Trauma-Informed and Evidence-Based Practices and Programs to Address Trauma in Correctional Settings

The prevalence of trauma and posttraumatic stress disorder (PTSD) is higher among individuals in prison and jail than in the general population. Research has shown a connection between trauma and criminality due in part to the coping mechanisms of aggression and substance misuse after a traumatic event. While the corrections environment itself may cause or exacerbate PTSD symptoms in some individuals, facilities can implement trauma-informed practices to minimize re-traumatization and reduce PTSD symptoms. This article documents the prevalence of trauma and PTSD within this population, and discusses how correctional facilities can implement trauma-informed practices and evidence-based approaches to assist individuals with trauma histories.

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Introduction

Posttraumatic stress disorder (PTSD) is an anxiety disorder determined with specific diagnostic criteria.[1] PTSD can occur following a traumatic event including physical or sexual assault, childhood abuse, war, a natural or manmade disaster, an act of terrorism, a fire, the sudden death of a loved one, the chronic or terminal illness of a child, and a plane or motor vehicle crash.[2] Only a small percentage of people who experience something traumatic in their lives develop PTSD, and for many, the symptoms improve or disappear within a few months.[3]

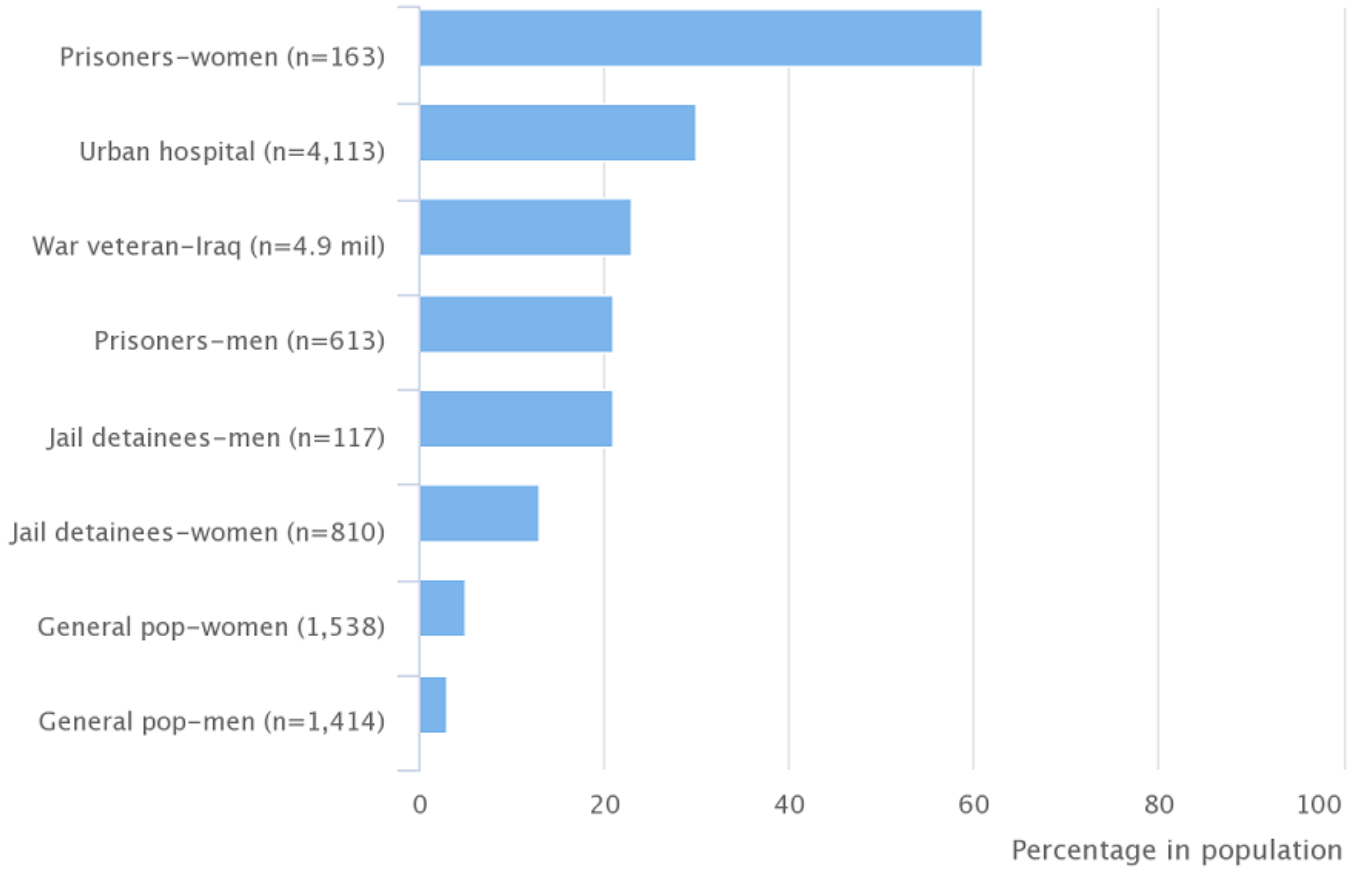
Exposure to violence and trauma can have a significant impact on one's day-to-day functioning, interpersonal relationships, and physical and mental health.[4] Coping strategies such as substance use and aggression may lead to criminal justice

