

# Residential Substance Abuse Treatment (RSAT)

## Training and Technical Assistance

### RSAT Training Tool: Trauma-Informed Approaches in Correctional Settings

This curriculum is a cross-disciplinary training curriculum designed to increase knowledge and awareness of the relationship between substance use and trauma among people involved in RSAT jail, prison and aftercare programs. It is directed at program planners and coordinators, counselors, case managers, behavioral healthcare providers, correctional officials and others.

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**TABLE OF CONTENTS**

**Acknowledgements .....2**

**About this Manual.....3**

    Audience.....3

    Purpose.....3

    Approach.....4

**Module I Introduction to Trauma–Informed Approaches.....5**

    A. Context and Background

    B. Self-Care Check

    C. Learning Objectives

    D. What the Research Tells Us

**Module II Understanding Trauma.....16**

    A. Introduction - What is Trauma

    B. What Research and Practice Tell Us

    C. The Impact of Trauma

    D. Review and Resources

**Module III Integrated Treatment and the Criminal Justice System.....31**

    A. Understanding Criminal Justice Theory and Practice

    B. Cognitive Behavioral Interventions

    C. Compatible Evidence-based Principles

    D. Review and Resources

**Module IV Implementing Trauma-Informed Approaches.....50**

    A. Foundations of Trauma-Informed Practices

    B. Identifying Triggers and Alternative Coping

    C. Integrating Trauma-Specific Interventions

    D. Review and Resources

**Knowledge Assessment.....83**

**Sources and References.....89**

# Trauma-Informed Approaches in Correctional Settings

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## **About This Manual**

### **Audience:**

This manual is intended for RSAT Program staff, including program planners, coordinators, addictions counselors, case managers, as well as correctional staff, including administrators and security staff. It is also intended for behavioral healthcare providers, volunteers, peer recovery specialists and Chaplains.

### **Purpose:**

This manual is a cross-disciplinary training curriculum designed to increase knowledge and awareness of the relationship between trauma and substance use disorders among people involved in RSAT jail and prison programs and aftercare.

The goal of this training is to introduce trauma theory, research and practice related to people involved in the justice system with substance use disorders who may also have histories of exposure to violence and trauma. Trauma-informed service systems are becoming the standard of care in behavioral health. Implementing trauma informed approaches in the criminal justice system is both challenging and logical when one considers the nature of the setting and the characteristics of the population.

In behavioral health, integrated treatment of co-occurring mental health and substance use disorders has taught us that successful recovery does not occur in a vacuum. The addiction treatment doorway is often the entry to a criminal justice system that must address needs in many areas to ensure successful rehabilitation and recovery, including mental health and trauma. Re-entering offenders benefit from broad-based approaches that target multiple risk factors associated with recidivism.

The expected outcomes of the curriculum are:

1. Increased knowledge about the effects of trauma, its mental health consequences and its relationship to recovery from addictive disorders.
2. The ability to implement trauma-informed approaches and recognize their purpose and promise.
3. To identify common objectives of substance abuse recovery and criminal justice rehabilitation.
4. To instill confidence in staff's ability to meet the challenges trauma presents in correctional settings through practical tools and resources for further learning.
5. To provide an overview of best practices for treating substance use disorders and co-occurring Posttraumatic Stress Disorder (PTSD), appropriate to RSAT programs.
6. To identify the impact of untreated trauma on both risk factors associated with recidivism and relapse into substance use.
7. Ability to champion trauma –informed approaches and their potential to increase institutional security and decrease the need for costly mental health services, seclusion and restraint.

Each module contains participatory exercises, resources for additional learning and a review of the topics covered. While it is impossible to address all aspects of programs and practices, the resources pages offer deeper information on a number of content areas.

**Approach:**

- **Evidence-based**-emphasizing best practices for trauma-informed and trauma specific approaches that have demonstrated effectiveness with offenders in substance use disorder treatment.
- **Integrated interventions**- cognitive behavioral approaches that attend to motivation, with an emphasis on values and personal responsibility; targeting trauma, substance use disorders (SUDs), mental health problems, anti-social attitudes and other associated risk factors for recidivism.
- **Recovery oriented**- recovery is possible from addictive disorders and trauma-related disorders; dynamic risk factors associated with recidivism respond to approaches aimed at behavioral change.
- **Present day accountability**- while trauma histories may be part of the inmate population's past, present day trauma approaches increase coping skills and empower them with greater control over their behavior---today.
- **Culturally Aligned**- attending to staff and inmate relationships, the needs of diverse offenders and the disparities they experience; aligning security concerns with therapeutic practices and attending to provider self-care.
- **Strength-based**- recognition that while trauma survivors have deficits in many areas they have substantial strengths in others; helping them identify the strengths they can draw upon in recovery increases self-efficacy.

## **Module I: Introduction to Trauma–Informed Approaches in Correctional Settings**

- A. Context and Background
- B. Learning Objectives
- C. Self-Care Check In
- D. What the Research Tells Us

### Learning Objectives

After completing this module, participants will be able to:

- Compare the prevalence and types trauma female and male offenders with substance abuse tend to experience.
- List the advantages of training correctional and program staff in trauma basics and addressing trauma in RSAT programs.
- Explain the impact of working with offenders with trauma histories on staff and identify steps to prevent secondary trauma.

## Knowledge Assessment Test

### I. True False Questions

1. Only RSAT program staff can benefit from training in trauma informed approaches.
2. Events are not considered traumatic unless the survivor witnesses or experiences them as a threat of death or injury to themselves or others, or a bodily violation.

### II. Multiple Choice Questions

3. The most common type of trauma women offenders experience is:
  - a. Domestic violence
  - b. Rape by a stranger
  - c. Child abuse
  - d. Sexual abuse
4. Trauma histories among inmates in RSAT programs are so common that
  - a. Trauma informed approaches are applied when it is certain someone has trauma.
  - b. It makes sense to use trauma-informed approaches whenever possible.
  - c. It is important to ask every inmate about past trauma.
  - d. It is best to overlook certain behaviors.
5. The most common type of trauma male inmates are exposed to is:
  - a. Violent abuse in childhood
  - b. Childhood sexual abuse
  - c. Prison rape
  - d. Seeing someone killed or seriously injured
6. The rate of PTSD is higher
  - a. For males than females
  - b. For people with learning disabilities
  - c. For females than males
  - d. For teens
7. Men and women are most likely to develop PTSD as a result of:
  - a. As a result of sexual abuse or rape
  - b. As a result of childhood
  - c. As a result of being attacked by a stranger
  - d. As a result of a natural disaster

Answers: False, True, d, b, d, c, a

## A. Context and Background

Prisons and jails are challenging settings for trauma-informed approaches. Prisons and jails are designed to house perpetrators, not victims. For an inmate with Posttraumatic Stress Disorder (PTSD), there are scores of unavoidable triggers----shackles, overcrowded housing units, lights that are on all night, loud speakers that blare without warning and severely limited privacy. Things like pat downs and strip searches, frequent discipline from authority figures and restricted movement may all mimic certain dynamics of past abuse (Owens, Wells, Pollock, Muscat, and Torres, 2008). All of these factors are likely to aggravate trauma-related behaviors and symptoms that can be difficult for staff to manage (Covington, 2008).

This same inmate with PTSD may also have a substance use disorder (SUD) and is likely to have found ways to use alcohol and drugs to cope with trauma responses and triggers in his or her life on the outside. Suddenly, those substances are no longer readily available. Consequently, trauma related symptoms tend to worsen when beginning to abstain from drugs and alcohol and upon entry into a correctional environment (Loper, 2002), even when inmates enter RSAT treatment by choice.

### Defining Trauma

Most of us have had difficult, perhaps even tragic experiences at some point in our lives. This is certainly true of many people in prisons and jails. But, this training is not about difficult experiences; it pertains to trauma, defined as:

- Terrifying experiences that violate and threaten the survivor's existence
- Shocking, unusual, overpowering events that evoke the fear of death or injury and helplessness

These events have a pronounced effect on our physical and cognitive functioning. The effects are dramatic, but temporary. However, under certain conditions, such as severe or repeated exposure to violence and trauma, these physiological and psychological responses can persist and become completely unpredictable. RSAT counselors can benefit from understanding how to help offenders with trauma histories control their behavior, recover from drug and alcohol use and rebuild a stable life in the community.

### Trauma is not limited to Female Inmates

Although the increase in women entering the criminal justice system brought attention to trauma among offenders, traumatic histories, such as exposure to violence, childhood physical abuse, combat exposure and sexual abuse are all **prevalent among male offenders as well**. However, men's responses to trauma may be very different from women's (Sarchiapone, Carli, Cuomo, Marchetti & Roy, 2009).



***How many people in prison and jail RSAT programs have been exposed to trauma? How many people are dealing with its lasting effects?***

These are some of the questions we will address in detail throughout this manual. Research has shown that two thirds of **men and women** in substance use disorder treatment **outside of correctional settings** report a history childhood trauma or abuse (Clark, 2001). It is reasonable to assume that the numbers are higher among offenders in RSAT programs. It is safe to estimate that at least one third of males and two thirds of females in RSAT programs may be experiencing lasting effects of trauma exposure that play a role in their continued use of drugs and alcohol.

The vast majority of women with SUD's in jails and prisons have experienced interpersonal or sexual violence in their lives, with estimates as high as 90% (WPA, 2006). Yet, ironically, many women, especially those who were homeless, drug addicted or living with dangerous partners prior to incarceration, are statistically safer while in custody than they were before entering a correctional facility, even though they may feel quite unsafe. For example, the estimated prevalence of sexual assault in US prisons, based on the most recent Bureau of Justice Statistics inmate survey, is about 4.3% (Beck and Harrison, 2010). Among women on college campuses, the estimated prevalence of sexual assault is 20% to 25% (Bureau of Justice Statistics, 2010). Some women offenders have reported feeling safe for the first time in years when they initially enter a facility. However, once they are without substances and exposed to the correctional environment, their traumatic histories still may cause acute distress (Covington, 2008).

For men entering a correctional facility, the conditions are different. The risk of being threatened, pressured or forced into sex and the possibility of witnessing another inmate being sexually assaulted increases exponentially when they enter jail or prison. The threat of violence and physical assault also increases for most male inmates. The triggering effect of custody environments is significant for men as well, although their responses, the nature of their past trauma and the behaviors they exhibit that are aimed at keeping them safe, may be very different from women's.

This manual will stress a realistic approach to working with offenders with trauma histories that is compatible with good correctional practice and institutional security. Buy-in from correctional staff, administration and security personnel is more likely when trauma-informed approaches are understood as congruent with safety and security, rather than a rehash of "the abuse excuse." Staff and offender safety becomes the overriding common goal. Security staff is responsible for maintaining order and must assume each inmate is potentially violent. When trauma-informed approaches are introduced as a tool to reduce disruptive behaviors and institutional violence, all staff can play a role in minimizing triggers and stabilizing offenders.

The most successful interventions in prisons and jails have goals that are congruent with the primary duties of correctional staff: public safety, safety of inmates in custody, rehabilitation and staff and institutional security. Good correctional practice requires environments that are highly structured and safe, with predictable limits, incentives and boundaries, as well as swift and certain consequences--applied fairly and consistently (Council of State Governments, 2010). Fortunately, good correctional practices can

help provide the type of stability trauma survivors with substance abuse need in order to learn new information and skills that promote recovery. These values are congruent with the key characteristics of a trauma-informed therapeutic community: safety, predictability, and consistent boundaries and limits---all of which were usually absent from the chaotic and abusive homes in which many offenders were raised.

**B. Objectives upon Completion of this Course:**

1. Participants will identify the characteristics of a traumatic event and the criteria mental health professionals use to diagnose Posttraumatic Stress Disorder (PTSD).
1. Participants will be able to discuss the prevalence of PTSD and the various types of traumatic experiences common among male and female inmates.
2. Participants will be able to explain the risk and needs principle and effective approaches to reducing criminal behavior.
3. Participants will be able to discuss the behavioral health consequences of trauma, its effect on inmates and the function of adaptations.
4. Participants will identify the connections between trauma and substance abuse and the effect of untreated trauma-related disorders on recovery.
5. Participants will be able to give examples of universal approaches for trauma-informed programs and list trauma-informed principles that can be applied to correctional facilities.
6. Participants will be able to identify appropriate trauma-specific, evidence-based practices used in correctional environments and cognitive behavioral models of integrated substance abuse and trauma treatment.
7. Participants will be able outline self-care measures and take precautions to reduce the risk of vicarious trauma.

**This manual is relevant for both correctional officers and treatment providers.**

The material introduces trauma-informed approaches to alcohol and drug treatment and evidence-based practices for integrating treatment of substance use and trauma-related disorders into RSAT programs. Although it is not intended to cover specialized de-escalation and related offender management skills tailored to security staff, correctional officers responsible for the supervision of inmates in RSAT programs will find it beneficial. Trauma-informed approaches can minimize triggers and help reduce violent or agitated responses. It also highlights the importance of self-care for corrections and treatment professionals, alike, working in settings where large numbers of offenders and many co-workers have been exposed to traumatic events. The subject matter is geared to staff that are faced with the challenges and limitations of implementing trauma-informed approaches within prison or jail settings.

### **C. Self-Care Check**

There is historically some reluctance on the part of addiction recovery service providers to open the trauma “can of worms,” especially in an institutional setting. Often clinical resources are limited within a prison or jail environment, and it may seem like the last thing one should venture into. That may be true in the case of certain offenders. Yet, staff training and information about trauma can go a long way toward creating an environment conducive to rehabilitation and staff and institutional safety. The fact is the trauma “can of worms” is likely to be opened up *by the institutional environment itself*; trauma-informed approaches actually help to keep the lid on things, even when trauma-specific treatments are not available (Komarovskaya, 2009). They can strengthen facility efforts to provide effective treatment, increase pro-social coping skills, reduce adverse events, and aid staff morale – all of which can lead to better offender rehabilitation outcomes.

**“Institutional Trauma” in Prisons and Jails-** Without effective tools to deal with the effects of trauma, some facilities can become highly reactive, even when inmates with past trauma are not violent and incidents pose a minimal threat to security. The system begins to rely on “management-by-crisis.” Inmates may re-enact the dynamics of their chaotic and abusive families (Miller and Najavits, 2012); the more the system responds with authoritative measures, the more deeply the dynamics are reinforced and a sort of “institutional trauma” develops. Staff may have experienced direct exposure to trauma from on the job injuries, witnessing prison violence, during prior military service or in their personal lives. They may have learned to function at the workplace in a state of constant hyper-vigilance or numb detachment.

Clinical staff may spend much of their time re-stabilizing offenders, rather than delivering evidence-based interventions that promote addiction recovery, target risk factors and behavioral change.

**Staff Reactions to Trauma Exposure in Correctional Settings-** Even experienced correctional staff that has developed good capacities to respond to inmates with trauma, typically lack formal training, and may be subject to emotional reactivity and burn out. Combine that with the challenge of managing a system that is perpetually under-resourced and staff may feel as overwhelmed by trauma as the inmates in their care. It is helpful if correctional staff training includes information about techniques to respond effectively to offenders with trauma-related disorders. Training should not be limited to program staff. Security staff should also be given information about triggers, trauma recovery approaches and the structure and goals of trauma-specific interventions (McCown, 2006).

