services, such as homeless and domestic violence services, have histories of physical and sexual abuse and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system. See Ask the Expert Welcomes Dr. Joan Gillece, THE HOMELESS HUB (2001), http://homelesshub.ca/resource/ask-expert-welcomes-dr-joan-gillece; Trauma Informed Care, NAT’L ASS’N ST. DIRECTORS DEVELOPMENTAL DISABILITIEs SERvs., http://www.nasddds.org/resource-library/behavioral-challenges/mental-health-treatment/trauma-informed-care/.

vant to the subject matter of the legal representation. Sarah Katz and Deeya Haldar recently wrote an article emphasizing the importance of helping law students identify and address the effects of their client’s traumatic experiences in the context of a family law clinic where many clients experienced trauma relevant to their family court matters. Katz and Haldar recognize that clients, based on the nature of the subject matter of certain cases, frequently seek legal assistance at times when they are highly vulnerable and emotional, and that they must share painful and intimate details of their lives. For these reasons, Katz and Haldar recommend that lawyers representing clients in practice areas such as family law, immigration, criminal law, juvenile law and child welfare, and veterans rights law, practice trauma-informed lawyering.

This article expands current scholarship by asserting that given the prevalence of trauma, lawyers serving the urban poor should presumptively adopt a trauma-informed practice approach regardless of the subject matter of the representation. The lawyer engaging in a

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13 Katz & Haldar, supra note 7, at 361–62.
14 While this paper focuses on urban poverty, it should be noted that people living in rural poverty also experience trauma that affects their behavior and has been linked to negative outcomes. See, e.g., Terri N. Sullivan et al., Relation Between Witnessing Violence
Trauma-informed practice can enrich the client experience generally and enrich it significantly for the many clients who come to the lawyer-client relationship with trauma histories. The recommendation that lawyers serving the urban poor engage in trauma-informed practice fits squarely within existing scholarship about client-centered lawyering, cross-cultural lawyering, and therapeutic jurisprudence.

Section I of the article defines trauma, and discusses the long-term effects that traumatic experiences may have on client behavior. Section II explores how trauma's effects may influence the lawyer-client relationship. Section III argues that trauma-informed lawyering is an approach that lawyers should presumptively take to improve their client representation, and concludes by recommending that: (1) lawyers and judges receive training on the influence of trauma; (2) while formal or informal inter-professional partnerships (including law, social work, behavioral health, medicine, and nursing) are particularly well-suited to offer comprehensive trauma-informed care to individuals experiencing urban poverty, lawyers working with clients alone can improve the quality of their services by broadening their understanding of trauma and providing trauma-informed legal care; and (3) empirical research be undertaken to measure health and therapeutic outcomes to clients as a result of trauma-informed legal intervention.

*and Drug Use Initiation Among Rural Adolescents: Parental Monitoring and Family Support as Protective Factors,* 33 J. CLINICAL CHILD & ADOLESCENT PSYCHOL. 488, 490, 495 (2004) (finding in a sample of sixth-grade students from "fairly poor, predominantly agricultural communities" that "witnessing violence predicted subsequent initiation of cigarette, beer and wine, liquor, and advanced alcohol use"); Carole E. Kaufman et al., *Stress, Trauma, and Risky Sexual Behaviour Among American Indians in Young Adulthood,* 6 CULTURE, HEALTH & SEXUALITY 301, 304, 311, 312 (2004) (finding in a representative sample that American Indian women aged 17 to 25 years old living in the Northern Plains who experienced a trauma had an increased probability of having multiple casual sexual partners); Jane Leserman et al., *How Trauma, Recent Stressful Events, and PTSD Affect Functional Health Status and Health Utilization in HIV-Infected Patients in the South,* 67 PSYCHOSOMATIC MED. 500, 501-02, 505 (2005) (finding that, among a sample of low-income HIV patients in the rural Southeast: "more trauma was related to worse health-related physical functioning (e.g., interference with walking and lifting), role functioning (limitations on work and activities), pain, and cognitive functioning (difficulty with reasoning, thinking, and concentrating). Total lifetime trauma, as well as sexual or physical abuse history, was shown to increase the risk of disability and health care utilization during the past 9 months"); Matthew J. Taylor et al., *Negative Affect, Delinquency, and Alcohol Use Among Rural and Urban African-American Adolescents: A Brief Report,* 22 J. CHILD & ADOLESCENT SUBSTANCE ABUSE 69, 77 (2013) (finding that negative affect was positively related to alcohol use in rural adolescents and that this relationship was mediated by delinquency; noting that other researchers have suggested that "community and individual stressors" result in negative affect and that the negative affect-delinquency relationship may be linked to "environmental and community stressors").
II. UNDERSTANDING TRAUMA AND ADVERSE CHILDHOOD EXPERIENCES

Trauma is a common experience for adults and children in the United States, and is especially common for people with mental and substance use disorders. National epidemiological studies show that approximately 70% of adults in the United States have experienced one or more traumatic events. Research further shows that families living in urban poverty encounter multiple traumas over many years, and that they are less likely than families living in wealthier communities to have access to the resources that may help support them through their traumatic experiences. As a result, families living in urban poverty tend to experience the negative effects of trauma at higher rates than families in wealthier communities.

According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), “[i]ndividual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.” To help understand this definition of trauma, SAMSHA conceptualizes trauma around three “E’s”: (1) event(s), (2) experience of the event(s), and (3) effect.

With respect to the first element, exposure to a traumatic or stressful event, trauma involves an individual’s experience of an “actual or extreme threat of physical or psychological harm.” The lawyer would likely recognize that events such as the client’s sudden loss of a loved one, child abuse, and domestic violence constitute traumatic events. However, the lawyer untrained about trauma may not consider that traumatic events can also include exposure to or witnessing natural disasters, community or school violence, house fires, acci-
dents, illnesses, crime, and homelessness. The lawyer untrained about trauma may likely not realize that broader societal experiences such as racism, which may cause the client to feel unsafe based on the risk of targeted violence and discrimination; and poverty, which may cause the client to worry routinely about hunger, violence, illness and accidents, and economic strain similarly constitute trauma.

Indeed, families exposed to urban poverty face a disproportionate risk of exposure to trauma based on factors such as low neighborhood safety, daily hassles, and racial discrimination. In a 2008 study with families in Baltimore City conducted by the Family Informed Trauma Treatment (FITT) Center and Maryland Coalition of Families for Children’s Mental Health, many adult family members reported coping with very high levels of stress. The study found the most common form of trauma reported by the families in Baltimore City was exposure to domestic and community violence frequently related to drug use and distribution. Families also reported struggling with the responsibilities and lack of resources needed to care for more than one generation.

Because what may be traumatic to one person may not necessarily be traumatic to another, the second component of trauma relates to the individual’s experience of the event and how the event impacts the individual both physically and psychologically. Factors such as the nature and severity of the traumatic incident, prior traumatic experiences, including child abuse, individual or family psychiatric history, accumulation of life stressors, cultural beliefs, the availability and strength of a support system, low socio-economic status, lack of education, and the individual’s developmental stage and


22 COLLINS ET AL., supra note 6, at 22 (citing Thema Bryant-Davis, Healing Requires Recognition: The Case for Race-Based Traumatic Stress, 35 COUNSELING PSYCHOLOGIST 135 (2007)).

23 Id. (citing Ibrahim Aref Kira, Taxonomy of Trauma and Trauma Assessment, 7 TRAUMATOLOGY 73 (2001)); Katz & Haldar, supra note 7, at 364–65 (citing KATHRYN COLLINS ET AL., UNDERSTANDING THE IMPACT OF TRAUMA AND URBAN POVERTY ON FAMILY SYSTEMS: RISKS, RESILIENCE AND INTERVENTIONS 22 (2010)).

24 COLLINS ET AL., supra note 6, at 22 (citing Martha E. Wadsworth, & Catherine DeCarlo Santiago, Risk and Resiliency Processes in Ethnically Diverse Families in Poverty, 22 J. FAM. PSYCHOL. 399 (2008)).

25 MD. COALITION OF FAMS. & FAM. INFORMED TRAUMA TREATMENT CTR., supra note 21.

26 Id.

27 Katz & Haldar, supra note 7, at 366–67 (citing Richard R. Kluft et al., Treating the Traumatized Patient and Victims of Violence, 86 NEW DIRECTIONS IN MENTAL HEALTH SERVS. 79 (2000)).
ability to process the event, influence an individual’s response to an event.\textsuperscript{28}

Finally, trauma is defined by the adverse effects it has on the individual. Traumatic experiences often cause a person to question, “Why me?” and cause the person to feel powerless, humiliated, guilty, shameful, betrayed, or silenced. Trauma’s effects can happen immediately or have a delayed onset. The effects can be short-lived or long lasting.\textsuperscript{29}

Similar to the difficulties shared by Ms. A., adult family members in the 2008 study of families in Baltimore City reported significant sleep and health problems. Some study participants had trouble keeping jobs because of the disruptions and stress caused by trauma.\textsuperscript{30}

Due to physiological changes in the brain, including the increased release of stress hormones and alterations in systems that detect danger and safety,\textsuperscript{31} people experiencing trauma can feel intense fear, helplessness, horror, emotional numbing, or detachment. They may experience physiological hyper-arousal including difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, an exaggerated startle response, or being in a constant state of arousal.\textsuperscript{32} They may have difficulties trusting others, and a tendency to develop unhealthy relationships.\textsuperscript{33} Finally, people who have experienced trauma may re-experience traumatic memories through dreams.

\textsuperscript{28} Collins et al., supra note 6, at 1, 2 (citing the AM. Psychiatric Ass’n, Diagnostic & Statistical Manual of Mental Disorders (DSM-4) (4th ed. text rev. 2000)); SAMHSA’s Trauma & Justice Strategic Initiative, supra note 19. In focus groups with families impacted by trauma, some families reported benefitting from the support of family members, while others reported that the stress and burdens caused by trauma made them feel alone and isolated because other people “don’t know what it is like to be in my shoes.” See Md. Coalition of Fams. & Fam. Informed Trauma Treatment Ctr., supra note 21.

\textsuperscript{29} SAMHSA’s Trauma & Justice Strategic Initiative, supra note 19. See also Katz & Haldar, supra note 7, at 359, 367.

\textsuperscript{30} Md. Coalition of Fams. & Fam. Informed Trauma Treatment Ctr., supra note 21.

\textsuperscript{31} Bessel van der Kolk, The Body Keeps the Score 2–3 (2014).


\textsuperscript{33} Judith Herman, Trauma and Recovery: The Aftermath of Violence – From Domestic to Political Terror, 88–95 (1992); Katz & Haldar, supra note 7, at 359, 366–67 (citing Sandra L. Bloom, The Grief that Dare Not Speak Its Name Part I: Dealing with the Ravages of Childhood Abuse, 2 Psychotherapy Rev. 408, 408–09 (2000)).
or flashbacks, and they may avoid people, places, and things related to the trauma.

A. The Adverse Childhood Experiences (ACEs) Study

In addition to the traumatic events that many clients experience as adults—and that may or may not be relevant to the subject matter of the legal matter for which the client seeks representation—research also suggests that many clients have experienced traumatic stress as children. Indeed, according to the Centers for Disease Control and Prevention, one in five Americans was sexually molested as a child; one in four was beaten by a parent to the point of a mark being left on their body; a quarter of Americans grew up with alcoholic relatives; and one of eight Americans witnessed their mother being physically abused.34 The Adverse Childhood Experiences (ACEs) Study and the robust medical research that has followed over the past twenty years demonstrate that childhood trauma has profound effects on brain development and, consequently, negative effects on adult behavior.35

The ACEs Study was jointly conducted over several years in the mid-to-late 1990s by the Centers for Disease Control and Prevention and Kaiser Permanente. The groundbreaking study aimed to determine the relationship between adverse childhood experiences and the leading causes of death in adulthood. The study measured the relationship between exposure to childhood emotional, physical or sexual abuse, or household dysfunction during childhood—known as adverse childhood experiences (ACEs)—and adult health risk behavior, health, and disease.36

The ACEs Study found that the more ACEs a person experienced in childhood, the more those people in adulthood experienced health risk behaviors and diseases that contributed to the leading causes of mortality in the United States at the time, namely, smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, drug abuse, parental drug abuse, a high lifetime number of sexual partners and a history of having a sexually transmitted disease,

34 Van der Kolk, supra note 31, at 1.
36 See generally Vincent J. Felitti et al., Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACES) Study, 14 AM. J. PREVENTATIVE MED. 245 (1998). Seven categories of ACEs were identified in a questionnaire completed by approximately 9,500 adults at a large HMO in Southern California. The seven categories included psychological abuse; physical abuse; sexual abuse; violence against mother; living with household members who were substance abusers; living with household members who were mentally ill or suicidal; and living with household members who were ever imprisoned. Id.
heart disease, cancer, stroke, chronic bronchitis, emphysema, diabetes, hepatitis, and skeletal fractures.\textsuperscript{37}

Numerous medical journal articles have been published since the release of the initial ACEs Study in 1998, and the CDC has continued to monitor the health impact on the original ACES study participants.\textsuperscript{38} Based on the results of the ACEs Study as well as the medical research that has followed, there is a well-established correlation between childhood traumatic events such as traumatic loss, separation, bereavement, domestic violence, impaired caregiver, emotional abuse, physical abuse, neglect, sexual abuse, community violence, sexual assault, and school violence, with negative adult health outcomes including obesity, diabetes, depression, suicide attempts, sexually transmitted infections, HIV, heart disease, cancer, stroke, and chronic obstructive pulmonary disease (COPD).\textsuperscript{39} Additionally, there is a strong correlation between childhood traumatic events with mental health problems, smoking, alcoholism, drug use, self-injury, risky sexual encounters,\textsuperscript{40} homelessness, prostitution, criminal behavior, unemployment, parenting problems, high utilization of health and social services, and shortened lifespan.\textsuperscript{41}

Studies confirm that high percentages of adults experiencing these health and social issues have, in fact, been affected by repeated and chronic trauma throughout their lifetime, including during childhood.\textsuperscript{42} Based on this research, and the fact that the adult clients in


\textsuperscript{38} Id.