involvement.[5] In fact, PTSD severity is positively correlated with frequency of arrest,[6] and PTSD increases the risk of recidivism among those who have been incarcerated.[7] Recognizing trauma histories within this population is important because prison itself can exacerbate PTSD symptomology: traumatic events can occur in correctional facilities and being incarcerated may trigger memories of traumatic events.[8]

Prevalence rates of PTSD are higher among those in correctional facilities than those in the general population and often are as high as the PTSD prevalence rates of populations known to experience high rates of trauma, such as war veterans (*Figure 1*).[9] One research study of men in jail and prison, for instance, found PTSD prevalence rates of 21 percent.[10] Another study showed the rate among women in prison was even higher at up to 61 percent, while the rate among women confined in jails was 13 percent.[11]

FIGURE 1

PREVALENCE OF PTSD BY POPULATION



DATA SOURCE: MULTIPLE STUDIES, SEE ENDNOTE FOR CITATIONS.[10:1]

The Illinois Criminal Justice Information Authority (ICJIA) Center for Justice Research and Evaluation conducted three studies on trauma experiences and PTSD prevalence among various groups within this population—female prisoners, male prisoners, and male jail detainees. The PTSD Checklist – Civilian version (PCL–C) was administered to individuals within all three populations to determine whether a PTSD diagnosis was likely. In addition, the Life Events Checklist (LEC) was administered to the men in prison and jail.[12] The LEC is a self-report measure designed to screen for potentially traumatic events in a respondent's lifetime. Across these studies, notable proportions of the three sub-populations demonstrated PTSD symptoms. The main findings from each study are described in further detail below.

Study 1: ICJIA researchers examined PTSD in a representative sample of 163 women in Illinois prisons. Sixty-one percent of the women surveyed met the criteria for PTSD, which confirms past findings that PTSD prevalence among incarcerated women is higher than in the general population. Eighty-three percent had been

negatively affected by a PTSD symptom within the past month. Similarly, 75 percent reported feeling very upset within the prior 30 days when something reminded them of a stressful past experience. Finally, 71 percent had experienced repeated disturbing memories, thoughts, or images of a stressful past experience, and avoided thinking about or talking about stressful past experiences.

Study 2: Authority researchers, in collaboration with WestCare Foundation (Illinois), conducted a survey of 613 male prisoners in Illinois.[13] The study found that 24 percent met the criteria for PTSD. The most common symptoms included being "super alert," watchful, or on guard (52 percent), having repeated, disturbing memories, thoughts or images of a stressful experience from the past(43 percent), and avoiding thinking about a stressful past experience (43 percent).

Of the men in prison in the sample, 90 percent had experienced at least one traumatic event in their lifetimes, and 64 percent had witnessed at least one traumatic event. Sixty-four percent experienced an assault with a weapon, 63 percent experienced the unexpected death of a loved one, 63 percent were involved in a transportation accident, and 61 percent experienced physical assault.