When clinical and non-clinical staff members understand their common goals, more offender interactions can focus on safety, personal responsibility, supporting good coping skills and reinforcing treatment gains. Trauma-informed offender management is an important security tool, but security staff will always be the judge of whether or not it is appropriate to use in a given situation. At times, security staff has important safety concerns that may trump the need to focus on trauma, but, any tool that helps security staff deal with inmates with mental health problems is generally welcomed.

### Exercise: Check-in

Before continuing with this course, please take a moment to gauge your potential reactions to this module. Trauma-informed approaches highlight self-care for clients and staff—beginning with you. Working with people who have trauma histories puts caregivers at risk for developing secondary trauma (also known as “vicarious trauma” or “compassion fatigue”). It is normal to have strong feelings when listening to stories of traumatic events (Skaatvitne and Pearlman, 1996). Those who are repeatedly exposed to stories and/or traumatic events need to take steps to protect themselves from the related stress and burn out. We will learn more about secondary trauma in later modules. For now, please use this self-care plan to identify some strategies that might help you manage reactions while reviewing this information or when you encounter intense situations while working with trauma survivors in correctional facilities.

Use this self-care plan to identify some strategies that might help you manage your feelings when dealing with intense information. Sample Self-Care Plan:

If I become exhausted, emotionally, numb or angry:

- I can talk to \_\_\_\_\_ about my feelings.
- I can take a break.
- I can stretch or exercise or go for a walk.
- I can eat something nutritious.
- I can eat something not so nutritious (chocolate!)
- I can think of some of my most successful clients.
- I can take a nap or lie down.
- I can watch something funny or entertaining.
- I can play with my pet or my children.
- I can shoot baskets or play another sport.

These things work well for me when I am overwhelmed at work:

- 1.
- 2.
- 3.

My clinical supervisor is:

## D. What the Research Tells Us

### Prevalence: The Case for Universal Precautions in RSAT Programs

**Universal strategies** address entire groups that share the same general risk. Universal strategies are applied to groups without any prior screening, when the entire group is capable of benefiting.

One of the primary reasons providers learn about trauma is because of the prevalence of traumatic histories among the populations they serve. In settings

like substance use disorder treatment and in jails or prisons, where it is very likely that the majority of clients are dealing with the mental health consequences of trauma, it is best to apply trauma-informed principles, as a “Universal Precaution,” at every client encounter possible and at every level of care, whether or not trauma screening is available. Since trauma-informed approaches are harmless and may even be helpful to individuals in RSAT programs that do not have traumatic histories, it is appropriate to apply them at the program level.

#### **How common is PTSD among the general population?**

In the general population 10.4% of women and 5% of men were found to have PTSD at one time or another in their past (NIMH, 2008). Females are more than twice as likely as males to develop the disorder.

Men in the general population are statistically more likely to be exposed to violence, but less likely to develop PTSD as a result. Men are most commonly exposed to traumatic events that involve seeing someone killed or critically injured or being physically assaulted themselves (Hills, 2004). Women are more likely to have been sexually victimized than men and very likely to have developed PTSD as a result. Women may also take longer to recover from trauma and are four times more likely than men to have long-lasting PTSD, and to have accompanying depression and anxiety (GAINS Center, 2002; National Center for PTSD, 2007).

#### **How common is this disorder among justice involved individuals?**

In recent studies of incarcerated populations, PTSD has been found in up to 48% of female inmates and up to 30% of male inmates (Tull, 2005). **Trauma may still gravely affect the way people see the world even if they do not have a PTSD diagnosis.**

Histories of trauma are very common among people with mental health and substance abuse disorders (or both). These people are at a higher risk for ending up in the criminal justice system. Research on violent offenders shows that they are more likely to have PTSD than not to (Carlson and Shafer, 2010). Studies of death row inmates have found significant rates of PTSD (Freedman and Hemenway, 2000).

Overall, higher rates of trauma and earlier age of trauma onset are associated with increased violence and

#### **TAPA Center Data on Exposure to Trauma in Jail Populations (Noether & Abruë, 2006)**

<i>Women</i>		<i>Men</i>	
91%	lifetime physical violence	86%	lifetime physical violence
65%	lifetime trauma witnessing	61%	lifetime trauma witnessing
75%	lifetime sexual trauma	32%	lifetime sexual trauma

victimization in prison (Komarovskaya, 2009). Data suggest that many more offenders have trauma histories, even if they are not diagnosed with PTSD (Gordon, Barnes and Van Benschoten, 2006).

The TAPA Center for Jail Diversion gathered data on offenders across 21 sites (see chart) and found high levels of exposure to traumatic events reported by both men and women entering jails, suggesting the high rate of trauma exposure found among women offenders may also be found among men (Noether and Abrue, 2005). The types of traumatic events, however, and their reactions to them may differ significantly.

Men in the criminal justice system are most likely to have experienced traumatic events related to witnessing a killing, (Sarchiapone, Carlia, Cuomo, Marchetti and Roy, 2008), followed by physical assault, often with a weapon (Johnson, Ross, Taylor, Williams, Carvajal, and Peters, 2006), and childhood sexual abuse (Weeks and Widom, 1998).

In a national survey of more than 4,800 male inmates in jails:

- 37%-52% had been attacked with a knife or other sharp object.
- 38%-47% had been shot at (excludes military combat).
- 5%-10% had been physically or sexually abused. (Greenberg and Rosenbeck, 2008).

Generally, sexual abuse is the most common type of traumatic event in the lives of women offenders, followed by intimate partner violence (Battle, Zlotnick, Najavits, Gutierrez and Winsor, 2002; Zlotnick, Najavits, Rohsenow and Johnson, 2003). Women offenders' victimization is also most likely to have occurred during their childhood; particularly, **childhood sexual abuse** has been reported in up to 55% of women in prisons (Blackburn, Mullings and Marquart, 2008; Raj et al., 2008).

Men in prison are twice as likely as women to meet criteria for antisocial personality disorder. Women in prison report greater rates of borderline personality disorder, major depression, eating disorders, and PTSD (Zlotnick et al, 2008). Women in prison compared to men, are also more likely, to report injection drug use and homelessness in the past six months, and to have past psychiatric hospitalizations and suicide thoughts, feelings or attempts (Clements-Nolle, Wolden and Bargmann-Losche, 2009).

The experience of rape is a traumatic event likely to result in PTSD for both men and women. In one study of almost 6,000 subjects with trauma-related disorders, approximately 65% of men and 46% of women said that rape was the most upsetting traumatic event they had experienced and developed PTSD as a result of it (Kessler et al., 1995; Ozer, Best, Lipsey, and Weiss, 2003).

### ***Why do some people get PTSD and other people do not?***

Many factors play a part in whether a person develops PTSD. Only about 8% of men and 20% of women who experience a traumatic event will develop PTSD (National Center for PTSD, 2007). Risk factors can make a person more likely to develop it and resilience factors can help reduce the risk of the disorder. Some risk and resilience factors are present before the trauma and others become important during and after a traumatic event.

Risk factors for PTSD include:

- Having a history of mental illness
- Sustaining an injury during the traumatic event
- Seeing people hurt or killed
- Having little or no social support after the event
- Added stress after the event, such as loss of a loved one, job or home

Resilience factors that may reduce the risk of PTSD include:

- Seeking out support from other people, such as friends and family
- Finding a support group after a traumatic event
- Feeling good about one's own actions in the face of danger
- Being able to act and respond effectively despite feeling fear
- Having a coping strategy, or a way of getting through and learning from it

Researchers are studying the importance of various risk and resilience factors. With more study, it may be possible someday to predict who is most likely to get PTSD and to prevent it. Given the family history and living environment of many offenders, the absence of resiliency factors may contribute to their vulnerability to PTSD.

### **What about Substance Abuse?**

*“Might [heroin’s] psychoactive effects be the best coping device that an individual can find? Is intravenous drug use properly viewed as a personal solution to problems that are well concealed by social niceties and taboo? Is drug abuse self-destructive or is it a desperate attempt at self-healing...”*

*~Vincent Feletti, MD, ACE Study*

Studies reveal that two-thirds of **men and women** in substance abuse treatment report childhood physical or sexual abuse (NIDA, 1998).

**Men with tend to use alcohol in response to traumatic experiences at a much higher rate than women.** Almost twice as many men (51.9%) with a history of PTSD report alcohol problems as compared to 27.9% of women (Tull, Baruch, Duplinsky & Lejuez, 2008). Alcohol, however, is far more likely than other drugs to be associated with assaultive crimes, especially when the perpetrator knows the victim (BJS, 2010).

**Up to 89% of women seeking alcohol and other drug treatment report a lifetime history of sexual or physical abuse** (Clark, 2001). For incarcerated women, a vicious cycle of trauma and addiction is likely to have its roots in girlhood. They may begin using substances to soothe negative states or to help numb emotions or withdraw when they feel unsafe. However, substances can also increase women's vulnerability to sexual exploitation, exposure violence, and risk of additional trauma—which ultimately, leads to a greater need for relief.

When women or men use substances to strategically manage responses to trauma, the temporary relief becomes a powerful reinforcer.

Traumatic experiences are not uncommon. Studies estimate that one in four adolescents will experience at least one traumatic event in their lifetime before the age of 16. There is a high correlation between trauma and the risk for substance abuse later in life. Teens that experience **both** trauma and substance abuse have much higher incidence of academic, psychological and social impairments and juvenile justice involvement (Costello, et al., 2002).

The National Institute on Drug Abuse (2008) indicates that two of the major risk factors for early onset of addiction are:

1. Childhood psychological trauma; and
2. Co-occurring disorders preceding the onset of addiction.

Research indicates that the earlier substance use is initiated, the more likely it is that a child or adolescent will have a substance problem during their adult life. Almost all adult pathological drinkers (96.8%) began drinking before age 21 (Grant & Dawson, 1997).

- Those who initiate alcohol use prior to age 15 are four times more likely to become alcohol dependent than those who start regular drinking at age 21 or older.
- Approximately 90% of individuals who develop chronic substance dependence disorders with associated severe, psychiatric and behavioral problems start using illicit substances while under the age of 18 (Dennis, 2002).

Addiction is increasingly seen, by many researchers, as a developmental disorder (with its roots in childhood and adolescence, potentially mediated by early trauma. Both result in changes to brain functions about which we know precious little. Whatever causes and connections may exist, we do know that:

- People with PTSD have repeatedly been found to have a high rate of substance-related disorders, and
- Rates of PTSD among clients in SUD treatment have been found in various studies to range from 19% to 62% (COCE, 2011).
- Treatment outcomes are worse for those with PTSD than for those with substance abuse alone and worse than outcomes for other for dually diagnosed clients and (Ouimette, Finney and Moos, 1999).



## Veterans and Trauma

PTSD is the most common mental health disability among Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans, according to a Veterans Health Administration (VHA) review of all discharges from active duty between 2005 and 2006. Men reported a higher rate of disability due to PTSD than women; women reported higher overall rates of mental health disabilities, but for a range of different mental health problems. The overall rate of PTSD diagnosis at the VHA was more than 9%; that rate is three times higher among OIF/OEF veterans than for those who served in other conflicts (DVA, 2010). Research indicates that about 1 in every 4 veterans will return from war with depression, posttraumatic stress disorder, or traumatic brain injury, and that these illnesses are often complicated by substance abuse, and problems controlling anger (Tanielian and Jaycox, 2008). Another recent study on National Guard personnel returning from Iraq and Afghanistan found more than 46% met the criteria for PTSD, substance abuse or another active mental health condition (Kline and Smelson, 2007).

Data on rates of specific types of combat trauma exposure ranged from 5% to 50%, with high numbers of veterans reporting exposure to several types of traumatic events. Vicariously experienced traumas (e.g., seeing a friend seriously wounded or killed) were the most frequently reported. Direct injuries were reported by between 10% and 20% of the OIE/OEF veterans surveyed (Kilmer, Eibner, Ringel and Pacula, 2011).

The prevalence of military sexual trauma (MST) among the population of VHA outpatients, as indicated by data from their universal screening program, collected shortly after its implementation in 2003, is 21.5% among women and 1.1% among men (Kimerling, Gima Smith, Street, and Frayne, 2007). Although about 1 in 5 women and 1 in 100 men seen in VHA facilities screen positive for MST, there are almost as many men seen in the VHA system that have experienced MST as women. This is because women comprise a much smaller proportion of the military, even though they experience a much higher rate of MST than men (National Center for PTSD, 2011).

It is important to note that self-reported rates of PTSD among veterans are higher, and that many veterans do not seek mental health services in the VA system for a variety of reasons, including stigma and fear of consequences for their military careers. Some researchers have indicated 17%- 23% rather than 9%, is a more reasonable estimate of PTSD among OIF/OEF veterans (Hoge, 2006; Shen and Arkes, 2009). Across studies there are a wide range of PTSD rates among those serving in Iraq and Afghanistan, with estimates ranging from 4% to 45% (Tanielian & Jaycox, 2008).

Veterans may experience a number of trauma -related symptoms that can put them at-risk for criminal justice involvement. Characteristically high rates of alcohol abuse among veterans (male and female) compound the risk of arrest. A study of returning veterans from Iraq and Afghanistan found SUDs in about 20% of those receiving treatment at the VA between 2001 and 2005, with many using drugs and alcohol to deal with the symptoms of trauma (National Survey on Drug Use and Health, 2007; Kang, et al 2003; Prigerron, et al. 2001). Alcohol, like other central nervous system depressants, functions as a readily available antidote to the highly and unpredictably aroused nervous system of a combat-exposed trauma survivor (Jacobson, et al., 2008).

National research reveals that almost 10% of jail and prison inmates across the country are veterans (Noonan & Mumola, 2007; Greenberg & Rosenbeck, 2008). Incarcerated veterans are typically dealing with many issues, including high rates of unsafe alcohol use and binge drinking (50%) --and co-occurring psychiatric illness (35%), such as Major Depression and PTSD. A substantial percentage (21%) experience chronic homelessness and there are high rates (73%) of unemployment (Maguire, 2003). As veterans return from multiple deployments and longer tours of duty, research suggests they may become more vulnerable to PTSD and other mental health related consequences of combat stress, and, unfortunately, increasing numbers may become involved in the criminal justice system (Hoge & Castro, 2005).

In a 2004 study of incarcerated veterans, substance abuse problems were often the direct cause of their imprisonment (BJS, 2007).