\textsuperscript{39} Johanna K.P. Greeson et al., Traumatic Childhood Experiences in the 21st Century: Broadening and Building on the ACE Studies with Data from the National Child Traumatic Stress Network, 29 J. INTERPERSONAL VIOLENCE 536, 539 (2014).

\textsuperscript{40} COLLINS ET AL., supra note 6, at 22 (citing Vincent J. Felitti et al., Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study, 14 AM. J. PREVENTATIVE MED. 245 (1998)); Christopher M. Layne et al., Cumulative Trauma Exposure and High Risk Behavior in Adolescence: Findings from the National Traumatic Stress Network Core Data Ser, 6 PSYCHOL. TRAUMA: THEORY, RES., PRAC., & POL’Y S40, S41 (2014).


\textsuperscript{42} Richard C. Christensen et al., Homeless, Mentally Ill, and Addicted, 16 J. HEALTHCARE FOR THE POOR & UNDERSERVED 615, 617-18 (2005) (finding high rates of sexual and physical abuse in homeless adults with co-occurring substance abuse and serious mental health disorders); Rachel K. Jewkes et al., Associations Between Childhood Adversity and Depression, Substance Abuse and HIV & HSV2 Incident Infections in Rural South African Youth, 34 CHILD ABUSE NEGL. 833, 840 (2010) (South African study finding childhood exposure to emotional, physical, and sexual abuse increased the risk of HIV in adulthood); Rebecca Vivrette & Kate Wasserman, Presentation, Baltimore Mental Health Outreach
the HIV Legal Clinic universally experience some combination of HIV, mental health and physical impairments, addiction, poverty, housing instability, and unemployment, it follows that most, if not all, of the clients have experienced trauma in their lifetime, likely during critical stages of child development. When I previously represented low-income clients in a domestic violence clinic and, before that, worked with families in an urban public child welfare system, the client experiences were similar.

Indeed, in a book that chronicles the lives of adult patients at an HIV medical clinic in Baltimore City, many patients share stories of trauma that they experienced as children. For example, Kathy B., a fifty-four-year-old woman living with HIV who struggled with drug use as an adult, describes being sexually abused as a child and remembers sleeping in the bathtub in her basement because it was the only safe place in her home where she could avoid her abuser. Alex B., a low-income man living with HIV, remembers that when he was in elementary school, loud pounding routinely woke him up between 5:30 and 6:30 in the morning from police raids in his home. Finally, Carmichael shared that when he was six years old, his cousin used to make him crawl under the porch and try to penetrate him.

These experiences are not unique to clients living with HIV. Sarah Katz and Deeya Haldar note in their article about trauma-informed pedagogy that many of the clients in their family law clinics similarly experienced trauma when they were children.

B. Understanding How Childhood Trauma Impacts the Developing Brain

Traumatic experiences impact children differently than they do adults. This is because childhood trauma occurs during critical periods of childhood cognitive and emotional development. It disrupts both

for Mothers (BMOMs) Survey Initial Report (Mar. 4, 2015) (on file with author) (reporting on a 2015 survey of 285 pregnant women or mothers of children under five years old in seventeen low-income neighborhoods in Baltimore City finding that one in five women endorsed all eight ACEs, with 92% reporting exposure to community violence, 56% reporting exposure to domestic violence, 11% reporting exposure to sexual assault, and 60% reporting having experienced four or more ACEs). See also Bessel van der Kolk, Developmental Trauma Disorder, 35 Psychiatric Annals 401, 402 (2005) (stating adults who experienced childhood trauma have significant use of medical, correctional, social, and mental health services, and make up almost the entire criminal justice population in the United States).

43 Cricket Barrazor, Life Don’t Have To End (2013).
44 Id. at 72.
45 Id. at 29–33.
46 Id. at 81.
47 Katz & Haldar, supra note 7, at 365.
48 Marylene Cloitre et al., A Developmental Approach to Complex PTSD: Childhood
the "brain architecture" as well as normal developmental processes. It also differs from adult trauma in that childhood trauma is predominantly interpersonal in nature and most often occurs based on the action or inaction of the attachment figure responsible for protecting the child. Finally, childhood trauma tends to occur in clusters such that children who experience trauma likely experience more than one type of adversity. And the more different types of trauma experienced during childhood, the greater the likelihood of functional impairments and high-risk behaviors in adolescence, leading to negative health and social outcomes in adulthood.

Based on the combination of factors unique to childhood trauma, exposure to adverse childhood experiences leads not only to the resultant health and social consequences established by the ACEs studies, but also to cognitive, behavioral and emotional symptoms that are both more severe and qualitatively different than symptoms resulting from trauma experienced as an adult.


49 Shonkoff & Garner, supra note 35.
50 Cloitre et al., supra note 48, at 406. See also Ford, supra note 32, at 847.
51 Studies show that "[i]ndividuals who experience a single trauma in childhood are likely to have experienced several types of adversity, with some studies suggesting that 81% to 98% of adults who report one adverse childhood experience report at least one additional experience"; another study demonstrates that 86% of children who had experienced any type of sexual victimization and 77% of children who had experienced physical abuse by a caregiver had experienced four or more types of victimization the preceding year. Bradley C. Stolbach et al., supra note 48, at 483 (citing Maxia Dong et al., The Interrelatedness of Multiple Forms of Childhood Abuse, Neglect, and Household Dysfunction, 28 CHILD ABUSE & NEGLECT 771 (2004); R.C. Kessler, Posttraumatic Stress Disorder: The Burden to the Individual and to Society, 61 J. CLINICAL PSYCHIATRY 4 (2000); David Finkelhor, Re-Victimization Patterns in a National Longitudinal Sample of Children and Youth, 31 CHILD ABUSE & NEGLECT 479 (2007)).
52 Indeed, Layne and his co-authors found that the 14,088 participants in their 2014 study, who were clients at agencies associated with the National Traumatic Stress Network, had histories of exposure to an average of more than four different types of trauma during childhood and adolescence. The most commonly reported traumatic events were traumatic loss, bereavement, separation, and various types of intrafamilial trauma. Layne et al., supra note 40, at S44. See also Ernestine Briggs, Links Between Child and Adolescent Trauma Exposure and Service Use Histories in a National Clinic-Referred Sample, 5 PSYCHOL. TRAUMA: THEORY, RES., PRAC., & POL'Y 101, 102 (2013).
53 For this reason, in 2009, Bessel van der Kolk and other researchers proposed a new developmental trauma disorder to include in the fifth edition of the Diagnostic and Statisti-
Scientists now understand that early childhood trauma changes the wiring and structure of the brain.\textsuperscript{54} Childhood trauma has relatively recently been shown to cause anatomical changes in the size and connections in the developing—and quite malleable—brains of young children.\textsuperscript{55} There are three primary regions of the brain that play a role in a person’s response to stress—the amygdala, the hippocampus, and the prefrontal cortex. The amygdala is responsible for detecting fear and preparing for emergency events. As with trauma experienced by adults, when the amygdala senses fear, it activates the body’s stress response, which is known as the “fight or flight” response.\textsuperscript{56} When a person is under stress, the amygdala tells the hypothalamus to begin the chain of events that ultimately leads to the production and release of stress hormones.\textsuperscript{57} While temporary increases in these stress hormones are normal—and, in fact, necessary to trigger a protective reaction in dangerous situations—excessively high levels or long-term exposure to stress hormones as a child, can damage the developing brain.\textsuperscript{58}

Under normal circumstances, the hippocampus, which stores long-term memory, and the prefrontal cortex, which is responsible for...
developing executive functions such as decision-making, short-term memory, behavioral self-regulation, and impulse control, are able to stop an increased release of stress hormones. However, because toxic stress at an early age changes the architecture and connectivity both between and within the hippocampus and the prefrontal cortex, early childhood trauma prevents these parts of the brain from reducing the increase in stress hormones and causes a person’s response to fear to go haywire—sometimes overreacting to minor events and, at other times, underreacting to danger.59

The likelihood and extent of changes in the brain depends on the type of response to the trauma experienced. Given that individual children—like adults—respond to stress differently, the extent to which early childhood traumatic experiences disrupt brain development is dependent on numerous factors including the intensity and duration of the child’s individual response,60 and the presence or absence of supportive, adult relationships in the face of trauma.61 Children who experience trauma of the type measured in the ACEs Study and subsequent line of research such as traumatic loss, bereavement, exposure to domestic violence, emotional abuse, impaired caretaker, physical abuse, neglect, sexual abuse, and community violence, and who lack relationships with adults who can help support them through these experiences, are more likely to exhibit changes in the structure and functioning of their brains during critical periods of development.62

Unlike adult trauma, when children experience trauma during this critical time in development, it stunts their learning about how to regulate emotion and interact with others in a healthy way,63 and can result in lifelong difficulties in regulating emotion and behavior, and controlling mood and impulsivity.64 This phenomenon can later present in adulthood as anxiety, depression, anger, aggression, social isolation,65 feelings of low self-esteem, self-blame, helplessness, hopelessness (especially in women),66 expectations of rejection and

59 Shonkoff & Garner, supra note 35, at e236–e237.
61 Shonkoff & Garner, supra note 35, at e236.
62 Id.
63 Cloitre et al., supra note 48, at 400.
64 Ford, supra note 32, at 841 (citing Wendy D’Andrea et al., Understanding Interpersonal Trauma in Children: Why We Need a Developmentally Appropriate Trauma Diagnosis, 82 AM. J. ORTHOPSYCHIATRY 187 (2012)).
65 Cloitre et al., supra note 48, at 400. See also van der Kolk, supra note 42, at 404.
66 Kaisa Haatainen et al., Gender Differences in the Association of Adult Hopelessness
loss, and trouble concentrating.\textsuperscript{67} People affected by childhood trauma commonly feel unsafe, guarded, stressed, and mistrustful.\textsuperscript{68} They may have trouble interacting with family members, neighbors, co-workers and supervisors.\textsuperscript{69}

Because the structure of the brain may be affected, in addition to self-regulatory problems, childhood trauma can impair lifelong decision-making, working and long-term memory; ability to distinguish danger from safety; social-emotional, language and cognitive skills; reasoning capacity;\textsuperscript{70} and result in problems demonstrating autonomy and initiative.\textsuperscript{71}

How might feelings of stress, anxiety, depression, anger, or low self-esteem present in the context of the client’s relationship with the lawyer? How might the client’s difficulties with trust affect the lawyer’s ability to provide high quality representation to the client? How might impairments in decision-making, memory, language, and cognitive skills impede the client-lawyer relationship? Are these behaviors necessarily the result of trauma? Does the underlying cause of the behavior matter in terms of the lawyer’s approach to representation?