Study 3: The Authority, in collaboration with WestCare Foundation (Illinois) and Loyola University Chicago, conducted a study examining trauma and PTSD among male jail detainees in Cook County Jail. Twenty-one percent of males surveyed were currently PTSD symptomatic (n=117). Almost half of the sample (48 percent) reported being "super alert," watchful, or on guard;, 47 percent reported repeated, disturbing memories, thoughts or images of a stressful experience of the past, and 43 percent reported feeling very upset when something reminded them of a stressful experience from the past.

Almost all of the male jail detainees in the sample reported personally experiencing at least one traumatic life event (97 percent). The three most commonly experienced events were physical assault (80 percent), assault with a weapon (78 percent), and the sudden or unexpected death of someone close to them (72 percent).

Overall, these studies confirmed that Illinois' prisons and jails house a significant number of individuals with PTSD symptomology and prior histories of trauma. This

report explores trauma in correctional settings and suggest practices and programs that can be implemented to assist individuals in prison.

Correctional Settings and Re-Traumatization

For some individuals, jails, prisons, and detention centers can further contribute to or be the source of trauma. The bright lights, loud noises, questioning by guards and staff, harsh physical handling/movement, restrictions, and sparse living quarters can be triggering.[14] Many correctional facilities are structured to maintain order through strict control of the environment and incarcerated individuals. Without consideration of PTSD symptoms, the policies and procedures intended to maintain safety and security within a facility may re-traumatize individuals who are limited in their ability to remove or avoid triggers.

PTSD symptoms can be categorized into four groups:

- Re-experiencing
- Avoidance
- Arousal and reactivity
- Cognitive and mood symptoms[15]

Within a correctional setting, these symptoms may be triggered by the physical structure and policies of the setting.

People suffer re-experience symptoms with nightmares and flashbacks, which can be triggered by memories or sensory elements that serve as reminders of a traumatic event. Environmental stressors of living in a correctional setting, such as the bright lights, loud sounds, and the overall powerlessness experienced by incarcerated persons can trigger re-experiencing.

Avoidance symptoms include avoiding places or objects that remind an individual of a traumatic event, or avoiding thoughts or feelings related to the trauma. These symptoms may also manifest as an overall avoidance of conflict and real or perceived threats to safety. Trauma experiences evoke a sense of powerlessness, similar to the feeling that prisoners who lack control, choice, or agency may experience during

incarceration.[16] Individuals who are incarcerated are often unable to evade triggers and may turn to avoidance methods rather than healthy coping mechanisms. In addition, some coping mechanisms, such as substance use, are not available while incarcerated.[17] Without further instruction or assistance in building healthy coping strategies that are feasible within the correctional setting, re-traumatization may continue.

Arousal and reactivity symptoms include a startle reflex, irritability, violent outbursts, hypervigilance, guardedness, difficultly sleeping, and an overall heightened state of awareness and arousal. PTSD arousal symptoms and responses can be triggered by mandatory pat downs, unannounced strip searches, or routine restraint practices.[18] These practices may exacerbate arousal symptoms and elicit aggressive or violent responses that compromise the safety of both prisoners and correctional officers. Incarcerated populations, particularly traumatized men, may be fearful of real or perceived threats of violence and sexual assault. As a result, they may demonstrate heightened reactivity and respond with aggression to protect themselves from future harm.[19]

Cognitive or mood symptoms include memory suppression, negative views of self and the world, feelings of guilt and shame, isolation, and numbing or inability to feel positive emotions. Research has shown that incarceration alone can impact an individual's psychological well-being, such that individuals may experience hypervigilance, interpersonal distrust, suspicion, alienation, exploitation, diminished self-worth, and PTSD.[20] Traumatic experiences may exacerbate these psychological symptoms and individuals may "check out" or socially withdraw to avoid re-traumatization. These same behaviors occur in a correctional facility, however, they may be viewed by correctional officers as disrespect of authority or by other incarcerated persons as disinterest in relationships, which can contribute to further isolation.