46% of veterans in federal prison were incarcerated for drug crimes

15% of those in state prisons were incarcerated for drug crimes

25% were intoxicated at the time of arrest

61% met the criteria for an SUD

This information on the rates of trauma among veterans in the criminal justice system, people with substance use disorders and incarcerated men and women, makes a strong case for learning more about best practice guidelines for trauma-informed RSAT programs. Integrated treatment that promotes recovery from both is recommended (Osher and Steadman, 2007). Skills that help with recovery from one disorder often help with recovery from the other. Conversely, any co-occurring disorder, left undetected and unaddressed can interfere with treatment engagement, contribute to relapse and to a return to drinking and drug use — and criminal behavior. By leaning about trauma, RSAT programs, at the very least, can ensure they do no harm, identify offenders in need of additional services and teach basic skills that will help offenders manage their responses, regulate their emotions and reduce the triggers that can lead them back to substances. This brief training will provide resources for further learning and guidelines for addressing trauma, trauma-related disorders and delivering trauma-informed substance abuse treatment in RSAT programs.

## Module II Understanding Trauma

- A. Introduction - What is Trauma (and how does it relate to substance abuse?)
- B. What Research and Practice Tell Us
- C. The Impact of Trauma
- D. Review and Resources

### Learning Objectives

After completing this module, participants will be able to:

- List examples of at least three physiological changes that take place when people perceive a threat to survival.
- Describe the characteristics of traumatic events that are most likely to cause serious mental health problems.
- Cite one example of each of the three major symptoms groups of PTSD.

## Knowledge Assessment Test

### I. True False Questions

1. It is normal for people who experience a dangerous, horrifying, life threatening event to have a primitive “fight or flight” response.
2. The primitive part of the brain that is responsible for responses to danger is called the cerebral cortex.

### II. Multiple Choice Questions

3. Trauma re-enactment tends to occur
  - a. When trauma survivors fail to learn their lesson from a past trauma
  - b. When trauma survivors begin to enjoy suffering
  - c. When inmates enter a prison environment
  - d. When people with trauma repeat patterns, hoping the outcome will be better this time
4. Dissociation refers to the symptom of zoning out and becoming psychologically absent in response to a trauma trigger and
  - a. interferes with the ability to learn new information about the world
  - b. is a symptom that requires medication
  - c. is a symptom that cannot be controlled in a prison setting
  - d. is a purposive attempt at avoiding responsibility
5. One of the symptoms people have that lead to a diagnosis of PTSD is
  - a. Persistent need to tell people about the traumatic event
  - b. Symptoms that cannot be managed without medication
  - c. Re-living the event through flashbacks and nightmares for a period of a month or more
  - d. A childhood history of watching their mother being treated violently
6. The symptoms of PTSD can be grouped into the following categories
  - a. Present day and past oriented
  - b. Anger, depression and anxiety
  - c. Re-experiencing, intruders and hyper-mania
  - d. Intrusion, avoidance and arousal
7. An example of the symptom of avoidance is
  - I. A female trauma survivor that flirts with male officers
  - II. A male trauma survivor who sends romantic notes to a female counselor
  - III. A male combat veteran who refuses to watch the news
  - IV. A female inmate who has flashbacks when she is strip searched

True, False, d, a, c, d, c

## A. What is Trauma?

### When does a difficult experience become traumatic?

Trauma is extreme stress brought on by ***shocking or unexpected events*** that ***overwhelm a person's ability to cope***, resulting in ***feelings of helplessness, and extreme fear and horror***. The survivor perceives the event as a ***bodily violation or a threat of serious injury or death to self or a loved one***. Events may be ***witnessed (vicariously) or experienced directly***.

The defining factor that separates a traumatic experience from distressing one is the **perception of a threat to survival to self or a loved one**. The threat of losing a child, witnessing people die or become injured during a disaster or war, or any type of invasive violation of the body, can be perceived as a threat to survival. Sexually invasive threats tend to be experienced as traumatic. All these threats result in the type of "primal" fear that activates distinct responses from the body and the mind.

**Some examples of events likely to be traumatic when experienced or witnessed include:**

- Hate crimes, genocide,
- Torture, combat and war
- Domestic violence and family violence
- Childhood physical abuse
- Adult or childhood sexual abuse or assault
- Natural or man-made disasters
- Automobile and airplane accidents
- Confinement, imprisonment, forced institutionalization
- Persecution, oppression and community violence
- Psychological and emotional abuse
- Childhood sexual abuse/exploitation
- Sex work, sexual exploitation or harassment
- Homelessness, displacement
- Medical trauma or intense surgical interventions

Trauma can play a central role in the onset, severity, and duration of substance dependency and has an impact on the recovery process. For offenders in RSAT programs, exposure to traumatic events such as violence or sexual abuse may have taken place during childhood, as adults, during the commission of their crime or while incarcerated. Histories of sexual and physical abuse are almost endemic to women offenders in need of addiction treatment. Traumatic experiences may have taken place prior to initiation of drug and alcohol use, while under the influence, and after active addiction has ceased.

Often, substance use becomes one of the primary coping mechanisms a trauma survivor relies on. For some, abstinence from substances combined with the stressors of the correctional environment, increases the effects of unaddressed trauma. Traditional substance abuse treatment programs that are not designed to address the co-occurrence of trauma and related mental health issues often are limited in their ability to engage and retain offenders or to result in lasting treatment gains (Messina, Grella, Cartier and Torres, 2010).

**Exercise 1:** The examples of events listed are not exhaustive, by any means. Please list a few events that have been reported as traumatic by people you have worked with:

1.

2.

3.

**What is the Nature of a Traumatic Experience?**

What one person may perceive as a frightening, traumatic event, another might experience as difficult or distressing, but not traumatic. One’s ability to cope, perception of control and safety, and level of preparedness can all affect the way an event is experienced and remembered. To some extent, trauma is in the eye of the beholder.

**Example:** Rochelle is Joan’s older half-sister. Rochelle lived with her dad for part of her childhood, but moved in with her sister, Joan, when their mom re-married. One night, the girls saw their mom’s new husband break her nose. Rochelle was devastated, but Joan was traumatized. Each perceived what they saw differently as illustrated below

Joan’s Perceptions	Rochelle’s Perceptions
Mommy is going to die. Her head is all bloody.	Got to get help. I think he broke her nose.
He is going to kill us too.	If he comes near me I’ll call the police.
My heart is racing. I have to cry.	We have to keep quiet, Joan, don’t cry.
This is happening to us because I am bad.	Why did I have to come back here to live?

**Exercise 2:** Check off what would qualify Joan’s experience as a traumatic event?  
 (see bottom of page 22 for responses)

- Perception of threat to her survival
- Overwhelms her capacity to cope
- Unusual, sudden or out of the ordinary
- Feelings of helplessness and extreme horror
- Threat of death or serious injury to self or loved one

How about Rochelle?

- Perception of threat to her survival
- Overwhelms her capacity to cope
- Unusual, sudden or out of the ordinary
- Feelings of helplessness and extreme horror
- Threat of death or serious injury to self or loved one

## B. What Research and Practice Tells Us

### The Adverse Childhood Experiences (ACE) Study

Compelling data has shown that multiple traumatic or adverse childhood experiences are a risk factor for addictive and mental disorders. One of the largest studies on childhood abuse and household dysfunction was conducted by the Centers for Disease Control and Kaiser Permanente.

The Adverse Childhood Experience (ACE) Study collected information about childhood from 17,421 cooperating adult HMO members that received routine physicals. In the original study, adverse childhood experiences were grouped into the 3 categories of abuse and 5 types of household dysfunction (shown below); other categories were later added. The total number of types of adverse experiences was added up to arrive at an ACE score. More than half of the participants reported at least one category of adverse childhood experience; researchers found that a history of multiple types of childhood trauma was highly correlated with serious chronic physical conditions (Felitti, 2007).

Types of Adverse Childhood Experiences	
Abuse by Category	Household Dysfunction, by Category
Emotional/Psychological (recurrent)	Substance Abuse
Physical (recurrent)	Mental Illness
Sexual Abuse (contact)	Mother Treated Violently
	Imprisoned Household Member
	Separated from biological parent

Source: ACE & their Relationship to Adult Health & Wellbeing. Felitti & Anda, CDC & Kaiser Permanente, 2005.

### The Impact of Childhood Trauma on Adult IV Drug Use and Adult Alcoholism

The ACE study also found that the number of types of adverse childhood experiences was *even more strongly* correlated to the risk of behavioral health problems including alcoholism and IV drug use. The results for mental health and substance abuse were dramatic, *but the results for women addicted to drugs were among the most dramatic.*

**Answers to exercise 2 on page 21:** Joan had all 5 of the qualifying factors and experienced the event as traumatic. Rochelle had one qualifying factor; the event was unusual, sudden or out of the ordinary. Rochelle was certainly distressed, but did not perceive the level of threat her to her survival that her younger sister did, and she was prepared to take some action in response to the events.

- Women who experienced 4 or more types of childhood *trauma* had 78% attributable risk for IV drug use.
- Women who did not experience any of these instances, by contrast, had only a .05% attributable risk for IV drug use.
- Women with histories of childhood sexual abuse were 60% more likely to abuse alcohol and 70% more likely to use illegal drugs.
- A male child who experienced at least 6 types of adverse childhood experiences compared to a male child who experienced none, had a 4,600% increase in the likelihood of becoming an injection drug user.
- Self-acknowledged alcoholism in men and women increased 500% in relation to adverse childhood experiences.
- Among the 7% of the sample that did experience 4 or more types of abuse or dysfunction, high rates of mental illness, tobacco and substance use, teen pregnancy and chronic disease were found (Felitti, 2007).

**NOTE:** Adverse Childhood Experiences Screening Questionnaires are available for use and in the Public Domain –both the Male and Female versions are available at: <http://www.cdc.gov/ace/findings.htm>

Since the study was conducted with a group of “middle class” insured adults, it is reasonable to assume that other groups, such as prison and jail inmates, have greater proportion of people that experienced compound abuse or dysfunction in childhood --- and can benefit greatly from trauma-informed substance abuse treatment in prison and jail RSAT programs!

**Exercise 3:** Please read the stories that follow carefully.

### Harriet’s Story

*I grew up with an alcoholic father and a bi-polar mother. My dad was a military man and was always either angry or distant. When my mom was delusional, she would beat me and my older brother, Pete. When I was 11, she went into a mental hospital and I went to live with my aunt. My uncle came into my room at night and sexually abused me for 2 years. When I went back home, I told Pete about the abuse—he broke into my aunt’s house and threatened my uncle with a gun. He got three years for assault with a deadly weapon for that. After Pete went away, I drank every night and started doing ecstasy.*

*I got addicted to pain meds and was using heroin with my boyfriend until I got pregnant at 17—that’s when he started hitting me. After Ashley was born, I tried to get away from him, even tried going into treatment. I finally left him after he broke my collar bone. I worked as a dancer for a while and had 3 arrests for possession and soliciting. I did some time, but they gave me a chance at early release, if I completed treatment. I jumped at the chance — the state had taken Ashley and I would have done anything to get her back.*



## Pete's Story

*My dad believed in discipline. When he caught me smoking behind the shed in 6<sup>th</sup> grade, he forced me to lie on my stomach with my pants off in the sun all day in the yard while he worked in his shed. He drank cold beer after cold beer until sundown. Then he switched my sun burnt butt and legs until welts popped out, and then made me smoke a cigarette. It didn't stop me from smoking, but it did make me hate him. I drank, huffed and started snorting crack.*

*I remember before Harriet was born I used to see him beat mom. No wonder she was so nuts. She thought she was the bride of Jesus and was usually pretty happy about that until she decided my sister and I were sending her messages from Satan. But, I loved my mom, and when she went away, so did my sister, Harriet. I couldn't stand the sight of the old man. So I left and lived in a tent in the woods for about a year, until Harriet came home.*

*I did break into our uncle's house after she told me what he did, and I would have shot him. But, my auntie was begging me to let him live. I was 17 when I went to prison. Things happened there I will never talk about. I stabbed one guy and hurt him pretty good. I got time added to my sentence, but it was worth it.*

### Exercise 3: Harriet and Pete's ACE Score

The ACE study used a simple scoring method to determine the extent of exposure to childhood trauma. Exposure to each category of adverse childhood events counts as one point; points are added for a total ACE score. An ACE score of 0 would indicate no exposure to any of the categories of adverse events, while a score of 8 would indicate exposure to all of the categories.

#### Based on these two stories, can you determine the following?

- Harriet's ACE score ----- her total number of types of adverse childhood experiences?
- Pete's ACE score?
- How many categories of adverse childhood experiences has Harriet's daughter, Ashley, had so far?

**For discussion:** What percentage of clients do you see who probably have an ACE score of 4 or more?

(see page 26 for answers)

What's YOUR ACE Score? Link: [Help me calculate my ACE Score](#)

### C. The Impact of Trauma

The ACE study helps us to understand the inter-generational nature of trauma.

Findings also suggest that adverse childhood experiences have a cumulative effect.

In other words, although any one of these adverse events in childhood might have a long-term effect, four or five of these factors, collectively, take a toll in adulthood. This research also suggested that trauma experienced early in life is likely to erode resiliency and lead to vulnerability to further victimization later in life.

In the next section, we will begin to talk more about how trauma can alter the brain's primitive response system. **This can leave survivors intensely fearful even when there is no immediate threat to their safety and numb or frozen when faced with clear and present danger.**

Learn More: The Adverse Childhood Experiences (ACE) Study at: <http://www.ajpm-online.net/article/PIIS0749379798000178/abstract>

Characteristics of traumatic events, that are likely to result in serious mental health problems involve:

- Interpersonal violence; intentional in nature, prolonged, repeated, and severe
- Sexual assault, rape or sexual abuse
- Begin in childhood or take place during adolescence, or other a critical developmental period.

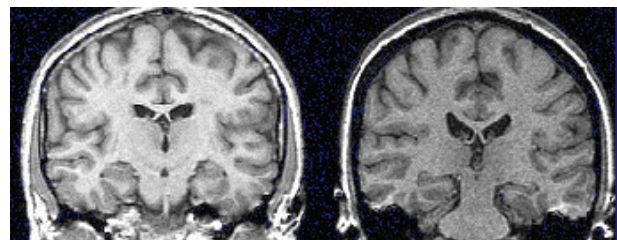
In one survey, 9.2% of persons experiencing any type of trauma developed PTSD, but 50% of those who had been raped, held captive, tortured or kidnapped went on to develop PTSD (SAMHSA, 2011). Survivors of trauma are also have an likelihood of future victimization and additional trauma (Council of State Governments, 2005).

***Dealing with the ongoing effects of the trauma is often more painful than the original event*** (Gillece, 2010).

### How the Brain and Body React to Trauma

We have all heard the story of a woman who sees her child trapped under a car and suddenly has the strength to lift the car off her child. Whether the story is accurate or not, it does illustrate the type of survival responses that are hardwired into our brains and bodies.

The Amygdala is the part of the brain that initiates primitive “fight or flight” responses. Events perceived as threatening cause the Amygdala release neurotransmitters that activate the adrenal glands. Within seconds, heart rate and respiration increase and prepare for a survival response. Blood flows out of the thinking



centers of the brain and into the limbs to prepare to run. When the threat is over, the brain should return the body to normal. When this process is disrupted, returning the body and brain to a normal state becomes difficult and unpredictable. This can lead to serious mental health problems, such as Posttraumatic Stress Disorder (PTSD).