III. THE INFLUENCE OF TRAUMA ON THE LAWYER-CLIENT RELATIONSHIP

David Binder and Susan Price first introduced the theory of client-centered representation in the clinical literature in the first edition of their interviewing and counseling text\textsuperscript{72} and it continues to be the central value in many law school clinics, particularly those representing individual clients.\textsuperscript{73} It is an approach to problem solving. The

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with Adverse Childhood Experiences, 38 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 12, 15-16 (2003).
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\item \textsuperscript{67} Collins et al., \textit{supra} note 6, at 22 (citing John Briere & Catherine Scott, \textsc{Principles of Trauma Therapy} (2006)).
\item \textsuperscript{68} Kathleen M. Connors, Presentation, Interdisciplinary Discussion: Impact of Trauma on Families (Apr. 7, 2016) (on file with author) (citing Robert S. Pynoos et al., \textit{Issues in the Developmental Neurobiology of Traumatic Stress}, 821 \textit{Annals N.Y. Acad. Sci.} 176 (1997)).
\item \textsuperscript{69} Collins et al., \textit{supra} note 6, at 1.
\item \textsuperscript{70} Shonkoff et al., \textit{supra} note 55.
\item \textsuperscript{71} Herman, \textit{supra} note 33, at 110; Cloitre et al., \textit{supra} note 48, at 400 (proposing a new DSM-IV diagnosis of Complex PTSD to capture the symptoms that result from childhood trauma such as the self-regulatory disturbances uniquely associated with repeated childhood adverse experiences). See also Shonkoff & Garner, \textit{supra} note 35, at e236-e237; van der Kolk, \textit{supra} note 42, at 404; Shonkoff et al., \textit{supra} note 55; Sophia Miryam Schussler-Fiorenza Rose, \textit{Adverse Childhood Experiences, Disability and Health-Risk Behaviors}, 26 \textsc{Population Health Matters} (2013).
\item \textsuperscript{72} David A. Binder & Susan C. Price, \textsc{Legal Interviewing and Counseling: A Client-Centered Approach} (1977).
\item \textsuperscript{73} David A. Binder, Paul Bergman & Susan C. Price, \textsc{Lawyers As Counselors: A Client Centered Approach} (1991); Katz & Haldar, \textit{supra} note 7, at 375; Jacobs,
model, which derived from the teachings of humanistic psychology aiming to put the therapeutic client in the position to solve their own unhappiness, the client in the central role in the lawyer-client relationship. Client-centered lawyering promotes decision-making by the client who is in the best position to weigh the non-legal consequences of various potential courses of action. In ensuring that decisions truly reflect the client's desires, values, and priorities—and not the lawyer's—client-centered lawyering requires the lawyer to understand the client's "frame of reference" to provide them with the capacity to make choices that affect their life.

Client-centered lawyering requires that the lawyer interact and communicate with the client in a manner that the client truly understands so that the client has the capacity to make an informed decision about the available choices. To do this, the lawyer is cognizant that factors such as personal relationships, world view, race, class, gender, sexual orientation, disability, religion, ethnicity, socio-economic status, and culture influence the many dimensions of the lawyer-cli-

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supra note 4, at 350 (citing Robert Dinerstein, Client-Centered Counseling: Reappraisal and Refinement, 32 ARIZ. L. REV. 501, 504 n.15 (1990), stating ninety-four law schools have adopted the Binder, Bergman & Price text). While client-centered lawyering is commonly discussed in the context of client interviewing and counseling, as Stephen Ellmann, Robert Dinerstein, Isabelle Gunning, Katherine Kruse, and Ann Shalleck point out in their textbook, the lawyer-client relationship extends beyond these discrete lawyering activities. Client interviewing and counseling are, in practice, "interwoven parts of the whole project of creating a lawyer-client relationship..." and occur throughout the course of an attorney-client relationship. See STEPHEN ELLMANN ET AL., LAWYERS AND CLIENTS: CRITICAL ISSUES IN INTERVIEWING AND COUNSELING 2 (2009); Dinerstein et al., supra note 3, at 290. See also Don Gifford, The Synthesis of Legal Counseling and Negotiation Models: Preserving Client-Centered Advocacy in the Negotiation Context, 34 UCLA L. REV. 811 (1987).

74 The client-centered therapist must: (1) have unconditional positive regard for the client, (2) possess acceptance or empathic understanding, and (3) identify with the attitudes and feelings they share with the client. See Robert D. Dinerstein, Client-Centered Counseling: Reappraisal and Refinement, 32 ARIZ. L. REV. 501, 538 (1990) (citing CARL ROGERS, CLIENT-CENTERED THERAPY: ITS CURRENT PRACTICE, IMPLICATIONS AND THEORY 9 (1951); Carl Rogers, A Theory of Therapy, Personality, and Interpersonal Relationships, as Developed in the Client-Centered Framework, in PSYCHOLOGY: A STUDY OF A SCIENCE, STUDY I CONCEPTUAL AND SYSTEMATIC, VOLUME 3 FORMULATION OF THE PERSON AND THE SOCIAL CONTEXT 185 (Sigmund Koch ed., 1959)).

75 Dinerstein, supra note 74, at 525.
76 Id. at 512–17, 547.
77 Id. at 507.
78 Id. at 543, 584. See also Dinerstein et al., supra note 3, at 291–92; Jacobs, supra note 4, at 350.
79 Dinerstein, supra note 74, at 585.
80 Dinerstein et al., supra note 3, at 290, 299 (stating the lawyer must understand that the client's views may be shaped by their connections to other people and communities such as family, friends and neighborhood, as well as communities of racial, ethnic, or national identity).
81 Id. at 290.
82 Id. at 294; Jacobs, supra note 4, at 354 n.29. As much as the client's views are influ-
ent relationship including forming a trusting lawyer-client relationship that facilitates both the client’s willingness and comfort in sharing candid, and sometimes deeply personal or “unfavorable” information; evaluating client credibility; developing client-centered case strategies and solutions; and exchanging information between the lawyer and the client involving communication and comprehension, memory, concentration, and cognitive abilities. So, too, does trauma influence these processes. Consider the below examples.

A couple of weeks into the student attorneys’ relationship with Ms. A. (the composite client whose narrative opens this article), the student attorneys scheduled a client meeting to review documentation relevant to the case. The student attorneys asked Ms. A. to bring all of her written correspondence with the Social Security Administration as well as bills and documentation of her expenses to help prove she was financially unable to repay the alleged overpayment. Despite having confirmed the meeting time and location with Ms. A. by phone, Ms. A. did not show up for the meeting. Nor did she return any of the student attorneys’ phone calls about the missed meeting. Having spent time preparing for the meeting and knowing that gathering this evidence was necessary to helping Ms. A., the student attorneys felt frustrated by Ms. A.’s seeming disappearance.

A week or so after the missed meeting, Ms. A.’s long-time social worker told the student attorneys that Ms. A. did, in fact, set out to go to the meeting. However, when Ms. A. got off the bus by the law school, Ms. A. realized that she had left all of the paperwork the student attorneys asked her to bring on the bus. Ms. A. shared with her social worker that she felt that she had “messed up” and went home. She told her social worker that she was too embarrassed to face the student attorneys.

While the student attorneys will never know if Ms. A.’s decision to go home rather than tell them she lost her paperwork was influenced by any experiences of trauma in her life, the lawyer should be aware that it might be. Avoidance of difficult or uncomfortable situations is, indeed, a common trauma response. Similarly, it is possible that trauma played a part in Ms. A. blaming herself for having

83 Susan Bryant identifies these lawyering skills as part of building cross-cultural competence. See Susan Bryant, The Five Habits: Building Cross-Cultural Competence, 8 CLINICAL L. REV. 33, 41–42 (2001).

84 Connors, supra note 68.
“messed up,” and expecting that the student attorneys would reject her by expressing anger or deciding they no longer were able to help her. Especially in a situation like this where the client has not yet developed a relationship of trust with the lawyer and may not feel emotionally safe, it is possible that Ms. A.’s behavior was influenced by trauma.

In representing clients with a history of trauma, there is great potential for the lawyer and client to misinterpret each other’s body language and conduct and, thus, misperceive one another’s message or attitude. If the student attorneys representing Ms. A. had not been trained about trauma, they may have attributed Ms. A.’s behavior to a lack of respect for their time or a scheduling conflict or transportation problems or forgetfulness. While it is possible that any of these factors may have contributed to Ms. A.’s conduct, by recognizing the influence of trauma, the lawyer expands their understanding of the range of uncertainties that influence client behavior and perspective.

In her article delineating five habits to build cross-cultural competency skills in lawyers, Susan Bryant describes a scenario in which a client in a custody matter does not follow through on setting up counseling for her eight-year-old daughter, despite having told the student attorney that she would do so. The student attorney in the case study attributes the client’s inaction to either the client’s indifference about the case or distrust of the student attorney’s advice. Through Professor Bryant’s habit of “parallel universes,” the student explores multiple parallel universes to explain the client’s behavior including: the client has never gone to a therapist and is frightened; in the client’s experience, only people who are crazy see therapists; the client has no insurance and is unable to pay for therapy; the client cannot accept that the court will ever grant custody to the husband, given that he was not the primary caretaker; the client did not think that she needed to get her child into therapy immediately; the client was procrastinating, or that race and class differences between the lawyer and client may account for the client’s failure to follow her lawyer’s advice.

Bryant describes that the point of the parallel universe habit is to “become accustomed to challenging oneself to identify the many alternatives to the interpretations to which we may be tempted to leap, on insufficient information” and that by “engaging in parallel universe thinking, lawyers are less likely to assume—usually on the basis of limited information—that they understand the reasons for clients’ be-

85 Bryant, supra note 83, at 43 (noting potential misperceptions between the lawyer and client based on cultural misinterpretations); Jacobs, supra note 4, at 380, 386 n.163.
86 Bryant, supra note 83, at 70–71.
Given the prevalence of trauma, might another explanation for the client's behavior be that, as a response to trauma, the client cannot foresee a positive outcome regardless of whether she pursues counseling? Or, that as a result of past trauma, she does not trust the lawyer's advice? Or, that she does not trust the therapist? Or, that as a result of trauma, she lacks the initiative to set up the counseling? Or, perhaps, the client may have been in therapy in the past herself, and the thought of engaging her child in therapy triggered thoughts about the traumatic events that caused the client to seek therapy, causing the client to avoid the issue in order to protect herself emotionally? Given the possibility that the client's inaction was influenced by trauma, the lawyer trained about the prevalence of trauma and trauma-informed lawyering, may have been able to anticipate the client's possible trauma-related concerns, and been able to either address the concerns or discuss alternative options.

As another example, student attorneys represented a low-income client living with HIV, posttraumatic stress disorder, addiction, and a history of experiencing and witnessing violence, in a Social Security disability hearing. Based on the student attorneys' extensive fact investigation, they knew that the client had significant difficulties controlling his emotions and anger, and an extreme inability to get along with others. One day, the client called the clinic office and a student attorney not representing the client answered the shared phone line. When that student attorney, who did not know the client's history or constellation of symptoms, told the client that her colleague was not in the office and offered to take a message, the client became extremely angry, raised his voice, and in the student's words "chewed her out" for answering her colleague's phone. Angered by the encounter, the student attorney instinctively attributed the client's behavior to rudeness and disrespect, and spoke sternly to the client. Could the client's outburst instead reflect difficulties regulating mood and emotion, and controlling anger as a result of a history of trauma? Without knowing the details of the client's trauma history, how might an awareness of the prevalence of trauma have changed the student's feelings about the phone call? How might it have changed the student's interaction with the client on the phone? How might the student attorney's curt interaction with the client have affected the client's ongoing relationship with the assigned student attorney and the clinic?

As yet another example of how trauma's effects might be seen in the context of the lawyer-client relationship, student attorneys represented a client who, as a result of the termination of her employment
and loss of income, accumulated hundreds of thousands of dollars in hospital and other debt. When the student attorneys learned of the client’s financial situation, they asked her to bring in her bills and offered to sort through them together. The client brought in many months’ worth of unopened overdue bills and collection notices that, had the client dealt with them earlier, could likely have been resolved through informal negotiation with creditors. The client, explaining why she did not open her mail and instead tossed it into a garbage bag, simply told the student attorneys that “nothing good ever comes in the mail.” Similar to Ms. A.’s avoidance reaction when she lost important paperwork on the bus, is it possible that this client’s decision to ignore her mail for many months could be explained, at least in part, by deeply rooted feelings of hopelessness or problems in initiative resulting from trauma?

A scenario that reflects the significance of the lawyer and client being able to exchange accurate and understandable information is when a student attorney conducted an initial interview with a client who wanted to take legal steps to ensure that if she died, her daughter would not be cared for by the father, with whom the family was presently living. The client’s speech was impaired as a result of a stroke she suffered in her late teens. The client could not, or would not, explain why she was concerned about dying, nor why she was concerned about the father raising her daughter. In order to best advise the client, the student attorney needed to understand more about the bases for the client’s concerns.

As this situation highlights, a critical component of the lawyer-client relationship involves the client providing factual information to the lawyer regarding the nature of the client’s problem. The lawyer routinely asks questions seeking additional factual information and clarifying facts that the lawyer may not understand or that may appear inconsistent. The lawyer will likely ask questions to try to get a complete picture of the factual situation, as well as ascertain the client’s goals and glean insights into the factors that may be influencing the client’s values and priorities.

In addition to the trust required to reveal intimate, and potentially embarrassing, information, from a purely cognitive standpoint, the client’s ability to communicate the information in a way that the lawyer may best understand depends on multiple skills that may be

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88 Inasmuch as a paramount goal of the lawyer-client relationship is to help the client resolve problems in a way that reflects the client’s unique values, goals and priorities, the lawyer must understand and respect the many influences in the client’s world that can impact the way they view the world, their view of their own situation, and the choices they have. Dinerstein et al., supra note 3, at 292.
impaired as a result of having experienced trauma. Indeed, if the client tries to explain her reasons for engaging in particular behavior in a way that does not make sense to the lawyer, or the client tells the story in a way that the lawyer perceives to be disorganized or illogical, the lawyer may assess that the client lacks credibility or that the client is not a reliable communicator of information. There are many factors that can interfere with the lawyers' and clients' abilities to understand one another's goals, behaviors, and communications. Susan Bryant recognized that cultural differences are one such factor, and Robert Dinerstein has more generally cautioned that lawyers should not expect clients to be clear about their goals or to know, or express, how the lawyer can help them.