Trauma-Informed Care

Correctional facilitates can curb PTSD symptoms within their populations with the following key components of trauma-informed care., outlined by the Substance

Abuse and Mental Health Services Administration's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC):

- Recognizing the impact of trauma on multiple areas of life and different paths to recovery.
- Being aware of the signs and symptoms of trauma.
- Structuring policies and practices that account for and are sensitive to people's potential trauma histories.
- Seeking to prevent re-traumatization.[21]

Key principles of trauma-informed care further build on these program components by emphasizing principles that create a trauma-informed setting. They include:

- Safety.
- Trustworthiness and transparency.
- Peer support.
- Collaboration and mutuality.
- Empowerment, voice, and choice.
- Cultural, historical, and gender issues.[22]

Taken together, these practices help to acknowledge an individual's history of trauma, understand their responses to trauma, and recognize the pathways survivors take in navigating safety and recovery.

Trauma-Informed Care in Correctional Settings

Successful trauma-informed practices and programming support survivors in coping with trauma symptoms and remove treatment access barriers.[23] Trauma-informed care in prisons requires addressing organizational policies and practices that may re-traumatize or trigger traumatic memories.[24] Failing to address these re-traumatizing practices poses a threat to both the individual and the stability of the setting.[25]

Changing policies and practices also requires a shift in the culture within an organization. Standards for trauma-informed practices highlight the need to educate

staff about the nature of trauma and to reframe behaviors in the context of trauma.[26] While certain behaviors may appear to be manipulative or avoidant, such as lying or isolation from others, these behaviors may be responses that survivors have learned to use to cope with trauma or protect themselves and others from potential harm.[27] Furthermore, effective trainings incorporate role playing and demonstrations that include trauma-informed practices, such as practicing de-escalation techniques and how to effectively communicate pat down procedures to prisoners when such practices are necessary.[28] Involvement from shift managers and higher-level staff also is recommended in order for these practices to be encouraged and reinforced throughout every organizational level within the correctional setting.[29]

Evidence-Based Practices and Programs to Address Trauma

Several models have been adapted for use in corrections to equip incarcerated survivors with helpful and healthy coping strategies that fit within the setting's structure, while encouraging prisons to align with more trauma-informed practices. For instance, treatment staff may help clients develop safety plans and create strategies for dealing with triggers.[30] Safety plans may incorporate coping and self-care techniques that equip survivors to respond to and manage their trauma symptoms. One example of this approach is called 'grounding,' through which survivors attempt to mitigate the onset of a flashback by connecting to the present moment or distracting themselves with something else (e.g., reciting the alphabet backwards).[31]

While these strategies can help individuals to cope with trauma, they do not adequately address the underlying history of trauma or the resulting negative behaviors. Comprehensive treatment models include practices that assist individuals in understanding trauma and its impact. This section outlines programs and therapy modalities that aim to address PTSD, and highlights several practices that may help to address trauma within incarcerated populations.

Seeking Safety

Seeking Safety is a program designed for the treatment of individuals with co-occurring PTSD and substance use symptoms. It has been used in correctional settings. The model teaches participants about the connection between trauma, coping skills, and substance abuse using a cognitive-behavioral approach paired with psycho-education modules.[32] The modules include 25 topics that address behavioral, interpersonal, and case management domains. These topics cover coping skills such as compassion, self-care, anger management, and asking for help.[33] This model can be used in multiple settings, inpatient, residential, and correctional facilities, and with individuals or groups. No specific degree is needed to implement this treatment model and training is not required for clinical implementation. Trainings, videos, and guides are available for purchase to teach staff how to conduct Seeking Safety.

Seeking Safety is considered an evidence-based program by the SAMSHA's National Registry of Evidence-based Programs and Practices. The California Evidence-Based Clearinghouse classifies the program as "supported by research evidence." A meta-analysis, or a statistical analysis of findings from 12 quantitative studies found that the Seeking Safety treatment model was more effective in decreasing PTSD symptoms than no treatment or alternative treatments.[34] Decreased drug use also is associated with participation in the Seeking Safety model.[35] A study of incarcerated women found that those who participated in Seeking Safety showed a significant decrease in PTSD symptoms from pre- to post-treatment and nine of 17 participants no longer met the diagnostic criteria for PTSD at the end of treatment.[36]

Trauma Affect Regulation: Guide for Education and Treatment

Trauma Affect Regulation: Guide for Education and Treatment (TARGET) teaches trauma survivors a seven-step process to gain control of their PTSD symptoms and understand how trauma changes the brain's normal stress response into an extreme reaction that can result in PTSD.[37] TARGET can be implemented within a variety of settings including schools, residential treatment centers, workplaces, and correctional facilities. The program can be administered to individuals or gender-

specific groups and has been translated into multiple languages. No specific educational degree is required to administer the model and implementation materials are available for purchase.