## Trauma and Altered Cognitive and Emotional Functioning

Cognition and emotion both involve chemical and physical processes within the brain. Trauma affects these processes by activating “fight or flight” responses in the primitive part of the brain (Phelps and LeDoux, 2005). Studies of brain function after prolonged or repeated exposure to danger or highly traumatic experiences suggest changes the brain’s normal processes (Bremner, 2002):

- Scientists speculate that as the pathways through which sensory stimuli reach the Amygdala are worn “deeper and wider”, activation of the “fight or flight” response becomes more excitable, faster and more automatic (Phelps, 2004).
- Ventricles may enlarge and crowd the path from the Amygdala to memory circuits; as these pathways narrow it slows down the brain’s ability to put information in context and decide whether or not it poses a threat (Smith, 2005).
- Young brains are more malleable, and just as the early introduction of substances profoundly affects the developing brain —the earlier the exposure to trauma, the more rapidly these changes take place and the more long-lasting they appear.

**Answers to exercise 3 from page 24: Note---score totals are subjective and answers are suggested, but discussion of other scoring and interpretation is encouraged.**

Harriet’s ACE score – 1= alcoholic father; 1= mentally ill mother; 1= incarcerated family member; 1= sexual abuse; 1= physical abuse; 1= emotional and psychological abuse; 1= separated from biological parent **Total = at least 7**

Pete’s ACE score-1= alcoholic father; 1= mentally ill mother; 1= physical abuse; 1= emotional and psychological abuse; 1= mother treated violently **Total = at least 6**

Ashley’s ACE score- 1= mother treated violently; 1= drug addicted mother; 1= incarcerated family member; 1= separated from biological parent **Total = at least 4**

## What is Post Traumatic Stress Disorder (PTSD)?

PTSD is an anxiety disorder that people can develop after seeing or living through a terrifying event. Not everyone exposed to danger and violence experiences it as traumatic. For example, many people who experience a serious automobile accident are temporarily affected. This is known as Acute Stress Disorder (ASD). However, when the effects last beyond a few weeks, it may become PTSD.

PTSD means that survival responses that protect us from harm no longer function normally. The body kicks into *Code Red* at inappropriate times; or becomes numb or disconnected in the face of real danger. PTSD can interfere with thinking and memory. Thoughts and reminders of a traumatic experience make emotions difficult to regulate. These changes can gain momentum and affect the way the brain processes information, which in turn sets physiological changes in motion...

....leading to changes in arousal, attention, perception and emotion

**Arousal**-Extreme excitability and responsiveness to external stimuli **or** numbing and detachment from the outside world.

Hyper-arousal←←←→→→numbing

**Attention**-The mind is directed away from triggers, absent and inattentive **or** toward them, deeply and exclusively focused.

dissociation←←←→→→ hyper-focus

**Perception**-Pupils dilate: vision and hearing are sharpened **or** dulled, with memory is absent

heightened←←←→→→dulled

**Emotion**-Feelings are devastating and painful **or** inappropriately detached from experience.

absent←←←→→→overwhelming

**Three Major PTSD Symptom Groups include:**

**Avoidance**

- ◆ Voluntary suppression of memory
- ◆ Restriction of daily activities
- ◆ Dissociation; substance use

**Arousal**

- ◆ Startle reflex
- ◆ Irritability and hyper-vigilance
- ◆ Sleep disturbances

**Intrusion**

- ◆ Flashbacks
- ◆ Nightmares
- ◆ Trauma Re-enactment

**Avoidance**—Altered states of consciousness, dissociating, numbing, checking out, memory lapses, unavailable for learning new information. Substance use, bingeing and purging, voluntary suppression of memory, restriction of daily activities, isolation, detachment from surroundings, submissiveness, avoidance of conflict and inaccurate perceptions of safety and danger.

**Arousal**—Startle reflex in response to being touched or loud noises, trouble getting to sleep; frequent awakening. Poor concentration; irritability, angry outbursts or violence. Constant guardedness, extreme distrustfulness; hyper-vigilance, emotional volatility-- or exhilaration in the face of danger, desensitization to pain and thrill seeking.

**Intrusion**—Unwanted thoughts and reactions, often triggered by sensory details that symbolize the trauma. Nightmares and flashbacks; re-running the event. Anxiety and physical distress in response to upsetting memories. Re-enactments that repeat the dynamics of the event in an attempt to triumph or find rescuers.

**Exercise 4:** Although both males and females with PTSD may have any and all categories of symptoms, can you guess which of the three groups of PTSD symptoms is predominant in females and which is more typical of males?

(see page 29 for answer)

### **Primitive Survival Responses to Fear and Trauma**

Prison and jail environments can trigger re-experiencing symptoms that make it difficult for inmates with trauma to adjust to a correctional environment and may make offenders difficult to manage. Some research has shown that trauma survivors in prison settings have been misdiagnosed with psychosis due to re-experiencing symptoms that were thought to be hallucinations. When treatment with anti-psychotic medications was ineffective, psychiatrists discovered the inmate was re-experiencing rather than hallucinating and sought a course of trauma treatment instead (Prescott, 2001).

Trauma reminders can trigger avoidance symptoms. Male offenders may react with emotional numbing that interferes with their ability to experience empathy and remorse. Women may avoid medical and dental care, may fail to show up when they have been referred to programs and may disassociate or “check out” during groups at the first sign of conflict, authoritative or confrontation. This has been identified by criminal justice researchers as a potential problem that may prevent offenders from engaging and benefitting from cognitive-behavioral interventions in prison (Brennan 2007). Establishing a safe environment and teaching trauma stabilization techniques are helpful at the earliest stages of program participation to ensure offender engagement.

Hyper-arousal symptoms are usually constant, rather than triggered and may lessen over time. Symptoms like angry outbursts, startle responses, constant tension and a violent response to authority, especially among males, can present a threat to safety and security. In addition to the measures mentioned above, regulating affect, teaching additional coping skills and self-soothing techniques in RSAT programs, if practiced over time, can lessen arousal responses and provide clients an alternative

to using substances for relief. Some of the primitive reactions below help explain the nature of these aroused states:

- **Fight**- hyper vigilance on conscious and unconscious levels, prepared to defend; flooding of physiological changes related to aggression.
- **Flight**- blood flows to the limbs preparing to run; flight is often thwarted, giving no relief or outlet to a primed nervous system. Avoidance, dissociation, hiding and other psychological “flight” behaviors can also become disruptive.
- **Fright**- responding with a state of terror, often to seemingly benign triggers; fright and anxiety permeates all areas of life. Shortness of breath, startle responses, sleeplessness and inability to focus or think clearly.
- **Freeze**- observed in animals, accompanied by slowed and shut down metabolism. Can also be a learned response as an attempt to remain invisible and safe; paralyzes the victim—actually making them more vulnerable and reinforcing helplessness in each new situation.
- **Flail**- perceived as aggression, but physical movement, such as flailing of the arms, is meant to create a safe space around the body rather than connect with a target. Animals puff up or fan out when an aggressor is closing in.
- **Shield**-Protective--- like flailing, shielding and raising hands over head and body to prepared for and attack. Trauma survivors may shield in response to noises or non-violent conflict.
- **Flirt**-Particular to some women offenders who survived sexual violence in childhood. Instinctive placating behavior for little girls who were sexualized in violent homes. Incest perpetration has been found to be highly correlated with violence (Edleson, 1999; Paveza, 1988).
- **Submit** –May render the victim more vulnerable, but more in control or able to escape. Animals will submit to predator if flight is impossible. Submission or under arousal in the face of danger may be labeled “risk taking” behavior.

**Answer to Exercise 4 from page 28:** Avoidant responses are more frequently seen in women; while arousal is more common in men. However, both men and women may have any and all types of symptoms.

## D. Review and Resources

### Module Review

- Traumatic events are differentiated from distressing experiences by feelings of extreme horror and helplessness, perception of a threat to survival –body injury, violation or death- of self or a loved one, overwhelming a person’s ability to cope.
- The ACE study demonstrated that the cumulative effect of multiple types of adverse childhood experiences can seriously impact physical and behavioral health.
- Interpersonal, deliberate and repeated or prolonged abuse and sexual assault and abuse are events most likely to cause trauma related mental health problems, especially when they start in childhood.
- Posttraumatic Stress Disorder (PTSD) is an anxiety disorder some people get after exposure to violence, victimization, combat or natural disasters. The survivor experiences the symptoms of avoidance, hyper vigilance or intrusion.
- Survival responses that are instinctively activated in our brains and bodies become unpredictable and deregulated with PTSD. This leads to changes in arousal, attention, perception and emotion.
- The emotions of panic and fear are stored along with the trauma memory. Physical responses that were activated during the original event, such as increased respiration, sweating, decreased blood flow to the brain and heightened hearing and vision, are triggered along with the memory.
- Women and men in prison tend to have high levels of trauma symptoms that can become worse once they are incarcerated and once they stop using substances. Male inmates tend to experience a high level of arousal symptoms and females tend to be more avoidant.
- Male veterans, and other males exposed to violence and danger, tend to use alcohol at a higher rate, possibly because its depressant effect helps control hyper-vigilant, anxious responses.

We will learn more about working with responses to trauma in correctional settings in the next module.

## **Resources**

**Web-based Resources:** The following web-based resources have helpful information for learning more about trauma and tools for program implementation.

1. SAMHSA Web site link to the Disaster Technical Assistance Center:  
<http://www.samhsa.gov/dtac/>
2. SAMHSA Web site link to the National Center for Trauma-Informed Care:  
[www.mentalhealth.samhsa.gov/nctic](http://www.mentalhealth.samhsa.gov/nctic)
3. National Child Traumatic Stress Network: [www.nctsnet.org](http://www.nctsnet.org)
4. Department of Veterans Affairs National Center for Posttraumatic Stress Disorder: [www.ncptsd.va.gov](http://www.ncptsd.va.gov)
5. National Association of State Mental Health Program Directors.  
<http://www.nasmhpd.org>
6. National Institute of Mental Health. <http://www.nimh.nih.gov/index.shtml>



## **Module III Integrated Treatment and the Criminal Justice System**

- A. Understanding Criminal Justice Theory and Practice
- B. Cognitive Behavioral Interventions
- C. Compatible Evidence-based Principles
- D. Review and Resources

### Learning Objectives

After completing this module, participants will be able to:

- Describe ways to distinguish which offenders are the most likely to benefit from programming.
- Name at least two risk factors associated with criminal behavior and give an example of how trauma responses can contribute to the risk of recidivism.
- Identify principles of evidence-based offender rehabilitation that are also considered best practice for people with substance abuse problems.

## Knowledge Assessment Test

### I. True False Questions

1. Criminal justice research shows that identifying low risk offenders when they enter prisons and putting them into intensive rehabilitation programs will have the greatest impact on reducing recidivism.
2. The most effective cognitive behavioral interventions take place in large groups where the entire community is present and continue till each member gets honest about their feelings.
3. Three of the biggest factors associated with criminal behavior are anti-social friends, anti-social personality traits and criminal values.
4. Risk, Needs and Responsivity theory states that the more of an offender's needs we can meet while an inmate is in prison, the less risk they present.

### II. Multiple Choice Questions

5. Trauma can make an offender more likely to recidivate when it affects his or her
  - a. view of authority
  - b. trust in institutions
  - c. cognitive functioning
  - d. all of the above
6. The term fidelity refers to
  - a. loyalty among thieves
  - b. an offender ability to adopt pro-social behaviors
  - c. a counselors ability conduct a group the way it's supposed to be done
  - d. family members that stand by a loved one during incarceration
7. Research shows that programs start to show a much greater impact when offenders remain in treatment for at least
  - a. 28 days long
  - b. 90 days long
  - c. 6 month long
  - d. 2 years or more

False, False, True, False ,d, c, b

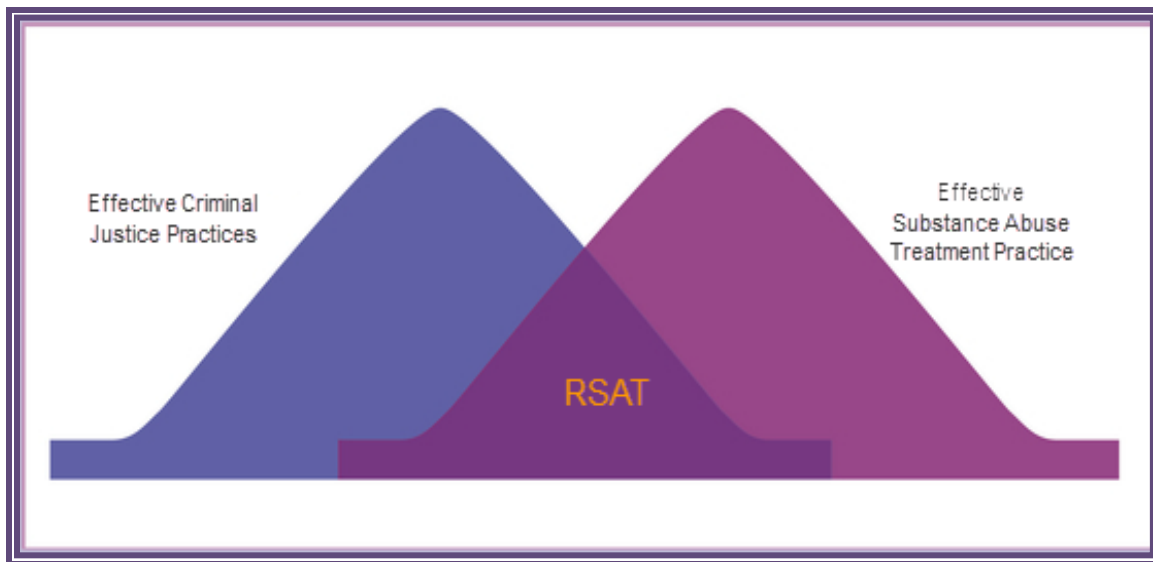
## A. Understanding Criminal Justice Theory and Practice

Both the Corrections field and the Alcohol and Drug treatment field have identified evidence-based approaches and best practices based on research and evaluation data. Although each system has different goals and outcome measures, there are many areas of overlap. Most in-prison rehabilitation programming has two primary goals:

- (a) to reduce disruptive behavior within the institution; and
- (b) to reduce the risk of recidivism when offenders are released to the community (Bonta, Pang, & Wallace-Capretta, 1995).

It is useful for staff working in RSAT programs to understand how prisons, jails and community corrections implement practices that have been shown to decrease criminal behavior and reduce recidivism.

It is also helpful to identify which evidence-based alcohol and drug treatment practices have been most successful with offenders. There are many points where both fields intersect. When programming consists mostly of practices and approaches that have been effective for both fields the client is more likely to benefit.



### Determining Risks and Needs, or Forensic Assessment

In the criminal justice system, effective rehabilitation begins with assessment of each offender's risk of difficulties, both while they are inside a facility and their risk of re-offending once they return to the community. Forensic assessments are usually administered when offenders enter a facility and often repeated before they leave to guide parole and release planning.