In the example of the client concerned about her daughter's father, the student attorney easily could have attributed the client's impaired communication to her having suffered a stroke. The student attorney could have spoken more slowly or suggested that they reschedule the meeting for a time when perhaps the client's mother could participate to help the client communicate with the lawyer. Instead, the student attorney chose to engage with the client in a trauma-informed manner with a deliberate awareness of the prevalence of trauma and the possibility that the client's impaired language and cognitive skills may, at least in part, be the result of trauma.

Given the likelihood of trauma, the student attorney was aware of the importance of fostering feelings of safety and trust. The student attorney made the client feel safe by reassuring her about client confidentiality, and expressly explaining that she wanted to ensure that the client and her son felt safe. The student attorney exhibited patience by asking open-ended questions and reassuring the client that the student attorney was not in a rush. The student attorney listened patiently to everything the client said, further signaling to the client that she had time. The student attorney was candid and transparent with the client about what she hoped to accomplish during the meeting and why it was important that she understand the bases of the client's concerns so that she could best help. The student attorney asked the client if she felt safe at home, and if she felt that her daughter was safe.

The client ultimately shared that her daughter's father had been sexually, physically, and verbally abusive towards her for years, and that despite her requests that he leave the home, the father refused. The client shared that although her mother lived in the same home with the client and the father, the sister was unaware of the abuse. Once the client began confiding in the student attorney, the client was

89 Bryant, supra note 83, at 42.
90 Dinerstein et al., supra note 3, at 292.
adamant that, because the mother was dealing with the stress of her own health issues, the client did not want her mother to know about the abuse.

While there were certainly no easy solutions to the client’s problems, with a more complete understanding of the client’s complex situation, the student attorney was better able to unpack the issues and discuss legal and non-legal options, as well as connect the client to supportive and therapeutic services. With the client’s permission, the student attorney shared the client’s situation with the client’s therapist and social worker (neither of whom knew about the abuse), and organized multiple meetings involving the social worker, therapist, client, and student attorney to develop a safety plan for the client and her daughter. Had the student attorney assumed that the primary cause of the client’s impaired communication was the stroke and chosen to reschedule the initial meeting to invite the mother, the client may not have returned to the legal clinic for help.

Another example highlighting how the client’s trauma-related cognitive impairments may impede communication between the lawyer and the client can be seen in the short-term limited representation cases that the HIV Legal Clinic handles. Student attorneys offer weekly brief legal advice to patients at an HIV medical clinic in Baltimore City. Many of the client’s stories of childhood trauma are shared in the book, Life Don’t Have to End.\(^91\) Clients typically meet with a student attorney one time for approximately thirty minutes to one hour. Based on the time constraints and the limited nature of the representation, it is important that the student attorney quickly and accurately gain an understanding of the facts relevant to the client’s problem. It is equally important that, based on that understanding, the student attorney provide information and advice to the client in a way that the client understands.

Particularly in this fast-paced setting, the student attorneys find it difficult to elicit a logical and understandable story from the client. Similar to what Susan Bryant describes in connection with cross-cultural lawyering, clients frequently get lost in their stories or wander all over the place.\(^92\) In addition to other factors that impede clear and organized storytelling, might trauma-related impairments in cognitive abilities and communication skills influence the client’s ability to stay focused on the facts relevant to the problem? Might a client’s trauma-related memory difficulties cause the client to confuse or forget details

\(^91\) Barrazotto, supra note 43.

\(^92\) Bryant, supra note 83, at 44 (noting that students sometimes describe clients who organize information differently than the students or the legal system as “wandering all over the place”).
that are relevant to the logical coherence of the story? Might the cli-
ent disassociating from a problem as a response to trauma have diffi-
culty providing information to the lawyer at all?

In addition to the challenge of relaying accurate and clear infor-
mation from the client to the lawyer, there exists the related problem
of communicating understandable information from the lawyer to the
client. In many cases, but almost universally in the brief advice cases,
clients routinely nod their heads and say little in response to the stu-
dent attorneys' attempts to explain substantive or legal process issues
such as Social Security disability or SSI benefits eligibility or appeal
rights, overpayments, or return to work rules for disability or SSI re-
cipients. Clients routinely thank the student attorneys profusely for
their help and do not ask any questions. Like the example cited by
Susan Bryant in The Five Habits: Building Cross-Cultural Compe-
tence, in response to questions by the student attorney such as “Do
you have any questions?” or “Does this make sense?” clients typically
say they understand and do not ask questions.93

Does this mean that the client truly understands? Might the cli-
ent's statement of understanding mean something other than true
comprehension? While there could be a variety of reasons for this be-
behavior, impaired cognitive, language or reasoning skills as a result of
trauma, or anxiety about initiating conversation with the lawyer as a
result of trauma, could play a role in this behavior. To the extent the
client experiences anxiety about interacting with the lawyer based on
distrust or concern that the lawyer will not understand or be able to
help, the client's response to this anxiety could be to avoid the en-
counter altogether.94

93 Id. at 43.
94 Communication problems between the lawyer and the client have been described in
the context of cross-cultural lawyering as well. Indeed, in her article, The Five Habits:
Building Cross-Cultural Competence, Susan Bryant, in describing Habit Four, which fo-
cuses on cross-cultural communication, shares an interaction between a lawyer and an
eight-year-old client, who is the subject of a child neglect proceeding. In their first meet-
ning, the lawyer uses a standard script to explain the proceeding and, thinking of the many
children who blame themselves for neglect proceedings against their parents, the lawyer
explains that neglect proceedings are brought by the state against the parents and not
against the child. The child was “subdued and reticent to talk other than saying, ‘I did not
do anything wrong.’” Later, after a court proceeding, the child asked the lawyer why there
were no police in the courtroom. The child told the lawyer that they thought you only get a
lawyer if you have done something wrong, and that everyone they knew who had a lawyer
went to jail. To maximize accurate and genuine communication between the lawyer and the
client, Professor Bryant encourages “culturally sensitive exchanges with clients” by varying
the lawyer's communication strategies in place of scripts, asking open-ended questions that
call for narrative responses and engaging in “attentive listening” to the child's story and
voice, and paying particular attention to developing trust and rapport at the beginning of
the interview. Bryant, supra note 83, at 72–75 (citing Gay Gellhorn, Law and Language:
An Empirically-Based Model for Opening Moments of Client Interview, 4 CLINICAL L.
Whether or not a client has experienced trauma, developing a trusting lawyer-client relationship is critical to facilitating the client’s willingness and ability to share information with the lawyer, as well as to ask questions or “challenge” the lawyer’s advice. Within the client-centered framework, critical aspects of the lawyer-client relationship involve the lawyer’s ability to form a trusting relationship with the client to allow genuine and accurate communication in order to develop case strategies, theories, and solutions that accurately reflect the client’s situation, and understand the client’s values, attitudes, and priorities by assigning the correct meaning to the client’s words, expressions, and behaviors.\textsuperscript{95} While there are many factors that influence the degree to which the lawyer and client develop a trusting relationship, including respective personalities, the client’s past experience with a lawyer or the legal system, and cultural differences,\textsuperscript{96} for the client who has experienced trauma, the client is even more likely to come to the lawyer-client relationship with deeply rooted feelings of distrust. For the client who has experienced trauma—particularly interpersonal trauma that impacts normal attachment, like that typically associated with childhood trauma—it may be even more difficult to form a trusting relationship with the lawyer.

As these examples highlight, just as cross-cultural lawyering scholars have expanded lawyers’ awareness of the many influences on the lawyer-client relationship to include cultural differences and similarities,\textsuperscript{97} emerging trauma-informed lawyering literature contributes that trauma, through its effects on client decision-making, trust, communication, problem-solving and reasoning capacity, memory, and concentration,\textsuperscript{98} similarly influences the dynamics of the lawyer-client relationship.\textsuperscript{99}

\section*{IV. Trauma-Informed Lawyering}

Given the prevalence of trauma and the effects it can have on client behavior and the lawyer-client relationship, good lawyering re-

\begin{thebibliography}{99}
\bibitem{95} Bryant, \textit{supra} note 83, at 41–42 (identifying the same aspects of the attorney-client interaction as implicated when lawyers and clients come from different cultures).
\bibitem{96} \textit{Id.}; Jacobs, \textit{supra} note 4, at 361 n.73.
\bibitem{97} Culture has been broadly defined as “the logic by which we give order to the world” and has been recognized as shaping attitudes, values, and norms of behavior. Bryant, \textit{supra} note 83, at 40 (citing \textsc{Raymonde Carroll}, \textit{Cultural Misunderstandings: The French-American Experience} 2 (1988)). See generally Jacobs, \textit{supra} note 4; Katherine R. Kruse, \textit{Fortress in the Sand: The Plural Values of Client-Centered Representation}, 12 \textsc{Clinical L. Rev.} 369, 388-90 (2006).
\bibitem{98} Susan Bryant identifies these lawyering skills as part of building cross-cultural competence. See Bryant, \textit{supra} note 83, at 41–42.
\bibitem{99} Katz & Haldar, \textit{supra} note 7, at 370-72.
\end{thebibliography}
quires that the lawyer develop trauma-informed competencies. A long line of clinical scholarship expands the methods of client-centeredness initially developed by Binder and Price.\textsuperscript{100} Trauma-informed lawyering further contributes to this approach and good lawyering generally, particularly for the many clients who have experienced trauma.\textsuperscript{101}

In addition to seeking to improve legal outcomes for the client who has experienced trauma, trauma-informed lawyering also improves the experience for the client generally and, for the client with a history of trauma, does so significantly. Fitting squarely within the scholarship of therapeutic jurisprudence, which recognizes that the lawyer is a "therapeutic agent" whose actions impact the mental health and psychological well-being of the client,\textsuperscript{102} trauma-informed lawyering promotes the overall well-being of clients by not only making legal services accessible for the client who may otherwise be unable to access justice due to trauma-related barriers,\textsuperscript{103} but also promoting healing and resiliency through a relationship built on trust, safety, and respect.\textsuperscript{104}

Given that clients come to lawyers to address problems that have legal as well as non-legal components, and that they come to lawyers oftentimes frustrated by their experiences, as well as interactions with


\textsuperscript{101} Given the client-centered approach to representation's roots in psychology, a practice philosophy grounded in behavioral health logically enhances the framework. Client-centered representation is based on a nondirective counseling model developed by psychologist Carl Rogers that posits that the client is capable of making all decisions for themselves, and should, therefore, take an active role in their counseling. \textit{See Gifford, supra note 73, 817–18.}


\textsuperscript{103} Rachel White-Domain, a lawyer with the National Center on Domestic Violence, Trauma and Mental Health, views the need to take more time with clients who have experienced trauma as an accommodation that allows the client to access legal services they may otherwise be unable to access. \textit{See Rachel White-Domain, Webinar, Trauma-Informed Legal Advocacy: An Introduction, NAT'L CTR. ON DOMESTIC VIOLENCE, TRAUMA & MENTAL HEALTH} (Feb. 25, 2016), http://www.nationalcenterondvtraumamh.org/training/traininga-trauma-informed-legal-advocacy-tila-project/ (under the heading "TILA Webinars" click on "Webinar Recording: Trauma-Informed Legal Advocacy: An Introduction").

\textsuperscript{104} \textit{Id.}
systems and bureaucracies, a positive interaction with the lawyer can provide support, alleviate stress and anxiety, and result in increased client satisfaction. As expressed by Mr. W., a former clinic client:

I have been very untrusting, and somewhat critical of dealing with the bureaucracy of Social Security. I experienced a 100% willingness by your [legal] students, to assist me with ... [my Social Security disability] matters. ... I was left feeling confident with the research result. I can now deal with my issue with a more positive outlook. ... What a display of humanism presented. ... Thank you so much for this beneficial program, which has alleviated many sleepless night and emotional stress.105

The lawyer can develop trauma-informed competencies by adopting approaches to practice common in the field of behavioral health.

A. Defining Trauma-Informed Practice

The concept “trauma-informed care” or “trauma-informed practice” has become increasingly prevalent in recent years, particularly in the legal services community serving victims of known abuse.106 This

105 E-mail from client to author (Apr. 8, 2016) (on file with author). Mr. W. is one of the people who share his story in Life Don’t Have to End. He never shared any of his life experiences with us nor did we ask. (I changed Mr. W.'s last name initial to protect his privacy). See Barrazaotto, supra note 43.