TARGET is listed in SAMSHA's National Registry of Evidence-based Programs and Practices as an evidence based program, is rated effective by the Office of Juvenile Justice and Delinquency Prevention Model Programs Guide, and the California Evidence-Based Clearinghouse classifies the program as "promising research evidence." In a study of low-income mothers with PTSD, those in the TARGET program reported a greater decrease in the severity of PTSD symptoms and negative beliefs about oneself and the world than members of a randomized control group.[38] A two-year study supported by the Office of Juvenile Justice and Delinquency Prevention found that each TARGET session attended by 12- to 17-year old boys and girls in juvenile detention centers was associated with a 22-percent decrease in disciplinary events and less time spent in seclusion.[39] TARGET also has been shown to reduce PTSD symptom severity, increase self-efficacy and self-integrity, and reduce reactive behaviors among incarcerated women.[40]

Trauma Recovery and Empowerment Model

The Trauma Recovery and Empowerment Model (TREM) is a group intervention program for female trauma survivors with severe mental health disorders.[41] TREM consists of five general topic areas that address the consequences of violent victimization, including PTSD, depression, and substance abuse. These five topic areas include:

- Empowerment.
- Trauma recovery.
- Advanced trauma recovery issues.
- Closing rituals.
- Modifications or supplements for special populations.[42]

TREM has been implemented within mental health, substance abuse, and criminal justice populations, and a version for male trauma survivors (M-TREM) also is

available. No specific degree is need for TREM leaders, but a two-day training is required prior to conducting group sessions. Materials are available for purchase.<

TREM is considered an evidence-based program by the SAMSHA's National Registry of Evidence-based Programs and Practices and the California Evidence-Based Clearinghouse classifies the program as "promising research evidence." A study of women trauma survivors showed a statistically significant reduction in anxiety symptoms compared with the non-TREM treatment group.[43] In another study of women in a residential substance abuse treatment program, the TREM intervention group had more favorable trauma treatment outcomes than the control group, which received treatment as usual.[44]

Sanctuary Model

The Sanctuary Model is a systematic approach that focuses both on people who seek services and those who provide the services. Goals of the model include working more effectively with traumatized clients, creating a collaborative treatment environment, and improving staff morale. The Sanctuary Model has been used in juvenile detention centers, domestic violence shelters, schools, and community-based mental health programs. No specific degree is required to administer the Sanctuary Model, but there is a cost associated with the certified training program and required manuals and guides.

The Sanctuary Model is considered an evidence-supported practice by the National Child Traumatic Stress Network and the California Evidence-Based Clearinghouse classifies the program as "promising research evidence." One study of youth in residential treatment facilities found that a higher percentage of youth from non-Sanctuary Model facilities were being readmitted in the 90 days following discharge than youth in facilities using the Sanctuary Model.[45] Using administrative and performance-based standard data, another study of girls in a juvenile detention facility found that it was physically and psychologically safer for both the juveniles and the staff after the implementation of the Sanctuary Model.[46]

Prolonged Exposure Therapy

Prolonged Exposure Therapy (PE) is suitable for adults with trauma exposure and PTSD. PE strives to teach clients how to safely remember and process traumatic events and reduce PTSD symptoms along with depression, anger, and anxiety.[47] This is achieved by having the client repeatedly encounter activities that are a reminder of traumatic events and revisiting the traumatic memory by retelling the event. It is mainly conducted in a community-based setting, outpatient clinic, or residential care facility by a licensed mental health professional or those working under their supervision. PE also can be used in a correctional facility. Training is available along with a manual describing how to implement the program.