At intake into a correctional facility the assessment process helps determine how dangerous an offender is and what type of programming will target their problem areas. Before an inmate enters the general prison or jail population, correctional officials have to determine:

1. What level of security is best;
2. Where the offender should be housed, and
3. What type of rehabilitation programs should be prioritized

***Assessment: The first principle of evidence-based correctional programming***

**Objectively Assess Risks and Needs:** Comprehensive risk and needs assessment systems are essential for effective supervision and treatment of offenders (Andrews and Bonta, 1998). Forensic assessment systems are actuarial, reliable methods for determining levels of supervision and services for individual offenders. They guide staff in matching programs to each offender's specific risks and needs (BJA, 2011).

A number of risk and need assessment instruments have been developed for these purposes and have been validated by research with offenders. Some states, like Ohio, have developed their own tools while others prefer widely-used instruments, such as the Level of Services Inventory or the Compass System. The assessment usually entails a structured interview with questions that cover several domains associated with criminal behavior, and a review of official records. They are designed to determine who is likely to re-offend and why (Andrews, Bonta, and Hoge, 1990).

Correctional systems make risk determinations based on this information and **classify** each inmate. The classification process assigns each offender a security level. Systems have different security grades, but they usually include: maximum, medium and minimum security. This allows correctional staff to assign the most dangerous inmates to closely supervised custody units, to house medium security inmates with the general population, or to perhaps send some inmates to a minimum security facility that offers treatment.

The information also helps correctional staff to determine offender needs and place them in the right type of rehabilitation programs. A pre-release assessment gathers the information prior to re-entry on what level of supervision offenders will need on are parole and what types of programs will be helpful once they return to the community (Gendreau, French, and Taylor, 2002).

## Risk, Needs, Responsivity (RNR) Theory

The prevailing criminal justice theory that guides assessment and rehabilitation is the Risk, Needs and Responsively theory, or **RNR** theory, which briefly states:

- Offenders have many different needs and factors that indicate different levels of risk.
- Certain needs are associated with high-risk inmates that are more likely to commit new crimes.
- Identifying high-risk offenders and assigning them to programs that target the individual needs that are the drivers of crime reduces recidivism (Andrews and Bonta, 1994).

**Who** needs intensive programming?

**What** should the programming target?

**How** do we deliver the programming so it will reach the offender?

RNR theory is based on research on factors associated with criminal behavior. The theory states that programs should only target needs associated with criminal behavior to have the desired effect on offenders, reduce criminal behaviors and preserve public safety.

What Forensic Risk and Needs Assessment Tells Us		
Assesses Risk <b>The “who”</b>	<b>Who</b> are the high-risk offenders?  Tells us who should be in intensive programs.	Research suggests that high-risk offenders should be in intensive, structured programs. Low risk offenders are unlikely to commit another crime and actually do better if they are <b>not</b> in programs with those who have long criminal histories.
Assesses Need <b>The “what”</b>	<b>What</b> has to be addressed to change their criminal behavior?  Indicates the risk factors the programming should target	Offenders have many unmet needs. Rehabilitation focuses only targeting needs that lead to crime. If an offender is assessed as very angry, he needs anger management; hostility and rage can lead to crime. But nutrition class, even, for those who eat poorly, is not useful; poor nutrition doesn't lead to crime
Assessing Responsivity <b>The “how”</b>	<b>How</b> programming should be delivered to best reach the offender.  Tells us the barriers to program effectiveness.	Offenders may not respond to programs if there are barriers that interfere. For example, job training that demands a lot of studying won't help an offender who can't read. Nor will a poorly implemented program produce the desired response.

Stated simply, RNR theory says that risk and needs assessment should tell us “**the who, the what, and the how**” of rehabilitation programming for each individual offender. Unlike medical care and behavioral health services, which are driven by diagnoses, a forensic assessment is driven by risks and likelihoods (Letessa, 2004). Scores can act as a screening tool and may result in a mental health referral for a clinical assessment, or a referral for further assessment for substance use disorders. However, they are not designed to determine clinical diagnoses or level of clinical care. Risk and Needs assessments also help determine which inmates would benefit from non-clinical programs like career and technical training programs, family services, GED or high school classes, and specialized programs, such as sex

offender treatment. ***It is helpful to understand that assessment means something very different to correctional staff than it means to clinical staff.***

**“The who”**.....*the Risk Principle - Targeting High Risk Offenders*

***The next principle of evidence-based correctional programs:***

**Target Higher-Risk Offenders:** Prioritize treatment resources for offenders who are at high risk to re-offend. Consistent findings from a variety of recidivism studies show that treatment resources focused on low-risk offenders produce little if any positive effect and may even have an adverse effect (McGuire, 2001, 2002). Maximum benefit is derived when interventions are directed toward moderate- and high-risk offenders.

**Exercise 1:**

Below is a chart of risk and needs assessment scores from a facility and the rates of recidivism that occur for each range of risk scores. The staff has applied the risk and needs theory to assign a cut off score for participation in a new pre-release program. All offenders below the cut off will fill out their parole plan as usual. The offenders who score above the cutoff point will join an intensive pre-release case management group. What do you think the cut off score should be?

*(answers on page 38)*

Risk Assessment Score	Recidivism Rate
Low (0-37)	18%
Low/Moderate (38-54)	30%
Moderate (55-75)	43%
High (76-115)	58%

Source: Lowenkamp and Latessa (2005). *Criminology and Public Policy*

- a) 100 and above    b) 25 and above    c) 76 and above    d) 65 and above

**“The what”**.....*the Need Principle...Targeting the drivers of criminal behavior.*

***The next principle of evidence-based correctional programming:***

**Address Offenders’ Greatest Criminogenic Needs.** The greatest emphasis must be placed meeting the offender’s needs that are most closely associated with criminal behavior. When the factors that lead the offender to commit crimes are effectively addressed, that person is less likely to commit crime (Elliot, 2001).

Research has identified the top factors that predict recidivism.

It is possible to influence most of them through effective programs.

Programs need to target the specific factors for offenders that led to their criminal behavior.

Programs that target three or more factors at a time have the greatest effect on recidivism

(Gendreau, French & Taylor, 2002).

TOP Risk Factors for Criminal Conduct and Recidivism	
Changeable	Static
Biggest predictor of future behavior is past behavior. History can't be changed, but is an indicator of risk.	<b>Criminal History</b>
<b>Substance Use</b>	If substance abuse is a risk factor, the offender should be referred for clinical assessment by treatment staff to determine severity and level of care. A history of substance abuse is associated with re-offending; however, clinical assessment determines if it is severe or recent.
<b>Criminal Thinking/Values</b>	Feeling entitled and that one's criminal behavior is justified, dodging responsibility for actions; valuing street smarts over integrity and achievement. Taking pride in criminal exploits and beating the "system." Hostility toward authority.
<b>Criminal Associates</b>	Difficulty separating from criminal associates also indicates the absence of pro-social, contacts. Increasing contact with supportive family, faith-based, recovery resources and other non-criminal associations is as important as avoiding past criminal ones.
<b>Anti-Social Personality Traits</b>	Not to be confused with a diagnosis of anti-social personality disorder; refers to traits such as impulsivity, restless aggressive energy, a taste for risk, poor problem-solving skills, weak self-regulation skills, low tolerance for frustration.

Andrews & Bonta. (1998). *The Psychology of Criminal Conduct*. Cincinnati, OH: Anderson

Criminogenic needs are the factors that have been shown to drive criminal behavior. Research has identified the five most powerful predictors of crime, as explained in the chart above. The risk and needs assessment will point out which of these factors are at play with each individual offender. This helps tailor programming to each offender. Assessment information is far superior to assigning offenders to programs based on offense or by making non-objective recommendations after taking a self-reported history. As the chart shows, most of the top predictors of recidivism can be changed through effective programs; only criminal history is unchangeable. The changeable factors are referred to as dynamic, and factors like criminal history are known as static.

For example, a drug offender may have a minimal history of drug use, but was convicted of sales and possession. The offender brags about the money he made and feels superior to people who work for a living. Substance use disorder treatment probably won't keep him from re-offending. His problem is that he thinks making money by selling drugs illegally is fine. This drug offender's risk factors are criminal values and criminal thinking. The changes that will keep him from re-offending will take place in programs that target his values and thinking, rather than focusing on his drug use.

These predictors of future criminal behavior apply to males and females. There are less predictive factors that are also significant contributors to a return to criminal

behavior and to recidivism. Poor use of leisure and recreational time, limited employment history and job skills and family conflict are also risk factors.

**Answers Exercise 1 page on 37:** If you answered c) or d) you are right! Either cut off captures offenders most likely to need the new group. Taking the higher scoring inmates in the moderate segment of the population is definitely acceptable if there are available slots. If space were limited, the staff would want to fill the program up with high risk offenders.

## **How Trauma Contributes to Criminogenic Risk Factors**

We know that trauma can result in changes in attention, perception, emotion and arousal. In the previous module we saw how distress from past trauma and PTSD symptoms can contribute to **substance use and dependency**:

Trauma survivors may use substances to sooth or avoid distressing emotional states that can result from traumatic events, reminders of the trauma or from re-living a trauma in dreams or flashbacks.

Trauma survivors also may use substances such as alcohol and heroin to self-medicate the physiological changes resulting from arousal, such as increased heart rate and respiration or heightened sensitivity to noises and light. They may also use substances such as cocaine and amphetamine to feel powerful and maintain the level of hyper-vigilance their reaction to trauma often demands.

In addition to substance abuse, **trauma can contribute to other risk factors** that are associated with criminal behavior. When trauma results in **highly aroused states it can also contribute to anti-social personality traits**.

- Impulsiveness, irritability, aggression and hostility can result.
- Weakened self-regulation skills result in dysregulated emotions.
- The perception of threat and danger, even when none exists makes defensive responses more likely.
- Emotional numbing can predispose survivors to thrill seeking behavior, disregard for their own safety and difficulty empathizing with others.

Repeated exposure to abuse and violence and symptoms of PTSD and can also shape thoughts and beliefs that contribute to **criminal thinking** (National Center on PTSD, 2011). Cognitive changes and belief systems that can accompany trauma can also contribute to **criminal values** and even to **criminal associations**.

- Trauma may result in a distrust of authority; and
- Trauma survivors may be drawn to companions that feel the same way.
- People who have been traumatized may have extreme beliefs about justice or revenge.
- They may seek retribution; they may also appoint themselves avengers, vigilantes and protectors for others.

Research conducted by the Veteran's Administration shows that higher rates of aggressive behavior are seen in those with PTSD, compared to those without PTSD.



For example, the National Vietnam Veterans Readjustment Study found that male Veterans diagnosed with PTSD versus those without PTSD committed significantly more acts of violence against family and others. On average, those with PTSD committed 13.3 violent acts in the prior year, compared to 3.54 acts for Veterans without PTSD; however, alcohol use in the presence of PTSD may be a more significant predictor of violent acts among veterans involved in the criminal justice system (National Center on PTSD, 2011).

**Exercise 2:** Below are quotes from clients with PTSD and substance use disorders in RSAT programs, about how trauma contributed to their criminal thinking and behavior. In the space provided enter the letter that indicates which risk factor best matches the trauma response described in the quote.

(answers and explanations on page 42)

- A. Criminal Thinking/Values
- B. Anti-social Personality Traits
- C. Criminal Associates

\_\_\_\_\_ *“When I got home from Iraq, I isolated from my family, stayed in the basement and drank. On 4th of July weekend, I could hear the fireworks going off. My wife wanted us to go downtown that night with the kids to see them. I got arrested after I made my kids get down in the bathtub and hide for 11 hours. When my wife tried to let them out of the bathroom, I fired six shots into the ceiling.”*

\_\_\_\_\_ *“I was sent to church camp every summer. One of the ‘brothers’ came into our bunks at night and did stuff. I didn’t know he was doing it to the other boys. I thought there was something about me that made him do it, so I was ashamed to tell. The summer I turned 14, I broke into the camp office, took all the cash I could find and ran away. I decided to make my way stealing and dealing. There was no reason to play by the rules. Nobody else did.”*

\_\_\_\_\_ *“I was terrified of my ex-husband. Even after I divorced and left town, he always tracked me down. I met Jared when I was trying to get away from him. One night my ex saw me get in a car with Jared. He chased us through the streets. Jared forced him off the road, got out and wailed on him. My ex-husband lost an eye and had to have his jaw reconstructed, but he never messed with me again. That night Jared went and got my stuff and moved me in.”*

### **Trauma, Risks Factors and Women Offenders**

Although women represent a small percentage of the prison population, it is a mistake to think that research on female offenders never applies to men. Some of what has been developed for incarcerated women with SUDs and trauma has been adapted for use with male offenders with PTSD in substance use treatment.

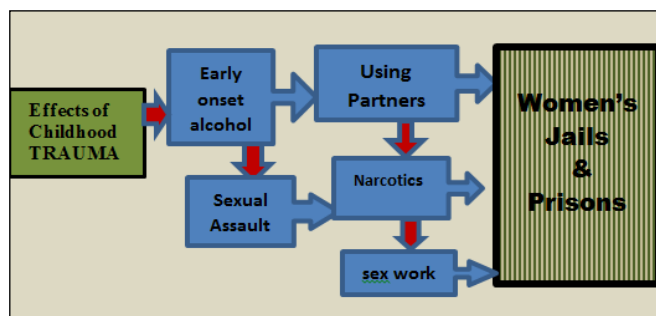
Addiction has been identified as the driver of rapidly increasing rates of incarceration in women (Grella and Greenwall, 2007); and, substance involvement is the primary reason they return to prison (MacDonald, 2008). Recently, research has shown trauma and mental health problems are major risk factors for recidivism among women offenders (Brennan 2007; Salisbury & Van Voorhis, 2009).

### Women’s Pathways to Felony Court

Salisbury and Van Voorhis (2009) present a model of child victimization and gender-specific pathways to criminal behavior. The model asserts that the mental distress of childhood victimization leads adolescent girls to medicate with alcohol or illegal substances, leading to eventual involvement in crime. Influence of criminal partners, domestic violence, poverty and poor work histories may be additional factors (Chesney-Lind, 1997). Feminist criminologists have put forth the “Pathways Theory” for a number of years.

New empirical studies on female offenders have supported the theory of distinct pathways to criminality for women (Brennan, Breitenbach and Dieterich, 2010). Not every pathway is associated with trauma, but it is central to the majority of them.

Pathways to Incarceration for Female Offenders w/ SUDs



### Trauma and Treatment Engagement

In a nationally validated study on risk and needs assessment tools developed specifically for women offenders, childhood physical and sexual abuse was associated with institution difficulties, such as rule infractions, violence and contraband. Active symptoms of mental illness, adult sexual abuse and intimate partner violence were found to be risks factors for recidivism (Van Voorhis, Salisbury, Wright and Bauman, 2008). But, perhaps even more compelling than research on trauma as a risk factor for criminality and recidivism, is the effect of active PTSD symptoms on the client’s ability to benefit from even the most effective treatment programs.