106 Trainings for legal service providers are becoming increasingly common, particularly for lawyers representing adults and children whose traumatic experiences are substantively relevant to the representation. For example, the Maryland State Bar Association held a day of service in March 2017 that included trauma-informed advocacy training focused on assisting military veterans. In 2016, End Violence Against Women International hosted a two-part webinar titled, The Neurobiology of Sexual Assault presented by James W. Hooper and advertised by organizations such as the D.C. Lawyers Project. See Serving Those Who Served Us: A Day of Legal Training & Service for Maryland's Veterans, MD. ST. BAR ASS’N LEADERSHIP ACADEMY. (Mar. 30, 2017), http://www.msba.org/Events/Committee_Events/LeaderAcad033017.aspx; Dr. James Hopper, Webinar, Neurobiology of Sexual Assault, END VIOLENCE AGAINST WOMEN (Sept. 2016), http://www.evawintl.org/WebinarArchive.aspx (click on “Full Description” links under the heading “Neurobiology of Sexual Assault 2-Part Webinar Series” to access slides and handouts). The D.C. Volunteer Lawyers Project provides legal representation to domestic violence victims and at-risk children in civil protection and family law cases in Washington, D.C. D.C. VOLUNTEER LAWYERS PROJECT, http://www.dcvlp.org/ (last visited Aug. 2, 2017). See also White-Domain, supra note 103; Katz & Haldar, supra note 7, at 370 (referencing resources for lawyers practicing in areas such as juvenile justice and delinquency, child welfare, family law, and domestic violence); ABA, Webinar, Practice Recommendations for Trauma-Informed Legal Services (July 2013), http://www.americanbar.org/content/dam/aba/administrative/child_law/5C_Patten%20Kraemer_Practice%20Recommendations%20for%20Trauma%20Informed%20Legal%20Services.authcheckdam.pdf (last visited July 19, 2017); Mercedes V. Lorduy et al., Presentation, A Trauma Informed Approach to Attorney Client Relationships and Collaborations: Strategies for Divorce, Custody, Protection Orders and Immigration Cases, NAT’L IMMIGRANT WOMEN’S ADVOC. PROJECT, AM. U. WASH. C.L. (July 29, 2015), http://library.niwap.org/wp-content/uploads/Powerpoint-Trauma-Informed-Approach-to-AttorneyClient-Relationships-and-Collaborations-1.pdf.
mode of service delivery has been accompanied by an ever-growing interest in training opportunities offered to service providers—most commonly in the behavioral health contexts of nursing, social work, psychiatry, and psychology.\textsuperscript{107} While there is no uniform model that defines the trauma-informed care approach,\textsuperscript{108} it is best understood as

\textsuperscript{107} See Kevin Huckshorn & Janice L. Lebel, Trauma Informed Care, in Modern Community Mental Health: An Interdisciplinary Approach 62 (Kenneth Yeager et al. eds., 2013). See also About NCTIC, SAMSHA, http://www.samhsa.gov/nctic/about (last visited July 31, 2017) (describing the mission of the National Center for Trauma-Informed Care (NCTIC) as “offer[ing] consultation and technical assistance, education and outreach, and resources to support a broad range of service systems, including systems providing mental health and substance abuse services, housing and homelessness services, HIV services, peer and family organizations, child welfare, criminal justice, and education.” Id.; Trauma Informed Care Series IV Clinical Providers MDAKL. AIDS Educ. & Training Ctr., https://www.maaetc.org/events/view/9568 (last visited July 31, 2017) (detailing a Trauma Informed Care Case Conference applying an interdisciplinary approach to trauma-informed care presented and discussed through a case).

\textsuperscript{108} For example, SAMHSA defines a trauma-informed approach as one in which a program, organization, or system “(1) realizes the widespread impact of trauma and understands potential paths for recovery, (2) recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system, (3) responds by fully integrating knowledge about trauma into policies, procedures, and practices, and (4) seeks to actively resist re-traumatization.” Trauma-Informed Approach and Trauma-Specific Interventions, SAMHSA, http://www.samhsa.gov/nctic/trauma-interventions. See also Katz & Haldar, supra note 7, at 369 (citing SAMHSA’s definition of trauma-informed practice as “acknowledging the prevalence and impact of trauma and attempt[ing] to create a sense of safety for all participants, whether or not they have a trauma-related diagnosis”). The National Child Traumatic Stress Network (NCTSN) defines trauma-informed practice as including: (1) routine screenings for trauma exposure and related symptoms; (2) culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (3) resources available to children, families, and providers on trauma exposure, its impact, and treatment; (4) efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) addressing parent and caregiver trauma and its impact on the family system; (6) emphasizing continuity of care and collaboration across child-service systems; and (7) maintaining an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience. Dierkhising et al., supra note 11, at 2. Sarah Katz and Deeya Haldar reference the Sanctuary Model created by psychiatrist Sandra Bloom that proposes seven characteristics of a trauma-informed organization: (1) a culture of nonviolence, (2) a culture of emotional intelligence, (3) a culture of social learning, (4) a culture of shared governance, (5) a culture of open communication, (6) a culture of social responsibility, (7) a culture of growth and change. Katz & Haldar, supra note 7, at 370, n.60. According to Roger Fallot and Maxine Harris, the five primary principles of trauma-informed practice are: (1) safety (including ensuring both physical and emotional safety), (2) trust (maximizing trustworthiness, making tasks clear, clarifying roles, establishing appropriate boundaries, and being predictable); (3) choice (prioritizing consumer choice and control); (4) collaboration (sharing power with clients); and (5) empowerment (prioritizing empowerment and skill building). Roger Fallot & Maxine Harris, Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol, 2.2 Community Connections 3 (2009), https://www.healthcare.uiowa.edu/icmh/documents/CCTIC-Self-AssessmentandPlanningProtocol0709.pdf. See also Elizabeth K. Hopper et al., Shelter from the Storm: Trauma-Informed Care in Homelessness Services, 3 OPEN HEALTH SERVS. & POL’Y J. 80, 81-82, 93 (2010) (reviewing the basic principles of trauma-informed care...
an approach to engaging people with histories of trauma that reflects a philosophy, culture and understanding about trauma symptoms, and that recognizes the role that trauma has played in their lives.

Trauma-informed care is a “strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.” Importantly, trauma-informed care, which aims to improve all aspects of service delivery to people who have experienced trauma, is different from trauma-specific interventions or treatment, which directly addresses the impact of trauma in order to decrease symptoms and treat the effects of trauma.

Four themes that cut across most definitions of trauma-informed care are: (1) trauma awareness, (2) emphasis on safety, (3) opportunities to rebuild control, and (4) strengths-based approach. In terms of trauma awareness, trauma-informed service providers incorporate an “understanding of trauma” into their work. Being trauma-informed fundamentally involves recognizing that “behavioral symptoms, mental health diagnoses, and involvement in the criminal justice system are all manifestations of injury rather than indicators of sickness or badness—the two current explanations for such behavior.” Consistent with this recognition, the National Center for Trauma Informed Care (NCTIC) suggests that the service delivery approach should be changed from one that asks, “What’s wrong with you?” to one that asks, “What has happened to you?” Critical pieces of raising awareness of how behaviors may reflect responses to traumatic experiences include staff training, consultation, and supervision.

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proposed by various workgroups, organizations, expert panels, and researchers, and concluding that each source presented a different definition of trauma-informed care).


110 About NCTIC, supra note 107.

111 Hopper et al., supra note 108, at 82.

112 Id. at 81.

113 Id. at 81–82.

114 SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., TRAUMA-INFORMED CARE IN BEHAVIORAL HEALTH SERVS.: QUICK GUIDE FOR CLINICIANS 7 (2014).

115 Katz & Haldar, supra note 7, at 369–90 (citing SANDRA L. BLOOM & BRIAN FARRAGHER, RESTORING SANCTUARY: A NEW OPERATING SYSTEM FOR TRAUMA-INFORMED SYSTEMS OF CARE 1, 7–9 (2013)).


117 Hopper et al., supra note 108, at 81.
Being trauma-informed means that all staff of an organization must understand the effects of trauma on the people being served so that all interactions with the organization are consistent.¹¹⁸

Since many people who have experienced trauma may feel—and some may in fact be—unsafe, a trauma-informed approach to service ensures physical and emotional safety. A safe environment includes maintaining privacy and confidentiality, and fostering mutual respect,¹¹⁹ including respect for cultural differences.¹²⁰ Emphasizing safety also includes avoiding potential triggers that could re-traumatize those receiving services.¹²¹ Because interpersonal trauma in particular often involves boundary violations and abuse of power, to ensure emotional safety, trauma-informed practice must set clear roles and boundaries that are established through collaborative decision-making.¹²²

Next, trauma-informed practice emphasizes the importance of choice in an effort to restore the control that is frequently taken away as a result of traumatic events.¹²³ Finally, trauma-informed practice focuses on people’s strengths and develops coping skills in a future-oriented setting.¹²⁴

B. Trauma-Informed Lawyering in Practice: Philosophical Framework and Concrete Strategies

Both because the lawyer is not trained to diagnose trauma or attribute specific client behavior to trauma, and because leaving trauma-informed lawyering to those cases where the lawyer attempts to identify relevant trauma will likely overlook clients who could benefit from the approach, lawyers representing clients experiencing urban poverty can improve the quality of representation by uniformly adopting a trauma-informed approach. While this approach may result in

¹¹⁸ Katz & Haldar, supra note 7, at 369 (citing Denise E. Elliott et al., Trauma Informed or Trauma Denied: Principles and Implementation of Trauma-Informed Services for Women, 33 J. COMMUNITY PSYCHOL. 461, 462 (2005)). See also Lori Beyer et al., Presentation at Taking on Trauma in Our Lives and Service Systems: A National Summit and Listening Session, Creating Cultures of Trauma-Informed Care (2011).

¹¹⁹ Hopper et al., supra note 108, at 81–82.

¹²⁰ Id. at 82.


¹²² Hopper et al., supra note 108, at 81.

¹²³ Id. at 82.

¹²⁴ Id.
the lawyer providing trauma-informed services for clients who may not be affected by trauma, trauma-informed lawyering will enrich the lawyer-client relationship generally, and enrich it significantly for the client with a history of trauma.125

Applying the behavioral health tenets of trauma-informed care to the context of legal services, much of good lawyering already incorporates trauma-informed practices. Indeed, strategies such as developing rapport, building trust, and promoting the clear and accurate exchange of information through active listening, are trauma-informed practices. However, for the client who comes to the lawyer-client relationship with deep feelings of distrust, disempowerment, anxiety, and hopelessness; impaired cognitive and language skills; or an inability to regulate mood as a result of trauma, the lawyer’s usual tools to build trust and rapport may be insufficient.

Establishing trust with a client who inherently distrusts due to trauma requires the lawyer to fundamentally understand what trauma is and the client’s possible responses to that trauma. The first step in trauma-informed lawyering is for the lawyer to adopt a mindset in which the lawyer considers the many possible explanations for the client’s behavior, and avoids making assumptions or judgments. The lawyer should consistently try to consider behavior from the perspective of the client and ask themselves, “What might be happening?”126 With this foundational mindset in play, the lawyer can then utilize concrete tools to facilitate information gathering and communication, and promote trust and safety that may resonate with the client affected by trauma.

125 Talia Kraemer & Eliza Patten, Establishing a Trauma-Informed Lawyer-Client Relationship (Part One), 33 ABA CHILD L. PRAC. 193, 198 (2014) (discussing the public health approach of “universal precaution”). While the focus of this article is the influence of trauma on the lawyer-client relationship, the lawyer’s understanding of trauma and its effects can improve physical and mental health outcomes for the client as well. A positive lawyer-client relationship can not only alleviate stress for the client but also provide physical benefits. For example, in the HIV Legal Clinic, clients often feel anxious and stressed as a result of a legal problem and, as a result, may not have the mental focus to take their medicine every day as prescribed or go to medical appointments. Medical adherence is critical not only to the client’s individual wellness but also to reducing the transmission of HIV within the community (because an individual is at significantly lower risk of transmitting HIV if they are virally suppressed). Clients have also shared that their medical conditions have worsened as a result of their stress. For example, Ms. A., the client whose narrative opens this article, endured numerous emergency hospitalizations due to flare-ups of her acute pancreatitis in the months following her job termination. Student attorneys represented another client in a Social Security matter who was hospitalized for ten days to treat high blood pressure resulting from the stress of awaiting a long overdue decision from Social Security about the reinstatement of her disability benefits.