PE is listed in SAMSHA's National Registry of Evidence-based Programs and Practices as an evidence-based program. The California Evidence-Based Clearinghouse classifies the program as "well-supported by research evidence." In addition, PE is classified as effective by the Office of Juvenile Justice and Delinquency Prevention Model Programs Guide. A randomized control comparison of patients in a psychiatric outpatient clinic who received PE treatment found PTSD to be significantly lower 12 months after treatment compared to those who received treatment as usual.[48] A study of women in PE therapy showed that they maintained decreased PTSD symptoms during a 5- to 10-year follow-up period.[49] A randomized control study of women with PTSD found that those in the PE group were less likely to meet PTSD criteria and more likely to be in remission from PTSD than those in a different form of therapy.[50]

Eye Movement Desensitization and Reprocessing

Eye Movement Desensitization and Reprocessing (EDMR) teaches adults with PTSD, phobias, or other mental health disorders resulting from trauma to reprocess traumatic memories and focus on positive experiences. The client focuses on stressful material associated with the traumatic event while at the same time focusing on an external stimulus. Side-to-side eye movements are most commonly used, but hand-tapping and audio stimulation are also common. EDMR can be used with youth and adults in a community-based setting, outpatient clinic, residential care facility, or correctional facility. EDMR should be administered by licensed

mental health professionals certified in EDMR. Training and implementation manuals are available.

EDMR is listed as an evidence-based program in SAMSHA's National Registry of Evidence-based Programs and Practices, the California Evidence-Based Clearinghouse classifies the program as "supported by research evidence", and EDMR is classified as promising by the National Institute of Justice on crimesolutions.gov. A study of female survivors of childhood sexual assault found that those who received EDMR maintained therapeutic gains 18 months post-treatment.[51] In a study comparing the effectiveness of EDMR, fluoxetine (a drug used to treat depression in adults), and pill placebo, those who received EDMR were more successful in achieving sustained reductions in depression symptoms and PTSD than the other two groups.[52] A randomized control study showed that those in EDMR had reduced PTSD symptom severity and a significantly greater decline in symptoms than those in a comparison therapy.[53]

Conclusion

A large proportion of men and women who are incarcerated in jails and prisons have experienced trauma and the rate of PTSD is higher within these populations than in the general population. In addition, correctional facilities may trigger PTSD symptoms and contribute to re-traumatization when their policies, practices, and procedures are not trauma-informed. Correctional officials can work to minimize these effects and properly address trauma among incarcerated individuals by screening and treating PTSD within their populations.

A variety of evidence-based programs designed to help individuals cope with PTSD in correctional settings already are available. Additional research can contribute to a stronger understanding of how effective trauma treatments being used outside of prison walls might be adapted to meet the needs of those who are incarcerated. In addition to helping incarcerated individuals cope with and heal from trauma, research suggests that trauma-informed PTSD programs may reduce incarceration rates by helping to alleviate symptoms that can lead to criminality and recidivism.

Correctional facilities that adapt to the unique needs of incarcerated individuals can foster both individual health and healing and public safety.

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9. **Note**: PTSD prevalence is unknown of those in community corrections and more research is needed. ↩

10. **Note**: PTSD prevalence rates vary by study and sample. Studies of men in prison, for instance, round ranges of PTSD prevalence from 4 to 21 percent and for women in prison ranges from 15 to 61 percent. **See the following studies for prevalence rates**: Gibson, L. E., Holt, J. C., Fondacaro, K. M., Tang, T. S., Powell, T. A., & Turbitt, E. L. (1999). An examination of antecedent traumas and psychiatric comorbidity among male inmates with PTSD. *Journal of Traumatic Stress*, 12(*3*), 473-484.; Powell, T., Holt, J., & Fondacaro, K. (1997). The prevalence of mental illness among inmates in a rural state. *Law and Human Behaviour*, 21(*4*): 427–438.; Butler T., & Allnut, S. (2003). *Mental Illness among New South Wales' Prisoners*. NSW Corrections Health Service.; Simpson, A. I. F., Brinded, P. M., Laidlaw, T. M., Fairley, N., & Malcolm, F. (1999). 8The National Study of Psychiatric Morbidity in New Zealand Prisons*. Auckland: Department of Corrections.; Brink, J. H., Doherty, D., & Boer, A.

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