Childhood physical and sexual abuse is associated with low program engagement for both men and women. Three domains of functioning are influenced by PTSD symptoms: cognition, physiological arousal, and emotions. PTSD symptoms in any of these domains can interfere with program engagement. Because trauma results in cognitive changes, it can interfere with learning and limit the effectiveness of cognitive approaches and psycho-educational treatment components.

In other words, traumatized clients may not respond the way other clients do to the same high quality treatment programs. Until they have tools to address the impact of childhood trauma they may be perceived as “treatment failures” or “chronic

relapsers” by substance abuse treatment providers (Brennan 2007; Covington, 2008; Gilfus, 2002; Komarovskaya, 2009; Van Voorhis, Salisbury, Wright and Bauman, 2008).

These engagement factors can be overcome by integrating trauma stabilization and coping skills training in substance abuse programs. Trauma-informed programs and cognitive behavioral trauma-specific interventions can help offenders master the skills that will set the stage for engagement in effective recovery programming.

### **Examples of Trauma-Induced Barriers**

**Flashbacks:** Reminders of past trauma during treatment resulting in flashbacks or other types of re-experiencing distract the client. Teaching the client to identify triggers and use grounding techniques -- in the here and now, and other safe coping skills keeps re-experiencing under control.

**Dissociation:** Trauma survivors often learned to “check out” in order to survive violent or abusive conditions. If this type of coping began in childhood, clients may tend to dissociate at the first sign of chaos, confrontation, aggression or distress. They “leave the room,” mentally and can’t benefit from the treatment. If RSAT programs strive for a safe and predictable environment, it reduces defensive symptoms and numbing responses, allowing trauma survivors to remain present and get more out of treatment.

**Arousal:** Keep in mind, arousal means physiological changes are occurring. The body is preparing for extreme survival measures. This makes concentration on mental tasks very difficult, especially if there is no outlet or release available for the physical manifestations of stress. Relaxation, movement, exercise and self-regulation skills are necessary tools for clients who are constantly in a highly aroused state. Groups and individual sessions are opportunities to teach awareness of their bodily responses and rehearse and reinforce ways “to get themselves off the ceiling.”

#### **(Exercise 2: Answers and Explanations from page 40)**

- B.** Edginess can lead to aggression and impulsiveness. Emotional numbing may result in only feeling alive when in danger, or an inability to feel appropriate empathy. Hyper vigilance can cause knee jerk reactions to triggers that can lead to violence.
- A.** Retribution and revenge at people or institutions for real or imagined wrongs can justify criminal behavior. Abuse by authority figures in childhood may lead to distrust of all authority and lead to criminal thinking, making it easier to join in criminal activities.
- C.** Survivors may feel kinship with tough and strong personalities with criminal tendencies and gravitate to them as protectors. Women offenders, in particular, may hook up with “rescuers” who are domineering males; someone that she believes can protect her from past abusers.

## B. Cognitive Behavioral Interventions

### What Works ?

As the diagram at the beginning of this module of the overlapping bell curves shows, the areas where research-based approaches apply to both the addiction treatment field and the criminal justice field are the resources for the most effective programs.

This section highlights practices and principles that have a research basis in **substance use disorder treatment** and **criminal justice**.

In the previous section of this module we established **who** should be the target population for intensive RSAT programs and **what** behaviors and issues should be the focus of treatment. Now we will look at **how** interventions approach clients. According to research, methods that are most effective with offenders are cognitive behavioral approaches.

*“The how” .....the Treatment Principle – use cognitive behavioral approaches*

#### ***The treatment principle of evidence-based correctional programming:***

**Use Cognitive-Behavioral Treatments (CBT).** Cognitive: targets attitudes and thought processes-- Behavioral: practices skills through modeling, role playing and reinforcement. CBT has been shown effective in changing both **substance using** behavior and **criminal behavior**. It is also an effective treatment approach for **PTSD, Depression** and other mental disorders.

In response to a request by the State of Washington Joint Legislative Audit and Review Committee, criminologists reviewed the research examining the effectiveness of programs offered by the Washington Department of Corrections. Programs were classified into to what works, what doesn't work and what we aren't sure about. Two approaches that work to address factors associated with crime relevant to RSAT programs are:

- ▶ **Targeting Substance Abuse:**
  - With In-Prison Therapeutic Communities with follow-up treatment upon release
- ▶ **Targeting Criminal Thinking :**
  - Through Cognitive Behavioral Therapy

The effectiveness of cognitive-behavioral interventions in prisons and jails is well documented (Andrews and Bonta, 2003). The National Institute of Corrections supports training in several evidenced-based curricula on restructuring criminal thought patterns and developing pro-social coping skills. Features that make them the approach of choice for correctional programs are their flexibility; they can be facilitated by many levels of staff and their focus on targeting observable behaviors (Van Voohris, Branwell and Lester, 2009). Research has consistently shown

cognitive-behavioral interventions to be effective at reducing recidivism, substance use and mental health problems, including trauma-related disorders (Andrews et al., 1990; Clark, 2010; Landberger and Lipsey, 2005).

### **A recent analysis of cognitive behavioral treatment for offenders reviewed 79 studies (Landenberger & Lipsey, 2005)**

They found the most effective interventions are behavioral:

- Action oriented
- Focus on current factors that influence behavior
- Offender behavior is appropriately reinforced
- On average, they documented that CBT reduced recidivism by 35%.

“**Cognitive restructuring**” targets a person’s attitudes and thought processes. It teaches individuals to recognize their thinking errors and to replace them with rational, pro-social thoughts. These strategies are focused on changing the client’s thinking patterns in order to change future behavior. Techniques like role plays, skill rehearsal, assigning real life practice and reinforcements allow individuals to try out new behaviors. The most effective treatment provides continuous opportunities for participants to practice new behavior patterns and skills.

#### **Evidence-Based Cognitive Restructuring Curricula for Corrections**

**Thinking for a Change** (Bush et al., 1998)

**Criminal Conduct & Substance Abuse Treatment** (Wanberg & Milkman, 2007)

**Moral Reconciliation Therapy** (Little and Robinson, 1998)

**Aggression Replacement Training** (Goldstein et al., 1998)

**Reasoning and Rehabilitation** (Ross et al., 1989)

**Reasoning and Rehabilitation 2** (Ross & Hilborn, 1996)

**Relapse Prevention Therapy** (Parks and Marlatt, 2000)

Specific to Women

**CALM** (Anger Management by Van Dieten, 1996)

**Moving On** (Van Dieten, 1998)

Link to descriptions and evaluations of curricula: <http://static.nicic.gov/Library/021657.pdf>

*Cognitive Behavioral Treatment: A Review and Discussion for Corrections Professionals*. Milkman and Wanberg, (2007)  
National Institute of Corrections Website.

Link to descriptions of evidence-based women’s curricula:

<http://www.orbispartners.com/originalsite/programs/programs.htm>

## Effective Cognitive-Behavioral Groups

Group time is a structured opportunity for members to rehearse skills and behaviors with coaching from program staff. Positive reinforcement for new coping skills and behaviors is essential. Peers can also encourage, give and receive positive feedback and reinforce new behaviors in RSAT programs.

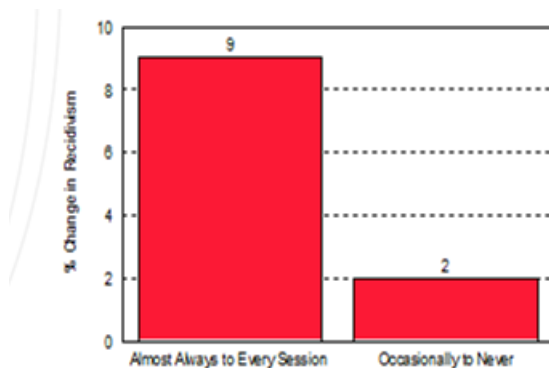
Role plays help strengthen these effects. The graph below shows the effect using role play exercises in almost every session has on recidivism. When the group facilitator consistently used role play techniques, recidivism was 7% lower (Lowenkamp & Letessa, 2002).

When staff is trained to consistently incorporate all elements of the intervention at each session, the outcomes improve. Manuals for CBT sessions contain several elements. If a counselor decides to skip an element, the session won't be as effective. Based on the chart below, think about what would happen if the counselor decided to skip role plays.

### Characteristics of Effective CBT Groups

- At least 2 sessions per week
- Smaller groups
- Staff was trained in CBT
- Implementation was monitored
- Used individual sessions and group
- Were intensive (more hours of CBT)
- Included higher risk offenders
- Had a focus on anger control
- Had a more treatment completers

**Role playing has a measurable effect!**



This brings us to the next principle of evidence-based correctional programming. It has to do with how well counselors and staff deliver the intervention. An RSAT program can have the right population and the most effective programs, but if the staff does not deliver them effectively, the outcomes won't materialize.

According to the Center for Therapeutic Community Research, there is a key association between program fidelity and treatment effectiveness (De Leon, 2010). Program fidelity is no accident, but rather an intentional implementation strategy that requires training and coaching, standards for program certification, and a supervision structure. Fidelity also requires maintenance, monitoring methods and refresher trainings. There will always be resistance to implementing new research-based practices, but RSAT professionals can become leaders in this effort.

**“The how well”** .....the Fidelity Principle – implement programs as designed.

**The Fidelity principle of evidence-based correctional programming:**

Programs that maintain fidelity to the intervention or practice are the most effective. Not only is staff trained in the intervention, but a system is in place to measure the minimum competencies required to deliver it correctly and to monitor fidelity to the model on an ongoing basis (BJA, 2011).

**Exercise 3:** *Jake has worked in the prison for 15 years. He was a probation officer many years and is not too happy working inside the walls. However, Jake is the type of case manager that will make sure an offender has a solid parole plan. He’ll make 20 phone calls if necessary and the offenders appreciate him. What Jake really does well, is tell stories, and he’s got a million of them. Jake is co-facilitating Seeking Safety group with RSAT staff twice a week, because he was told he had to. On Tuesdays and Thursdays you, along with the RSAT clients, get to listen to Jake tell stories during group. The clients seem to prefer listening to Jake to working in group. What do you think the result will be if the group continues as is? What should you do about it?*

1) The Seeking Safety groups may not be effective	True	False
2) Substitute a story from Jake for one of the parts of the format and still allow him to tell stories.	True	False
3) If you use Jake’s stories to teach skills, you can deliver the groups with fidelity	True	False
4) Best to meet with your clinical supervisor to find a way to restore integrity to the program	True	False
5) Jake has to be confronted in group	True	False

(answers on page 48)

Neither trauma survivors, nor offenders do well in unstructured groups. Predictability, structure and goals provide order and safety for the participants and make the counselor’s job easier, not harder. CBT is like a recipe; you can be as creative as you want as long as you have all the necessary ingredients. Picking and choosing parts of an intervention may result in leaving out the most potent elements. In some cases, adaptations are possible, but they are best made in consultation with researchers, authors or practitioners experienced with the intervention. However, when fidelity is compromised to the degree described in the exercise, the RSAT clients in the Seeking Safety group with Jake probably will not learn the skills that can give them the relief they deserve.

According to a 2010 publication from the Center for Effective Public Policy on implementing evidence-based practices, **“The interpersonal relationship between**

**staff and the offender, along with the skills of staff, may be as or more important to risk reduction than the specific programs in which offenders participate (p, 9)."** Jake is also doing something well. The quality of his relationship with the offenders is apparent. He goes the extra mile for them, believes in them and they know it. He has a good rapport with group....and with populations that have high rates of trauma, that shouldn't be underestimated. If Jake is trained to deliver the Seeking Safety intervention as outlined, he might become the ideal co-facilitator. Maintaining fidelity to the **spirit** of the intervention also has an impact on its effectiveness.

### **C. Compatible Evidence-based Principles**

This module has outlined fundamental research based-principles that apply to the criminal justice field. Fortunately, there are many findings that parallel what we know to be true about effective addiction treatment. In 2006, the National Institute on Drug Addiction (NIDA) published a research-based guide on the **Principles of Drug Abuse Treatment for Criminal Justice Populations**. Many of these principles apply to RSAT programs and to offenders with trauma.

The first principle listed, Principle 7, should sound familiar. It reinforces the value of targeting the risk factors associated with criminal behavior, which we covered in the first section of this module.

- **Principle 7:** *Treatment should target factors that are associated with criminal behavior*

We have also touched on Principle 11, the need for integrated treatment. The next module offers greater detail on integrated treatment for co-occurring PTSD and substance abuse. Offenders with co-occurring disorders are **twice as likely** to have their **community supervision revoked** and will need specialized transitional re-entry services.

- **Principle 11:** *Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach*

Now we will look at two more principles common to both evidence-based correctional programming and effective addiction treatment. The next principles of effective addiction treatment are related to motivation and length of treatment. The NIDA publication lists them as:

- **Principle 10:** *A balance of rewards and sanctions encourages pro-social behavior and treatment participation.*
- **Principle 3:** *Treatment must last long enough to produce stable behavioral changes.*

In the criminal justice world it is referred to as the dosage principle.

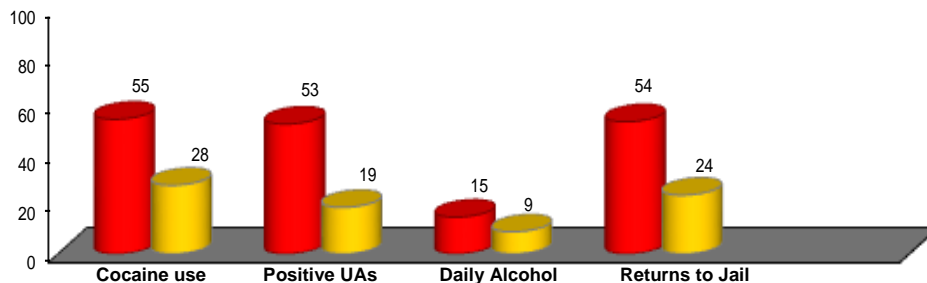


**“How long”** .....*Dosage Principle-treatment must be long enough to result in changes.*

**The dosage principle of evidence-based programming is:**

**Determine Dosage and Intensity of Services:** Higher-risk offenders require significantly more structure and services than lower-risk offenders. Staff should match programs to each offender’s specific risks and needs regarding criminal behavior (BJA, 2011).

The graph shows the difference in rate of relapse to substance use between jail offenders who had at least 90 days of treatment ( the yellow column) and those who had less than 90 days treatment (red column). The differences are dramatic; the group that had the benefit of more than 90 days of treatment had significantly lower returns to custody and fewer positive drug tests. Long term programs, such as RSAT are much more effective, especially when they are followed up with community services upon release.



Source: NIDA, 2006. Treatment is the Key: Addressing Drug Abuse in Criminal Justice Settings

We know the longer the individual stays engaged with treatment and recovery support, the better his or her chances of recovery are. However, in criminal justice settings good data is also available on the intensity of services. Dosage is driven both by clinical assessment, but also by forensic assessment. It pertains to both length of treatment and the intensity. New research has resulted in guidelines on the amount and intensity of CBT treatment required to bring about changes in high risk offenders.