126 White-Domain, supra note 103.
1. Philosophical Framework

Inasmuch as trauma-informed care is a way of thinking—a philosophical framework—more than a formulaic approach, its implementation in the legal setting most fundamentally requires the lawyer to come to the lawyer-client relationship with the mindset of “What happened or is happening to the client?” as opposed to “What is wrong with the client?”127 Adopting this way of thinking will help the lawyer interact with the client with respect and equality and in a way that helps empower the client who may feel broken or weakened as a result of trauma.128 A client testimonial shared during a trauma training held in 2017 at the University of Baltimore highlights the significance of this mindset:

During every incarceration, every institutionalization, every court-ordered drug treatment program, it was always the same: I was always treated like a hopeless case. All people could see was the way I looked or the way I smelled. It wasn’t until I finally entered a recovery-oriented, trauma-informed treatment program, where I felt safe and respected, that I could begin to heal. . . . Someone finally asked me, “What happened to you?” instead of “What’s wrong with you?”129

To adopt this way of thinking, the lawyer must understand the widespread prevalence and impact of trauma, as well as recognize signs and symptoms of trauma-related behavior.130 With training on the prevalence and effects of trauma, the lawyer will be able to consider a broader range of explanations for a client’s behavior and develop more empathy and understanding of the client’s goals and values. The lawyer’s awareness of trauma expands the lawyer’s thinking about the range of possible explanations for client behavior.131

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127 About NCTIC, supra note 107.
128 RELIAS LEARNING, 5 KEY ELEMENTS TO TRAUMA-INFORMED CARE, WHITE PAPER 4 (2016).
129 Meade Eggleston, Dir., Veterans Psychol. Clinic at the Univ. of Balt., Presentation on Trauma-Informed Care for Veterans (Mar. 30, 2017) (on file with author) (quoting Toner Cain, a Team Leader with SAMHSA’s National Center for Trauma-Informed Care).
130 Key aspects of a trauma-informed approach include: (1) realizing the wide-spread presence and impact of trauma; (2) recognizing signs and symptoms of trauma-related behavior; (3) responding by integrating knowledge about trauma into policies, procedures, and practices; and (4) resisting re-traumatization when interacting with clients and providing services. Eggleston, supra note 129 (citing SAMHSA’s National GAINS Center for Behavioral Health and Justice and SAMHSA’s National Center on Trauma-Informed Care).
131 The consideration of trauma as a possible explanation for the client’s behavior expands the habit of “parallel universes” set forth by Susan Bryant. Bryant, supra note 83, at 70–72. Katz and Haldar also suggest that law students be trained to recognize that what a client may be describing, or the behavior the client may be exhibiting, may be indicative of trauma. See Katz & Haldar, supra note 7, 382–83.
Particularly at times when the lawyer is judging the client’s behavior negatively such as when the lawyer feels frustrated that the client did not show up for a scheduled meeting, or when the lawyer feels disrespected that the client yelled at them on the phone,\textsuperscript{132} when the client tells their story in an illogical or disjointed way, or when the lawyer feels annoyed that the client did not follow through on the lawyer’s advice, the lawyer who is overtly aware of an expanded range of possible explanations for the client’s behavior, including trauma, may feel less judgmental and engage with the client more patiently and respectfully.

Lawyers can begin to understand the influence of trauma on the lawyer-client relationship by seeking out training opportunities and by engaging with behavioral health professionals with expertise in trauma and staying current on this developing dialogue within the legal community. While training opportunities for lawyers are most often geared toward lawyers representing clients in cases in which the trauma is relevant to the legal matter,\textsuperscript{133} the lessons are equally applicable for cases not involving abuse. In the HIV Legal Clinic, Kathleen Connors, a social worker,\textsuperscript{134} teaches a class about poverty and trauma, and facilitates case rounds in which she guides law students to recognize the many sources of possible trauma in their clients’ lives. Connors facilitated a similar session for the first time in fall 2016, during the University of Maryland Carey School of Law’s clinic-wide orientation, including students working with low-income clients in the areas of criminal, landlord-tenant, gender violence, tax, mediation, and disability rights law.

While expanding the range of possible explanations for the client’s behavior, the lawyer must take care to avoid making assumptions about the client’s experience of trauma or its effects. While the lawyer can improve the experience for the client by recognizing the possibility of trauma, the lawyer must take care to avoid creating or

\textsuperscript{132} Trauma-informed care requires that everyone working in an office be trained about trauma, not only the individual lawyer. Because the client interacts with other people in the office, including the office receptionist, the lawyer’s colleague who answered a shared phone line and others, it is important that the client’s experiences foster trust and feelings of safety. Katz & Haldar, supra note 7, at 369 (citing Denise E. Elliott et al., Trauma Informed or Trauma Denied: Principles and Implementation of Trauma-Informed Services for Women, 33 J. COMMUNITY PSYCHOL. 461, 462 (2005)). See also Beyer et al., supra note 118.

\textsuperscript{133} See examples of trauma-informed practice training opportunities, supra note 106 and accompanying text.

\textsuperscript{134} Kathleen Connors has over thirty years of experience as a clinical social worker working with traumatized children and their families. Connors is an instructor at the University of Maryland School of Medicine, Department of Psychiatry, Project Director of the Family Informed Trauma Treatment Center (through a SAMHSA-funded grant), and Program Director of the Taghi Modarressi Center for Infant Study.
perpetuating stereotypes. As cross-cultural scholarship teaches, no single characteristic singularly defines a person's experience. As with other areas of difference, the lawyer must remain "cognizant and critical" about the assumptions that they bring to the lawyer-client relationship, and simultaneously recognize that no single characteristic or behavior defines an individual's experience. To the extent that the lawyer can be aware of the prevalence of trauma and its possible effects, yet not assume its existence in every case, the lawyer will be in a better position to exercise the necessary professional judgment about possible strategies and approaches to take in a specific interaction.

2. Practical Strategies

In addition to adopting a philosophical framework through which the lawyer considers the range of possibilities that may be influencing client behavior—including experiences that the lawyer may not understand—the lawyer can also use concrete tools to promote trust and emotional or physical safety, as well as to empower client decision-making. Inasmuch as establishing and maintaining a lawyer-client relationship of trust and safety is critical to promoting open and accurate communication, client engagement, and client satisfaction, the lawyer can improve the quality of representation by incorporating some or all of the following strategies into their practice.

Transparency. Because the client affected by trauma may feel confused or overwhelmed by the legal process, it is important that the lawyer be fully transparent with the client about the legal case in order to facilitate trust and minimize feelings of powerlessness. This strategy can be effective in various situations in the lawyer-client rela-

135 Dinerstein et al., supra note 3, at 296.
136 Bryant, supra note 83, at 41.
137 See SAMHSA's GAINS CENTER FOR BEHAVIORAL HEALTH & JUSTICE TRANSFORMATION, http://gainscenter.samhsa.gov/ (last visited Aug. 2, 2017). The GAINS Center provides technical assistance to several of SAMHSA's justice-related grant programs and to the field, including trauma-informed response trainings, strategic planning workshops, and policy academies. See also SAMHSA'S NATIONAL CENTER ON TRAUMA-INFORMED CARE (NCTIC) & ALTERNATIVES TO SECLUSION AND RESTRAINT, https://www.samhsa.gov/nctic (last visited Aug. 2, 2017). NCTIC provides training, consultation, and other technical assistance to courts, jails, prisons, and other justice system partners.
tionship. For example, in the case of Ms. A., where the student attorneys felt uncomfortable asking Ms. A. personal questions about her relationship with her children's father, the student attorneys could explain why they are asking the questions. Transparency about the lawyer's role, especially in situations in which the lawyer needs to ask questions that might seem irrelevant or call for stigmatized information, is a helpful tool in promoting a good lawyer-client relationship.

As another example, student attorneys in the HIV Legal Clinic must ask clients for documentation verifying they are living with HIV to comply with the requirements of a Ryan White HIV/AIDS Program Grant. While this can be an uncomfortable conversation with all clients, for the client whose legal matter is wholly unrelated to their HIV status, the question could impede the lawyer-client relationship from its inception. To promote trust, the student attorney is transparent about why they need to ask the question, that is, that the clinic receives grant funding to provide free legal services for people living with HIV and the funder requires documentation verifying that the client is eligible for services under the grant. When explained in this context, the client does not appear taken aback by the request.

As another example, in situations in which the client floods the lawyer with an overload of information, or wanders from topic to topic in a seemingly unfocused way, the lawyer's candor and transparency about what they want to accomplish and the purpose of the interview may help focus the meeting. As with the clinic's onsite brief advice cases where the student attorneys meet with clients back-to-back every hour, the students often struggle to balance efficiency with patiently allowing the client to tell their story at the client's own pace. Particularly in a time-limited interaction such as this, the lawyer's candor and transparency about what they want to accomplish may help focus the discussion. Through transparency, the lawyer may also better engage the client in developing solutions to some of the challenges they may have interacting with the lawyer, the opposing party, or the judge.

Yet another example is the lawyer's note taking during a client meeting. While taking notes may signal to the client that the lawyer wants to remember everything the client says, some clients may find note taking to be objectifying. Because the lawyer often needs to take notes to remember important information for the case, being

139 Katz & Haldar, supra note 7, at 387 (citing Judy I. Eidelson, Post-Traumatic Stress Disorders: Representing Traumatized Clients, PHILA. BAR ASS'N FAM. L. SEC. CLE (2013)).
140 Id. at 389.
141 White-Domain, supra note 103.
transparent about this need can dispel the client’s suspicions. For example, the lawyer should ask the client if it is okay that they take notes and explain that they typically take notes in order to ensure that they accurately capture what the client says. With this kind of explanation, the client gains control of the lawyer’s note taking. With a client who seems uncomfortable with the lawyer’s note taking, the lawyer may also read back a summary of the notes so the client knows they are accurate. Transparency around note taking communicates to the client that the lawyer thinks accuracy is important.\textsuperscript{142}

\textit{Predictability.} The lawyer might help the client feel emotionally and physically safe by previewing what lies ahead in terms of the lawyer-client relationship and the broader legal process. Recognizing that the legal process may be unfamiliar and scary for the client, especially for the client predisposed to anxiety as a result of trauma, consistently keeping the client informed of future steps and explaining things in advance may increase their sense of safety and security.\textsuperscript{143} To promote trust and safety through predictability, the lawyer should consider scheduling more frequent meetings with the client.\textsuperscript{144} The lawyer could also schedule meetings on regular days and times.\textsuperscript{145} Even if regular in-person meetings are not feasible for whatever reason, including lack of time, transportation, or childcare, the lawyer could ask the client if they want to schedule weekly phone check-ins at the same day and time each week.

Clearly defining roles and responsibilities also maximizes predictability, especially with clients whose traumatic experiences may have resulted from unhealthy relationships and who, as a result, may be unclear about boundaries and roles. The lawyer should discuss with the client early in the relationship the lawyer’s role, the nature of the services that the lawyer does and does not provide, and what the lawyer can and cannot accomplish for the client. Similarly, the lawyer should explain the client’s role, emphasizing the client’s decision-making power and agency. The lawyer should explain confidentiality, and provide the client with reliable information about the lawyer’s schedule, availability, and contact information.\textsuperscript{146} The lawyer may also ex-

\textsuperscript{142} \textit{Id.}
\textsuperscript{143} \textit{Id.} (cautioning that the lawyer must find the balance between providing too much information that could be overwhelming versus providing enough information to minimize surprises); Kraemer & Patten, \textit{supra} note 125.
\textsuperscript{144} See Katz & Haldar, \textit{supra} note 7, at 392 n.149.
\textsuperscript{145} Kraemer & Patten, \textit{supra} note 125.
\textsuperscript{146} Habit Four of Susan Bryant’s five habits for building cross-cultural competencies involves paying conscious attention to the process of communication to ensure that accurate and genuine communication is occurring. To do this, Professor Bryant cautions against “scripting” parts of the interviewing such as explaining confidentiality, building rapport, and explaining the legal system and process. Instead, Professor Bryant suggests using a
plore the client's assumptions about the lawyer-client relationship, and ask about the client's prior experiences with a lawyer or the legal system, as well as what went well and what did not go well.147

Patience. Because building trust takes time, the lawyer needs to invest extra time in developing the lawyer-client relationship, and exercise patience and consistency in their dealings with the client.148 As such, the client must feel that the lawyer is patient, present, and available.149 Melissa Tyner, who directs the University of California at Los Angeles (UCLA) School of Law's veterans clinic, reports that the trauma-informed approach employed in her clinic involves the law students "tak[ing] pains to establish rapport" with clients who have likely suffered PTSD or brain injuries.150

When time permits, exercising patience might mean allowing more time for a client meeting, scheduling more frequent in-person meetings with the client than would otherwise be necessary, or offering breaks during a meeting.151 However, for the busy lawyer, investing extra time in the lawyer-client relationship may be challenging. Given the realities of practice, the lawyer often meets with the client in time-limited situations such as the one-hour brief advice sessions in the HIV Legal Clinic, or in a courthouse hallway during a short break in proceedings. Recognizing that the message to be communicated through the lawyer's exercise of patience is that the lawyer has time for the client, and that the client and the client's case is important, the lawyer can convey this intent even in the face of time constraints.

For example, the busy lawyer might try to schedule short, but more frequent, check-ins with the client to convey her presence in the relationship.152 Clients frequently seek the HIV Legal Clinic's representation in SSI or Social Security disability appeals having unsuccessfully applied for benefits for years. For those clients who were previously represented by counsel, clients often complain not about the outcome of their previous cases but, rather, about the fact that they had so little contact with their lawyer during the approximate nineteen-month wait time for a Social Security hearing in Baltimore City.153 Based on this lack of communication, clients have reported

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147 Kraemer & Patten, supra note 125.

148 Katz & Haldar, supra note 7, at 388-89; Hopper et al., supra note 108, at 84-85.

149 Kraemer & Patten, supra note 125.

150 Sloan, supra note 12.

151 Katz & Haldar, supra note 7, at 388-89; White-Domain, supra note 103.

152 While limited resources may necessitate high caseloads, empirical evidence measuring positive outcomes to clients based on trauma-informed lawyering may provide support for grant funding to hire additional staff and permit reduced caseloads.

feeling that the lawyer did not provide good representation, that the lawyer did not know enough about the client's situation, and that they did not trust the lawyer.

Even when the lawyer lacks time, using the strategy of transparency, the lawyer can make sure that the client knows they are important by overtly addressing the time limitation. For example, the lawyer with only forty-five minutes to meet with a client for a brief advice session could acknowledge that the meeting might feel rushed based on the time allotted for the meeting, and assure the client that that this does not mean that the lawyer does not care about the client or the issue. Similarly, in situations where the lawyer only has five minutes to talk on the phone to the client, the lawyer can expressly acknowledge the limitation and schedule a follow up call on another specific date. By being transparent, the lawyer communicates that the client is important, and that the lawyer is committed to the client and to the case even when time limitations might signal otherwise. To prove that the lawyer is reliable, the lawyer must then follow through on their promise to talk at a later date.

**Client Storytelling.** When circumstances permit, the lawyer who allotst extra time for meeting with the client allows the lawyer to create space for another trauma-informed strategy—storytelling. For the client who has difficulty remembering information as a result of trauma, permitting the client to share their story without interruption can facilitate the client's memory. To create a space for storytelling, the lawyer should first explain to the client the information the lawyer wants to know, and then give the client space to tell their story without interruption. The lawyer must become comfortable with pauses and periods of silence that signal to the client that the lawyer has time, and allows the client to feel in control of how to tell their story. Rather than interrupting the client's storytelling, the lawyer could jot down any questions and save them for the end of the interview.

Another technique that may encourage the client to trust the lawyer and share information is for the lawyer to encourage the client to share more—or even different—information with the lawyer at a later date. The lawyer can communicate that they understand that it is sometimes difficult to share information with someone the client just met, and that the client can share information if the client remembers anything after the meeting—even if it might be different than what the client shared that day.

**Physical Environment.** Creating a sense of emotional and physical safety for the client might involve ensuring that the physical envi-

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154 White-Domain, *supra* note 103.
155 *Id.*
vironment is calm and soothing. As one example, the John Marshall Law School opened a veteran’s clinic in 2013 in a space designed with deliberate attention to creating a “calm environment with muted paint colors and sound-insulated windows that let in plenty of natural light.” While this is certainly one good way to create a calm space, lawyers do not necessarily need to renovate their office space to enhance safety and create a calm environment for the client.

Offering the client options within the physical space is another good technique to promote the client’s feelings of safety and control which, in turn, can reduce anxiety, foster trust, and facilitate good communication and informed decision-making. For example, the lawyer can be thoughtful about where to conduct and whom to include in client meetings to maximize the client’s comfort. Even in an office without natural light or significant space, the lawyer should ensure that the room is well lit. To the extent possible, the lawyer should create options for the client to choose where to sit. The client may not want to sit with their back to the door, or may not want the lawyer to be seated between the client and the door. To the extent possible, the lawyer should sit beside rather than across a table or desk from the client in an effort to minimize power differences.

While Ellmann, Dinerstein, Gunning, Kruse, and Shalleck do not reference trauma-informed lawyering by name in their book and article on legal interviewing and counseling, they do discuss approaches to lawyering that fit within the trauma-informed framework. For example, they discuss the importance of “context” in shaping the lawyer-client interaction, and use the example of the lawyer’s choice about where to conduct a client meeting. They question whether meeting at the client’s home is considered a routine option or whether it would be viewed by the lawyer as “an atypical response to an extraordinary situation,” and note that such norms are important in shaping the lawyer’s views about the range of available choices in developing the lawyer-client relationship. They similarly consider the lawyer’s decision about whether to include or exclude a family member in the client interview, acknowledging that the presence of a support person may well impact the client’s comfort, trust, willingness or ability to express their desires, and even the relationship they have with that person.

156 Sloan, supra note 12.
157 White-Domain, supra note 103.
158 Eggleston, supra note 129.
159 Ellmann et al., supra note 73; Dinerstein et al., supra note 3.
160 Dinerstein et al., supra note 3, at 294.
161 Id. at 303. The lawyer must consider the implications that involving a support person in a client meeting may have on preserving client confidences both under rules of profes-
Body Language and Verbal Communication. The lawyer must also be aware how their words, body language, and conduct might inadvertently heighten the client's already existing feelings of low self-esteem, self-blame, rejection, or hopelessness. The lawyer should strive to use relaxed body language and verbal communication when interacting with the client.

In the example in which the student attorney felt that the client "chewed her out" for answering her colleague's phone line, what strategies might the student attorney have tried to utilize in an effort to de-escalate the client's anger? After first considering the many explanations for the client's loss of emotional control to prevent the student from concluding that the client was rude, the student attorney might then have used verbal communication strategies. Concrete strategies to restore calm include speaking slowly, using short sentences, and speaking calmly without raising one's voice. By modeling calm behavior, and taking care to dissipate conflict between the lawyer and the client, these verbal communication strategies can serve to communicate safety and give control to the client.162 Likewise, the lawyer might defuse the client's anger or hostility by validating the client's frustration, and being conscious to not become defensive, which could escalate angry behavior.163

In the instance where Ms. A. left all of her paperwork on the bus and decided to go home, when the student attorneys finally connected with the client more than a week after she missed the meeting, they were careful not to say to Ms. A., "Why did you miss the meeting?" — a question that could lead Ms. A. to feel that the lawyer thought she did something wrong—and, instead, asked, "What happened?"—an open-ended question that conveys that the client's behavior was caused by some external experience. Phrasing the question as "What happened?" will help foster trust and comfort, particularly so for the

sional ethics and the evidentiary attorney-client privilege. The lawyer must not assume that the client's decision to involve a support person in a meeting means that the client consents to the lawyer's disclosure of information in the presence of that person. Md. Atty's Rules of Prof'l Conduct r. 1.6 (Md. Bar Ass'n 2016) (preventing the lawyer from disclosing information relating to the representation of the client without the client's informed consent unless the disclosure is impliedly authorized to carry out the representation). In addition to the ethical obligation to protect client information, the lawyer must consider discussing with the client how the presence of a third party could destroy the client's ability to claim the attorney-client privilege if the legal matter ends up being litigated. See, e.g., Gregory Sisk & Pamela Abbate, The Dynamic Attorney-Client Privilege, 23 Geo. J. Legal Ethics 201, 233-234 (2010) (the communication between the client and the lawyer must have been made in confidence for the attorney-client privilege to attach).

162 White-Domain, supra note 103; Eggleston, supra note 129 (recommending being thoughtful about language and avoiding punitive and disrespectful language).

163 Katz & Haldar, supra note 7 (citing Judy I. Eidelson, Post-Traumatic Stress Disorders: Representing Traumatized Clients, Phila. Bar Ass'n Fam. L. Sec. CLE (2013)).
client who has experienced trauma. The lawyer may also employ strategies to try to dissipate certain behaviors the lawyer knows may be manifestations of trauma, such as appearing withdrawn, angry, or suspicious. The lawyer might make the withdrawn client feel more in control of the interview by overtly affirming how difficult it is to share information.

Since both of these interactions occurred on the phone, the student attorneys could not engage with the client through body language. However, in an in-person interaction in which the client seems to lose control of their emotions or becomes upset, the lawyer can often make the client feel safe—and counter the client’s reaction of fear—through body language. For example, the lawyer might try sitting at a slight angle so that the lawyer is not facing the client head on or towering over the client. The lawyer should never touch the client without the client’s consent. The lawyer should give the client sufficient space and not crowd the client. The lawyer should use gentle eye contact that communicates sincerity and genuineness. The lawyer should not cross their arms, or put their hands on their hips or in their pockets. The lawyer should avoid abrupt movements. And, finally, the lawyer can model calm behavior by breathing slowly and staying relaxed.

Client Control/Empowerment. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in trauma-informed care, “[i]mportance is placed on partnering and the leveling of power differences. . . . Healing happens in relationships and in the meaningful sharing of power and decision-making.” To counteract the client’s feelings of powerlessness often resulting from traumatic events, the lawyer should promote client decision-making in a lawyer-client partnership that will help the client regain control over their life. For clients who have experienced trauma, the lawyer’s client-centered framework can be improved by employing strategies to overcome possible feelings of client powerlessness that may impede decision-making. For example, in a situation in which the lawyer has

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164 See Hopper et al., supra note 108, at 81–82; Katz & Haldar, supra note 7, at 369; Kraemer & Patten, supra note 125; White-Domain, supra note 103; Gillece, supra note 121; Homelessness Programs and Resources, supra note 121.
165 Katz & Haldar, supra note 7 (citing Judy I. Eidelson, Post-Traumatic Stress Disorders: Representing Traumatized Clients, PHILA. BAR ASS’N FAM. L. SEC. CLE (2013)).
166 White-Domain, supra note 103.
167 NAT’L CHILD TRAUMATIC STRESS NETWORK, WHAT’S SHARING POWER GOT TO DO WITH IT? (2016).
168 Katz & Haldar, supra note 7, at 387; Kraemer & Patten, supra note 125; Hopper et al., supra note 108, at 82 (stating that “because control is often taken away in traumatic situations, and because homelessness itself is disempowering, trauma-informed homeless services emphasize the importance of choice for consumers”).
trouble connecting with the client because the client either shuts down, or appears angry or agitated, the lawyer can try stopping the interview for a moment and overtly asking the client what might help. Even if the client does not have a suggestion to offer, by employing this strategy, the lawyer communicates that the client is in control and that the lawyer is willing and committed to allowing the client to take the lead to create a safe space.169

In terms of substantive case strategy, the lawyer should also strive to work in partnership with the client when possible to promote the client's feelings of control. For example, in the Social Security overpayment case with Ms. A., the student attorneys explored arguing an innovative "trauma defense" in support of Ms. A.'s request for waiver of her overpayment theorizing that Ms. A.'s delay of just a few months in reporting her return to work to the Social Security Administration was due to her prioritizing the safety of herself and her family during the period of homelessness and domestic violence. When discussing the potential case theory with Ms. A., she adamantly opposed it. Ms. A. did not want her narrative to involve any mention of her personal family situation and, instead, was insistent that her story remain focused on the fact that she told Social Security about her return to work within a reasonable timeframe. Ms. A. did not want to admit any delay in reporting her return to work, nor make any excuse for it. Allowing Ms. A. to control the narrative she wanted to tell, the student attorneys developed a new case theory. Not only did they empower Ms. A., they also were successful in discharging the $35,000 overpayment.170

Reliability. In order to foster the trust that is critical to establishing a good lawyer-client relationship, particularly with the client who has difficulty trusting other people as a result of trauma, the trauma-informed lawyer must consistently follow through on tasks,171 including returning phone calls promptly, providing case updates regularly, and completing any other task undertaken in a timely manner. For example, to alleviate the anxiety that one of the clinic's transgender clients felt about the legal process in his name change and gender identity case, the attorney went to great lengths to provide weekly updates to the client about the legal process, even when there were no

169 White-Domain, supra note 103.
170 Previous scholarship has discussed the value of storytelling and the importance of allowing the client to determine their narrative. See, e.g., Lucie E. White, Subordination, Rhetorical Survival Skills, and Sunday Shoes: Notes on the Hearing of Mrs. G., 38 BUFF. L. REV. 1, 46-52 (1990). See also Bryant, supra note 83, at 47 n.49 (discussing an immigration case in which the lawyers changed their strategy for presenting evidence of persecution because the client viewed evidence of injury to an area of her body to be private).
171 Kraemer & Patten, supra note 125.
significant developments to report. The client communicated how the case updates helped reduce his anxiety in an e-mail that read: "I'm so anxious but I do thank you from the bottom of my heart for staying on top of everything it makes me feel like the process is going at a consistent speed."  

**Avoid Re-Traumatization.** The trauma-informed lawyer should also anticipate issues or interactions that may be particularly difficult for the client and seek to avoid "triggering" or activating a memory of the trauma. A central tenet of trauma-informed lawyering is to do no additional harm. For example, before exploring their possible case theory with Ms. A. about her need to prioritize safety, and asking Ms. A. questions about what they suspected was an abusive relationship with her children's father, the student attorneys consulted with the clinical social worker who teaches the clinic class on trauma. The students were concerned that Ms. A. might react negatively to their questions, and that they might damage their relationship with Ms. A. by asking them or that they might trigger a trauma response. Based on the consultation, the student attorneys realized that their concern was as much about their own discomfort broaching the topic as it was about potentially re-triggering trauma for the client. The social worker confirmed that assuming the questions were asked in a respectful, non-threatening way in the context of the trusting and safe lawyer-client relationship that had been established, it could in fact be beneficial for the client to talk about the abusive relationship if she wanted. According to the social worker, if the client sensed the student attorneys' discomfort discussing personal aspects of the client's situation; the client might feel judged, which, in turn, might foreclose open communication and trust.