High-risk offenders should receive a minimum of 300 hours of cognitive-based interventions over a period of 6-12 months. Moderate-risk offenders should receive a minimum of 200 hours over 3-9 months, and low-risk offenders should receive a minimum of 100 hours of cognitive-based interventions. Additionally, during the initial three to nine months post-release, 40%–70% of a high-risk offender’s time needs to be occupied with a combination of routine structured time including work, and appropriate services (Bourgon and Armstrong, 2006; Latessa, 2004; Gendreau and Goggin, 1995).

Answers to Exercise 3 from page 46: True, False, False, True, False

## Motivating RSAT Clients

Another point of overlap between criminal justice research and addictions research is importance of the client/offender's intrinsic motivation. Motivational Interviewing (MI) is a technique that works very well with most approaches that integrate substance use treatment and trauma recovery. Trauma survivors are generally very uncomfortable with confrontational or authoritative approaches, which are likely to trigger behaviors or feelings that are difficult to manage. Good Motivational Interviewing skills are an asset for any staff member learning to facilitate cognitive behavioral groups with substance abuse clients who have trauma histories. Trauma recovery involves working to empower people that have, at some point, experienced a frightening loss of control. MI emphasizes reinforcing that the responsibility for change rests with the client. The autonomy and accountability is compatible with trauma recovery principles. Remember MI and trauma-informed approaches should be directive, but not authoritative; they should be highly structured, but not confrontational.

*“The why”.....Motivation Principle- rewards and sanctions encourage participation.*

***The motivation principle is: the desire to change is dynamic and can be increased.***

**Enhance Intrinsic Motivation:** Staff must be able to relate to offenders in interpersonally sensitive and constructive ways in order to enhance intrinsic motivation in offenders. Research findings suggest that motivational interviewing (MI) and motivational enhancement therapy can effectively enhance the offender's desire to initiate and maintain behavior changes (Miller and Rollnick, 2002; Miller and Mount, 2001).

Although there are very few studies on MI with incarcerated individuals, it has demonstrated effectiveness in community corrections (GAINS, 2011). MI is consistent with criminal justice theory and research; motivation is seen as a dynamic factor that can be shaped and changed. Many offenders may be ambivalent about treatment and recovery, but they are all motivated to leave prison. The accent on goal setting and target behaviors is also compatible with case management, pre-release planning and meeting the conditions for release.

Rewarding new behavior thorough recognition is a powerful motivator. The option of sanctions is an available reinforcer, but the research shows that the use of rewards and incentives has a greater effect on behavioral change (Marlowe, 1999).

Reinforcing positive change, noticing and affirming behavior among clients with trauma that shows they can regain control is one of the goals of trauma-informed approaches. Rewards need to be introduced before offenders leave prison and jail based programs. Sanctions are only helpful if an infraction is detected. Once RSAT

clients are released, it will be much more difficult to detect infractions, but if rewards are used to shape behaviors, parolees will want to get caught doing the right thing. Research suggests that planning a tiered level of privileges, reduced supervision requirements and other forms of recognition for treatment gains is effective, provided it is immediate and predictable (CEPP, 2010). Sanctions that are necessary should be delivered immediately. The time between the detection of the behavior and the sanction influence its effectiveness.

When planning graduated sanctions when dealing with traumatized populations considering the level of danger, risk and intention is important. An initial sanction that can lead to progressively more severe levels of discipline if the behavior persists, or that will be fully erased if behavior is changed works well. Most important all offenders should know what the penalties and rewards are and why well in advance. This limits emotionally volatile situations.

## D. Review and Resources

### Module Review

- RSAT programs are most effective when they combine evidence-based approaches to substance use disorder treatment with evidence-based approaches to reducing criminal behavior.
- The objective of the forensic assessment process is different from the goal of a clinical assessment. Forensic assessments measure risk factors associated with crime and determine which offenders are high risk and therefore most likely to benefit from intensive programs.
- Programs that target the top risk factors for recidivism such as criminal thinking and values, and criminal associates, along with substance abuse have the most success with offenders. High risk offenders are most likely to benefit from intensive programs.
- Individual clients may have barriers they need to overcome. Active symptoms of PTSD can act as a barrier, even when the right clients are in the right program. Integrated, trauma-informed programs can strengthen the clients' ability to focus on recovery by increasing coping skills and reducing triggers.
- Cognitive behavioral treatments are the most effective and have the benefit of also helping with mental health problems, criminal behavior, trauma and substance abuse. Cognitive treatment targets thinking "errors" that result in a flawed belief system and behavioral approaches rehearse and reinforce new behaviors and coping skills.
- The length of time an inmate remains in an RSAT program is important. Research shows that lasting changes and treatment gains rarely sustain unless clients can complete at least 90 days of treatment. Role plays, motivational counseling and skills training are effective, provided the counselor remains true to the intervention the way it was written.
- Integrated treatment is compatible with research on effective practices with offenders. Clients in RSAT programs with co-occurring disorders can benefit from the same type of approach that is effective with most offenders: targeting factors associated with crime, intensive, long term treatment and community follow up.

## **Resources**

### **Evidenced Based Practices for Re-entering Offenders.**

*Note: A complete listing of CSAT Treatment Improvement Exchange publications is available on line at: <http://kap.samhsa.gov/products/manuals/tips/index.htm>*

#### **Practice: Engagement and Motivation**

Evidence-based Source: Motivational Interviewing, Motivational Enhancement Therapy, TIP 35- Enhancing Motivational Change in Substance Abuse Treatment (1999)

#### **Practice: Case management**

Evidence-based Source: Tip 42: Substance Abuse Treatment for persons with co-occurring disorders; TIP 27-Comprehensive Case Management for Substance Abuse Treatment (1998)

#### **Practice: Recovery Support Services**

Evidence-based Source: Tip 42: Substance Abuse Treatment for persons with co-occurring disorders. And Most TIPS listed above contain a section on Peer to Peer Recovery Support Services

**Resource:** Faces and Voices of Recovery:  
<http://www.facesandvoicesofrecovery.org/>

**Resource:** Witness Justice: <http://www.witnessjustice.org/>

#### **Practice: Culturally Sensitive Services**

Evidence-based Source: Substance Abuse Services for Persons w/ HIV/AIDS (2000)

TIP 29 Substance Use Disorder for People w/ Physical and Cognitive Disabilities (1998)

TIP 25- Substance Abuse Treatment and Domestic Violence (1997), Tip 42: Substance Abuse Treatment for Persons w/Co-occurring Disorders.

**Resource:** Women's Re-entry Toolkit Women's Prison Association:  
<http://www.wpaonline.org/resources/toolkit.htm>

## **Module IV Implementing Trauma-Informed Care**

- A. Foundations of Trauma-Informed Care
- B. Identifying Triggers and Alternative Coping
- C. Integrating Trauma-Specific Approaches
- D. Review and Resources

### Learning Objectives:

After completing this module participants will be able to:

- Name three elements of trauma-informed approaches and identify two distinguishing characteristics of trauma specific programs.
- Define and utilize the PEACE approach to dealing with unavoidable triggers and the RICH model of healing relationships.
- Identify integrated treatments for SUDs and co-occurring trauma-related mental health problems.

## Knowledge Assessment Test

### I. True False Questions

- A. If you are dealing with an inmate who is experiencing a flashback to a traumatic event, you should ask him or her to describe the event.
- B. People with PTSD often respond to treatment that does not go back into the past and deal with the event and their feelings about what happened.

### II. Multiple Choice Questions

- C. The RSAT program in the county jail has trained all staff in trauma and has a group in the TC that offers inmate education on trauma and PTSD. They screen for trauma, and refer clients to a local program upon release where offer in a Seeking Safety group. The RSAT program is:
  - a. Trauma specific
  - b. Dual diagnosis
  - c. Trauma informed
  - d. Negligent
- D. One way to help an RSAT client get grounded is to
  - a. Ask them to describe what they see out the window
  - b. Ask them to tell you about their childhood
  - c. Repeat a directive loudly and clearly until they comply
  - d. Ask them to tell you exactly what type of distress they are experiencing
- 5. When dealing with an inmate with PTSD it is better to
  - a. Not mention possible triggers they may encounter
  - b. To ask them to quietly tell you about their traumatic experience
  - c. To give them a series of simple and direct orders in a calm voice
  - d. To give them information about what going to happened and why and prepare them for any unavoidable triggers.
- 6. RICH is an offender management model based on
  - a. Respect, information, caring and honor
  - b. Respect, information, caring and honesty
  - c. A model of trauma-informed communication principles
  - d. Research conducted by the Centers for Disease Control
- 7. The current type of trauma treatment preferred in RSAT programs is
  - a. Exposure therapy
  - b. Based on present day coping skills
  - c. Group therapy where events are recounted in safe, supportive settings
  - d. Psychotherapy that gives insight into why they responded as they did

False, True, c, a, d, c, b

## **A. Foundations of Trauma-Informed Approaches**

Trauma-informed substance abuse programs assume all clients potentially have a history of trauma. In Module II we learned about universal application of trauma principles in RSAT treatment programs. That means programs are designed with clients that are dealing with the effects of trauma in mind.

Clients with trauma in SUD treatment have sometimes felt discouraged and have not benefited from treatment programs that failed to respond to their needs regarding past trauma and related mental health problems. Others have felt unsafe during SUD treatments and found them “re-traumatizing.” Re-traumatization can be defined as aspects of treatment, usually unintentional, that mimic dynamics of past abuse and trigger a trauma response (Harris and Fallot, 2001).

Old style therapeutic communities that used confrontation, boot camps and hot seats tended not only to be ineffective for clients with SUDs but “re-traumatizing” and even damaging to those with trauma and PTSD. Requiring clients to forgive abusers or develop a belief in a higher power are also contra-indicated for trauma survivors. Encouraging peers to confront each other, efforts to tear down clients, eliciting surrender and admissions of powerlessness, humiliating and shaming are all practices that don't work well for trauma survivors with substance use disorders.

### **Goals of Trauma-informed Approaches**

A trauma-informed approach has two initial goals; to do no harm and to increase client safety. The measures outlined in this module are relevant to RSAT programs in correctional settings and can **decrease** the likelihood of problems people with trauma often have in SUD treatment:

- Low program engagement
- Increased trauma-related distress due to institutional triggers
- Inaccurate mental health diagnoses and ineffective medication management
- Relapse into substance use
- Decreased self-efficacy; learned hopelessness in clients
- Depression and increased risk of suicide
- The use of seclusion and restraint

Although behavioral healthcare providers have started to show an interest in trauma-informed correctional settings, the correctional system itself stands to gain the most from understanding how to manage the large numbers of offenders who are dealing with the consequences of trauma. They also have the most to lose in terms of high recidivism, risk to staff and institutional violence from highly aroused, hyper-vigilant criminals in overcrowded facilities.



## Harriet's Treatment Experience

**Exercise 1:** Which of these choices below seems like the best trauma-informed response for Harriet? Choose from the answers below.

*"In 1991 I finally got away from my boyfriend who was beating the crap out of me, and got into a treatment program. After about 5 days without drugs and alcohol, I began having flashbacks about my uncle. I felt dirty and all the time and started taking 6 or 7 showers a day. The treatment center said they weren't equipped to deal with my symptoms and dropped me off at a psych hospital. I guess I wasn't equipped either because I kept using. I went back to my boyfriend and didn't get away 'til after he broke my collar bone."*

- a) We can start you on a medication for obsessive compulsive disorder to help you get through this.
- b) Many women in early recovery have things like that surface and have been able to learn ways to cope.
- c) We are transferring you to a dual diagnosis program.
- d) I know this is difficult, but it is important to keep the focus on your alcohol and drug problem right now.

(See explanation of answers on page 61)

## Two Levels of Capacity With Regard to Trauma

### Trauma-informed substance abuse programs:

- *All staff* understands trauma and its impact on the addiction and recovery process
- Services have been designed to enhance safety, minimize triggers, and prevent re-traumatization.
- Relationships between staff and clients are based on equity and healing; survivors are empowered with information, referrals and hope.

### Trauma specific services

- Clinical and program staff have specialized training in integrating trauma treatment and recovery practices into substance abuse programming.
- Specific groups and effective interventions are aimed at coping with the aftermath of trauma, decreasing symptoms of trauma-related disorders and increasing knowledge about trauma.
- People are empowered with skills and techniques to manage and lessen the effects of trauma in ongoing recovery.

Trauma-informed practices can help create safe treatment environments in RSAT programs where healing interactions are possible. This is important even if trauma specific interventions are not available. Although trauma-specific interventions have been found to be more powerful in reducing symptoms of trauma-related disorders than trauma-informed services alone (Morrissey et al., 2005), they are most effective when delivered in a trauma-informed environment. The combination of the two is more effective than either one alone.

### **Principles of Trauma-Informed Approaches**

Applying this set of principles correctional settings, that guide the culture of treatment programs, in is challenging, but possible. No matter how triggering an environment may be, therapeutic relationships with staff that understand and embody these principles can result in a more effective treatment experience for offenders with trauma histories. These principles are compatible with evidence-based substance use disorder treatment and motivational approaches. They are easily integrated into treatment programs and compatible with cognitive-behavioral programs aimed at changing criminal thinking.

1. Recovery from trauma encompasses multiple aspects of people lives, involves changing deep-seated beliefs and gaining knowledge and skills that restore a sense of choice and control.
2. The assumption of a trauma history guides every encounter, whether or not clients screen for, disclose or even remember trauma and whether or not trauma treatments are available.
3. Responses and defense mechanisms are reframed as survival strategies that serve or once served a safety function and are seen as adaptive efforts at resiliency.
4. Creating safety is a primary task; the safer and more predictable the treatment environment, the better the engagement.
5. Education and information about trauma and recovery is part of treatment.
6. Power equity is the basis of helping relationships that are founded on respect, information, connection and hope.

**Exercise:** The chart below compares trauma-informed treatment to traditional treatment. Think about where you work now or have worked in the past.

In the light blue shaded columns rate each of the statements according to how accurately they describe the program on a scale of 1 to 4.

- 1= strongly agree with the statement
- 2= somewhat agree the statement
- 3= somewhat disagree the statement
- 4 = strongly disagree with the statement

Add the numbers in each column. The heading of the column has the lowest score best describes your program. Is your program more traditional or more trauma-informed?