V. Conclusion

Given the prevalence of trauma, lawyers representing clients experiencing urban poverty should presumptively adopt a trauma-in-
formed practice approach regardless of the subject of the legal matter. Trauma-informed lawyering will enable the client to engage more deeply in the lawyer-client relationship, thereby enriching the client experience generally, and significantly so for the client with a history of trauma.

Just as lawyers can enrich the client experience by providing trauma-informed representation, so, too, can the judicial system and administrative agencies promote healing and access to justice for marginalized populations. While there has been some system reform in recent years to incorporate trauma-informed practices in systems where consumers have experienced abuse, such as child welfare agencies and family courts, the approach has not been adopted in other settings.

In addition to training lawyers, courts, and administrative agencies on the prevalence and influence of trauma, creating formal and informal inter-professional partnerships among lawyers and social workers, in particular, offers a rich opportunity to provide comprehensive care to individuals affected by trauma. While lawyers alone can improve the quality of their legal services by understanding and practicing trauma-informed lawyering, inter-professional collaborations create norms that allow lawyers to consult with social workers about how to discuss issues with clients, make referrals for therapeutic interventions, and gain additional insights about trauma.

Likewise, social workers can learn from lawyers to screen for legal issues, and refer clients to lawyers both for advice about preventing legal crises from arising and to address existing legal needs such as in the case of Ms. A. Such inter-professional partnerships allow lawyers and social workers to learn from each other about the manifestations of trauma in specific cases, and to provide resources to each other to ensure that the service delivery is consistent and trauma-informed. Moreover, collaboration between lawyers and social workers

177 In 2013, SAMHSA released Essential Components of Trauma-Informed Judicial Practice. In the draft guidelines, SAMHSA sets forth common examples of courtroom communication or courtroom procedures, notes how a trauma survivor might hear or perceive them, and suggests another, more trauma-informed approach. As one example, when a judge asks, "Did you take your pills today?" the client may feel, "I'm a failure. I'm a bad person. No one cares how the drugs make me feel." A trauma-informed approach would be for the judge to ask, "Are the medications your doctor prescribed working well for you?" Essential Components of Trauma-Informed Judicial Practice, SAMHSA 4 (2013).

facilitates inter-professional problem solving such as the comprehensive safety plan developed for the client living with her abusive partner and concerned about the safety of her daughter.\footnote{Professionals involved in interdisciplinary conversations must act in compliance with rules restricting disclosure of client information including HIPAA’s Privacy Rule, \textit{see}, \textit{e.g.}, HHS’s \textsc{summary of the HIPAA Privacy Rule}, \url{https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html} (last visited Jan. 14, 2018) (limiting the healthcare provider’s ability to share protected information), and professional ethics. \textsc{Md. Atty’s Rules of Prof’l Conduct r. 1.6} (Md. Bar Ass’n 2016) (preventing the lawyer from disclosing information relating to the representation of the client without the client’s informed consent unless the disclosure is impliedly authorized to carry out the representation).}

Finally, empirical research should be undertaken to measure the benefits of incorporating a trauma-informed approach to lawyering. While trauma-informed lawyering improves the experience for clients, particularly for those clients affected by trauma, empirical research documenting such client outcomes as increased client satisfaction, client retention, reduced overall stress and anxiety, increased lawyer empathy,\footnote{Katz & Haldar, \textit{supra} note 7, at 376–77.} increased trust of the lawyer,\footnote{Dinerstein, \textit{supra} note 74, at 546–56 (noting many of these same benefits from a client-centered approach to lawyering).} and improved health outcomes\footnote{Based on my experience representing clients living with HIV and other medical conditions, I have seen numerous clients experience aggravated symptoms and medical complications triggered by their increased stress and anxiety. By making the legal process more accessible to clients through a trauma-informed approach, clients would experience reduced stress and anxiety and, as a result, experience improved health outcomes. \textit{See} Kraemer & Patten, \textit{supra} note 125 and accompanying text.} would promote a more universal implementation of the practice and potentially generate sources of funding for providers.

\footnote{179 Professionals involved in interdisciplinary conversations must act in compliance with rules restricting disclosure of client information including HIPAA’s Privacy Rule, \textit{see}, \textit{e.g.}, HHS’s \textsc{summary of the HIPAA Privacy Rule}, \url{https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html} (last visited Jan. 14, 2018) (limiting the healthcare provider’s ability to share protected information), and professional ethics. \textsc{Md. Atty’s Rules of Prof’l Conduct r. 1.6} (Md. Bar Ass’n 2016) (preventing the lawyer from disclosing information relating to the representation of the client without the client’s informed consent unless the disclosure is impliedly authorized to carry out the representation).}

\footnote{180 Katz & Haldar, \textit{supra} note 7, at 376–77.}

\footnote{181 Dinerstein, \textit{supra} note 74, at 546–56 (noting many of these same benefits from a client-centered approach to lawyering).}

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Multigenerational Trauma

Parent = educational decision-maker = client

Child = student = “subject” of the advocacy
Traumatic Experiences

- Domestic violence
- Childhood neglect, physical & sexual abuse
- Incarceration
- Substance & alcohol abuse
- Disability
- Community violence
- Victim of crime
- Bullying
- Systemic Oppression, Racism
Representing the Adult Client

- Develop rapport & trust
- Be present – Listen - Observe
- Be honest
- Client-centered
Students Who Have Had Traumatic Experiences: What Schools Observe

- **Fight**: verbal & physical aggression, disrespect
- **Flight**: hall-walkers, skipping classes, running out of building
- **Freeze**: dissociation, unresponsive to questions, inattention
- **Somatic Complaints**

**Result in:**

Increased Suspensions, Increased Absenteeism, Decreased Academic Performance
Trauma-Informed Individual Advocacy in School Setting

- Educating staff about trauma
- Understand student’s needs
- Advocate for appropriate interventions
- Creative problem-solver
- Monitor/Follow-up
Some interventions

- Behavior Intervention/Support Plans
- Safety Plans
- Parent communication
- Small setting
- Evaluations
- Teach & support use of coping skills
- Teach social skills & provide opportunities for use
- Routines/Structure transitions
- Specialized academic instruction
Trauma-Informed Schools

- Looking at child through trauma lens
- Shifting from blaming child to how to support
- Proactive rather reactive
- Consistency
- School wide buy-in
“Trauma Exposure Response”

(from Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others, chapter 4, by Laura van Dernoot Lipsky with Connie Burk, 2009)

• Helpless or hopeless
• Feelings that you are “Never Enough”
• Hypervigilance
• Diminished creativity
• Inability to embrace complexity
• Minimizing
• Chronic exhaustion/ physical ailments
• Deliberate Avoidance
• Dissociative Moments

• Sense of persecution
• Guilt
• Fear
• Anger & cynicism
• Inability to empathize/ numbing
• Addictions
• Grandiosity
How to Handle:
“Awareness, Balance, Connection”
(from https://www.nctsn.org/resources/taking-care-of-yourself)

• Be honest with self
• Self-care: exercise, nutrition, sleep, mindfulness
• Set limits & personal boundaries
• Talk with colleagues
• Down-time with family & friends
Resources on Childhood Trauma & Trauma-informed Schools

- https://www.traumaandlearning.org/home
- https://traumasensitiveschools.org/
- https://www.nctsn.org/
- https://www.rand.org/topics/childhood-trauma.html
- Https://www.elc-pa.org/?s=trauma
Resources on Secondary Stress

- [http://www.compassionfatigue.org/index.html](http://www.compassionfatigue.org/index.html)
Resources on Trauma-informed Lawyering

- http://www.traumainformedlaw.org/
- http://www.nationalcenterdvtraumamh.org/trainingta/trauma-informed-legal-advocacy-tila-project/
UNDERSTANDING COMPLEX TRAUMA

Stacey Forrest, M.Ed.
Asst. Exec. Director, Justice Resource Inst., CT Division
Training Faculty at The Trauma Center, JRI
Special thanks to: Kristine Kinniburgh, Director of Trauma Services at JRI CT, for ARC Reflections slides
Traumatic experiences are those that are overwhelming, invoke intense negative affect, and involve some degree of loss of control and/or vulnerability. The experience of trauma is subjective and developmentally bound.

Multi-layered nature of trauma:
- Overt harm (i.e., physical/sexual abuse)
- Lack of need fulfillment (i.e., neglect)
- Interpersonal context (i.e., betrayal of caregiving expectations; loss, abandonment; working models)
- Interference with developmental tasks
“Research during the past 10 years... has revealed that young brains have both fast-growing synapses and sections that remain unconnected. This leaves teens easily influenced by their environment and more prone to impulsive behavior.

- Human and animal studies...have shown that the brain grows and changes continually in young people—and that it is only about 80 percent developed in adolescents.

- The last section to connect is the frontal lobe, responsible for cognitive processes such as reasoning, planning, and judgment. Normally this mental merger is not completed until somewhere between ages 25 and 30."

*The more purple the better!*
NORMAL VS. ABUSED BRAIN

Healthy Brain
This PET scan of the brain of a normal child shows regions of high (red) and low (blue and black) activity. At birth, only primitive structures such as the brain stem (center) are fully functional; in regions like the temporal lobes (top), early childhood experiences wire the circuits.

An Abused Brain
This PET scan of the brain of a Romanian Orphan, who was institutionalized shortly after birth, shows the effect of extreme deprivation in infancy. The temporal lobes (top), which regulate emotions and receive input from the senses, are nearly quiescent. Such children suffer emotional and cognitive problems.
Prioritization of those domains of skill / competency / adaptation which help the child survive their environment and meet physical, emotional, and relational needs.

De-emphasis of domains of development which are less immediately relevant to survival.
The trauma response is predicated on a rapid sequence of perception of danger and rapid, survival-oriented reaction.

A primary goal of trauma-focused intervention is to cultivate and build capacity for child and adult reflective curiosity: active, directed awareness of internal and external experience that in turn allows for modulation of arousal and goal-directed behavior.

Get Curious Not Furious
Brain process under typical conditions

Observe → Input → Interpret → Process → Evaluate Options → Plan → Act

Joshua Arvidson, 2011
Alarm system
“Express Route”

Observe → Interpret

React (Flight - Flight - Freeze)

Act

DANGER

Process → Evaluate Options → Plan

Joshua Arvidson, 2011
With repeated stress, the Alarm System “Express Route” becomes the main road.
ALTERED THREAT PERCEPTION

Young people and youth experience a profound sense of shame and damage. Their self concept is shaped by the terrible things that have been said or done to them.

Shame is isolating and leads to a profound sense of loneliness.

Poor self esteem; perceived incompetence; expectations for failure and poor body image are experiences related to shame.
Perception is more important than reality

Human beings are biologically primed for survival: in the face of danger, our physiological organism will seek survival

When threat is perceived...

- Activation of “survival centers”
  - Recognition/labeling of fear/danger
  - Activation of “fight/flight/freeze” response
  - Continued levels of arousal
- Shutting down of non-essential tasks
  - e.g., Higher cognition

Behavior Makes Sense

ARC Reflections — an ARC-informed caregiver training curriculum for foster parents, kin and other caregivers — was written by Blaustein and Kinniburgh with support and consultation from the Annie E. Casey Foundation.

© 2017, The Annie E. Casey Foundation, Baltimore, Maryland

Blaustein 2004
WHAT IS A “TRIGGER”?  

A trigger...  
- Is a signal that there is something dangerous in the environment *right now*, based on the individual’s past experience with danger  
  - May or may not mean there is actual danger present  
  - May or may not be associated with specific memories of an event  
- Shifts us into “danger (self-protect) mode”  
- Mobilizes us: Puts us on the “express road” to action
SO NOW WHAT??
TREATMENTS THAT HELP

Core Components of Trauma-Informed Evidence-Based Treatment

- Psychoeducation and parent support, conjoint therapy, or parent training
- Emotional expression and regulation skills
- Anxiety management and relaxation skills
- Cognitive processing or reframing
- Body-based therapies

Hartman, 2010
BEHAVIORS THAT ARE OPPOSITIONAL, EMOTIONALLY CHALLENGING, OR PHYSICALLY DANGEROUS CAN BE ESPECIALLY HARD

- **Common “traps”:**
  - Resorting to control tactics
  - Overreacting or underreacting
  - Lack of self care and affect management
  - Choosing the wrong intervention or response if you don’t understand the WHY of the behavior

- **To do’s** (maybe sometimes hopefully if we can!)
  - Proactivity goes a long way
    - Don’t become reactive
    - *Reflect*, don’t react
  - Consider the function of the behavior so you choose the best response/recommendation/outcome
  - Practice affect management always (know your buttons)
  - Ask why
  - Think about services to meet needs
  - Think about replacement survival skills

Ask – do they have the skills and capacity to meet these expectations?
Stacey Forrest, M.Ed., Assistant Executive Director; JRI Connecticut, Trauma Center Adjunct Training Faculty – sforrest@jri.org