Rating	Trauma-informed Programs	Traditional Substance Abuse Programs	Rating
	Minimize practices that may re-traumatize; sensitive to individual adaptations	No awareness of triggering aspects of treatment in program planning	
	client choice and empowerment maximized, power and control minimized	Accent on powerlessness, breaking down self-will and surrendering control	
	Programs are structured and goal oriented, without being authoritative	Programs are authoritative, but sometimes lack structure	
	Collaboration focused (client with staff)	Compliance focused ( client surrenders)	
	Staff training and professional development in research-based approaches	Clients labeled resistant as a fallback when scope of training is exhausted	
	Understand the function of adaptive behaviors such as, trauma re-enactment and self-injury	Behaviors are seen as intentionally provocative, volitional, and self-destructive irrational and self-destructive	
Adapted from : <i>Fallot &amp; Harris, 2002; Cook et al., 2002; Ford, 2003; Cusack et al., 2004; Jennings, 1998; Prescott, 2000</i>			

What did you learn about your program? Whatever the response, this exercise , this modules contains ideas and resources that can improve programs' trauma – informed capacities.

### Primary Care PTSD Screen (PC-PTSD)

**Description-**The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events.

#### **Instructions:**

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?  
YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?  
YES / NO

3. Were constantly on guard, watchful, or easily startled?  
YES / NO

4. Felt numb or detached from others, activities, or your surroundings?  
YES / NO

Current research suggests that the results of the PC-PTSD should be considered positive if a patient answers "yes" to three

## Trauma Screening Guidelines

Screening for the effects of trauma, current safety and trauma related disorders does not require extensive questioning about the past. Effective screens may consist of as little as four questions. (PC-PTSD Screen)

Current safety, symptoms and functioning are more relevant than the details of past events. Remember screening is part of trauma-informed care, but only a qualified mental health professional can diagnose trauma-related mental health disorders.

- Explain the screening in advance, how the information will be used to benefit the client.
- Let the client know that *yes* or *no* answers are fine unless he or she wishes to say more.
- Use valid screening tools that focus on present-day symptoms such as the Trauma Symptom Checklist
- If screening for specific types of past trauma, use a checklist the client can read and mark rather than asking about past abuse during an interview.
- Give the client as much control as possible, including time and location, passing on questions and taking breaks.
- Be aware of your own nonverbal responses during the interview.

If the clients become upset or agitated redirect by asking about strengths, the people and things that helped them get through how these events affect them today and what works to help feel better. Grounding techniques can also be helpful ( page 63)

Trauma screening tools and measures can be found at the [National Center for PTSD](#). Below is to a list of all measures available from the Center's website

Trauma Exposure Measures  
PTSD Screens  
Adult Self Report  
Adult Interviews  
Deployment Measures  
Child Measures  
Assessment Request Form

## **Safety-Informed Referral to Additional Trauma Services**

Programs that don't offer trauma specific services can refer to agencies that do offer them as a follow up once offenders are released to the community. Re-entering offenders with histories that include intimate partner violence and sexual assault should be offered referrals to community resources that can assist them.

- Those experiencing mental health symptoms that interfere with functioning can be offered an evaluation for psychiatric medication and counseling services.
- If an offender is also a victim of a crime, they may benefit from community-based victim advocacy services, whether or not they choose to report the crime.
- Women or men in danger from a partner or family member upon re-entry, may benefit from safety planning and referral to domestic violence provider.
- Children of offenders can benefit from specialized services to help mitigate the effects of having an incarcerated parent and exposure to trauma or violence.
- Some ethnic or religious practices, churches or synagogues and other faith-based supports offer solace and recovery support from trauma and grief groups

**Secondary Victimization or Sanctuary Trauma** refers to humiliating or harmful experiences that are a result of an institution's response to a victim of a traumatic event. For example, some women veterans have indicated that reporting a sexual assault put them in more danger of death or bodily injury than the assault itself; victims of Hurricane Katrina were left in the Superdome without water and shot at after many of them sought help after losing their home and loved ones. Sanctuary trauma can have a disastrous effect on help seeking behaviors among survivors.

It is not unusual for them to avoid doctors, dentists and medical care. Since trauma memory is more like sensory information than a logical narrative, many people store memories of past trauma in their bodies. Some find it too difficult to tolerate medical exams and may not follow up on appointments. Offenders who may have been stigmatized by providers or have experienced secondary victimization are less likely to follow through with referrals unless they are personally connected or introduced to a contact that is understanding and safe. For offenders with trauma histories a "warm hand-off" to community resources and support is helpful. Phone introductions and names of agency contacts for re-entering offenders can make a difference. Peer recovery support for people with mental disorders, addiction recovery support, and vet to vet programs are valuable connections.

### Answers Exercise 1- Harriet's Treatment Experience (from page 56)

- a) *We can start you on a medication for obsessive compulsive disorder to help you get through this.*
- Although an assessment by a mental health clinician should take place, assuming trauma symptoms are the result of another disorder that requires medication is premature.
- b) *Many women in early recovery have things like that surface and have been able to learn ways to cope.*
- Normalizing the behavior, expressing empathy and offering information and hope are key elements of trauma-informed care.
- c) *We are transferring you to a dual diagnosis program.*
- Trauma-informed integrated treatment should monitor clients in early recovery to see if symptoms improve or worsen.
- d) *I know this is difficult, but it is important to keep the focus on your alcohol and drug problem right now.*
- The impact of trauma often interferes with a client's ability to focus and remain mentally and physically present in treatment.

### **If you chose (b) you have a great feel for trauma-informed care!**

Delayed onset of PTSD can occur. Sometimes people don't have a reaction to the trauma until much later. Something may trigger the reaction or recollection, or the onset of PTSD symptoms is for reasons which are not clear. It is common for women in substance abuse detoxification programs to be flooded with memories of past trauma. In jail programs, in particular, where offenders with addictive illness come in directly from the street, the combination of detox and incarceration can bring trauma memories to the surface. These individuals may need trauma-informed support and treatment as soon as possible. They can also benefit from ongoing mental health assessment and can sometimes present a suicide risk, even if only for a short period. However, this doesn't mean they should be immediately labeled or medicated or deemed in appropriate for RSAT programs.

People with trauma histories often do not categorize themselves as survivors and are not always cognizant of the effects of violence they may have grown up around. Others may not remember their childhoods, and for others, living with the threat of violence may have become the norm. The term survivor may not be useful for some. In these cases the goal is not to get the client to remember past trauma or to consider themselves a victim. The goal is to help the client feel better by teaching them skills to cope with triggers. If they can identify the triggers, the symptoms they experience, or anticipate their reactions and apply grounding and other coping skills, it can provide relief and help them control behaviors.

## Trauma Stabilization

Trauma stabilization establishes safety and teaches coping skills to help clients' manage responses that can interfere with treatment engagement and learning. Once the skills have been mastered, information about recovery is better absorbed. Tools that are useful to clients and easily taught by staff are:

- **Grounding**—directing attention to the “here-and-now” and using the five senses to connect with the present ---away from sensory recall of the past, flashbacks of negative experiences and anxious emotional states. Teach different grounding techniques, practice them in group and encourage clients to use grounding on their own.

*“When the CO told me to pick up the mop, I could feel myself starting to get crazy. I could feel something pounding up through my chest and into my throat; my fists were clenched. I began grounding. I counted the trees outside that lined the fence perimeter. Then I counted how many colors were on each tree. I forgot why I was so pissed off and picked up the mop.”*

- **Self-soothing**—preparing a menu of comforting and calming procedures in anticipation of a triggered response that clients can have readily available and share with support people and counselors. Helping clients identify their safe coping skills, sources of support or relief outlets and methods they have used in the past help themselves feel better.

*“I made the list to share in group of things that make me feel better: my dog; riding my motorcycle; going fishing; and eating outside. The ones I can do while I am in here are: looking at pictures of my daughter; writing letters; reading letters from my girlfriend; looking at fishing magazines and saying the serenity prayer. The best thing for staff to do when I am agitated is to remind me how much I love my daughter or talk about what we did the last time she visited.”*

- **Self-care**—learning to self-monitor emotional states, to evaluate choices and actions, and actively pursue emotional, mental, and physical healing. Encouraging wellness, attention to health care and stress reduction. Identifying triggers and unsafe people and situations and making plans to limit exposure or find support.

*“I decided that I am not going to watch movies that have violence or rape scenes. I was watching Law and Order Special Victim’s Unit every week on the tier with some other girls. I noticed I can’t sleep those nights and I feel depressed. I like the show, but right now I am not going to watch it.”*

- **Strength-based**—building self-efficacy by pointing out successful efforts to regain control, maintain abstinence, use grounding and other new coping skills; reinforcing the clients ability to change thinking and behavior and to assert control. Pointing out survival skills and how they can be used in recovery.

*“I never thought I could control myself when someone got in my face like that. But, you’re right; I did it for years around my stepfather before I was old enough to take him. Even when I was 8 or 9 years old I wanted to kill him every time he started in on my mom or my little brother. But, I had to control myself, and I guess I got good at it.”*

## B. Identifying Triggers and Alternative Coping

### Trauma Memory and Triggers

*“A century of study of traumatic memories shows that: They generally remain unaffected by other life experiences; They may return, triggered by reminders at any time during a person’s life, with the same vividness as if the subject were having the experience all over again; These memories are primarily sensory and emotional, frequently leaving victims in a state of speechless terror, in which they may be unable to articulate precisely what they are feeling and thinking.” ~ Bessel van der Kolk (1996)*

Theoretically, traumatic memory is stored differently from regular memory, isolated from every day consciousness and tied to the primitive part of the brain, allowing the survivor to function without the interference of overwhelming memories. However, when the memory surfaces, the emotional and physiological responses associated with the trauma are set into motion. Sensory cues and internal states activate intense “fight or flight” reactions. This may occur even when the survivor isn’t able to consciously recollect the event. The trauma survivor may have little control over these processes, reinforcing feelings of powerlessness and violation.

In an earlier module we met Harriet and her brother Pete. Below, each of them discuss triggers they identified during RSAT treatment. These triggers influenced urges to use drugs, avoidance, emotional volatility and risk of violence.

**Harriet** -*“When I was on probation, I had to go to a substance abuse group with a bunch of other probationers. Every week I dreaded it. I got high afterward. I never spoke, missed as many groups as I could, and took off the minute it was over. The counselor’s summary said I was resistant to treatment and refused to participate. I never knew why I hated it so much until I learned about my triggers. There was one other woman in the group and about six guys; four of them wore leather jackets. It was the smell. When I was 15, I took off with a group of bikers to party one weekend. To make a long story short, they raped me in a field near my school. I just can’t be around the smell of leather.”*

**Pete**-*“When I got out, this time, I had a good job at a warehouse pulling orders. I even got promoted to shipping, but it didn’t last. My foreman used to bring his son to work on Fridays and park the kid in my office all afternoon. He was a good kid, and I usually bought him a soda. One Friday he must have brought home a bad report card, because the kid had to stand in the corner all afternoon. I finally got him a soda and told him to have a seat. My boss came in and started yelling at the kid, and then started in on me for interfering. I just got crazy with him. I was yelling in his face and raising my fist at him. He told me I was fired and to get out. I was waiting for him outside with a tire iron. I left when I realized that I wanted to beat him to death, and he had actually been OK to me. What I wanted was to use that tire iron on my father.”*



## Education and Information about Triggers

Having a plan in advance to reduce reactions to reminders or “triggers” puts the client in charge even when he or she is emotionally upset. Encourage clients to identify triggers and develop coping skills to deal with them. This is the same type of skill that clients develop to plan for high-risk using or drinking situations.

### Work with each client to answer the following questions

- What kinds of reminders are difficult to deal with?
- What helps you calm down when you are triggered?
- What are the things staff can do to help when you are reacting to a trigger?

The Institute for Health and Recovery created a safety tool to help list calming strategies the client can use to cope with triggers. Seeking Safety uses a list of safe coping skills. These can be posted in group rooms or used at hand outs.

## Creating Safety: Dealing with Shared Triggers

Shared triggers are those that trigger both trauma symptoms and urges to use. Some examples clients describe are:

- Anniversaries of the traumatic events; holidays
- Movies with scenes that are reminiscent of the event
- Personality traits, physical characteristics or mannerisms similar those of the perpetrator
- Authority figures or authoritative personalities

Women who were sexually abused as children may react dramatically when their daughters approach the age when their own abuse began, and may not even consciously know why they have become so fearful. Anniversary reactions are common among veterans and the VA has a webpage to help them prepare themselves. Because trauma memories are often stored without words, it is not uncommon clients to not know *why* something has triggered them or to have a clear memory of the traumatic event.

***“The more proactive we become by asking what helps and what makes things worse in times of crises, the greater opportunity we have to align with clients in their healing.”*** - Laura Prescott (*Prescott et al, in press*)

The goal of identifying triggers and coping tools in treatment is to build skills and teach stabilization methods clients can take with them and use in ongoing recovery. RSAT programs are situated in the triggering environment of a jail or a prison. Programs can introduce these stabilization, grounding, self-care and self-regulation skills in initial phases of treatment and take advantage of the many opportunities correctional environments afford for practice. These types of skills may be needed sooner rather than later in a correctional environment. Group work on these basic tools can proceed even if more in depth trauma specific interventions are left for when clients are farther along in treatment (Miller and Najavits, in press).

## Minimizing the Effects of Unavoidable Triggers

In correctional settings there will be environmental trauma triggers that are unavoidable. Obviously, not every trigger can be eliminated—but they can be defused.

**PEACE** is an acronym for the approach to coping with unavoidable triggers:

**Predict and prepare**—*“When we go to court, your husband will be in the room. Tell me what steps would make you feel safest in court...What would you like to do to take care of yourself afterward?”*

Remember to keep the information flowing, and look for the safest approach for traumatized individuals. If a client is caught off guard, the instinctive reaction may be mistrust. Secrets, subterfuge and damage may have been the backdrop of their childhood.

**Enlist**—*“What has helped you in the past not to drink when you had to deal with your mother yelling at your kids?”*

The RSAT counselor’s job is to continually reference areas of strength and prompt the survivor to expand the skills they already possess. It is likely the person across the desk from you has walked through unimaginably difficult experiences. Fostering awareness that they are equipped with some unique survival gear is empowering.

**Acknowledge**—*“Many people have a difficult time sleeping when the lights are on all night.—it is like - invasive. I can understand why it makes you anxious. I don’t think I could sleep with the lights on either.”*

The late psychologist, Alice Miller, encouraged the role of the therapist as an “enlightened, empathic witness to the survivor of obvious cruelty.” Affirmation and acknowledgement, normalizing and witnessing the daily struggles, and nothing more, is sometimes all that is required.

**Choice and control**—*“We have to search everyone’s cell for contraband because a weapon was found earlier today. Do you want to be in the room when I check yours or is it better to do it while you are in group?”*

It is important not to underestimate the dignity of choice. The smallest domains of control that are left to offender with trauma are often of great value. In most situations it is possible to carve out some remnants of choice and freedom. It is often appreciated.

**Explain**—*“We ask each person to go through the metal detector. Then an officer does a pat down. This is because it keeps weapons out of the unit and makes it safer for everyone. The pat down is necessary because not every weapon is made from metal.”*

Hyper-vigilance is a constant state for some offenders. They may have survived danger by searching out harmful intent--all motives are suspect. In the absence of information, speculation leads to guarded conclusions. Explanations put people at ease.  
(Miller, 2010)

## The Trauma Conversation, Redirecting and Giving Voice

Silencing clients who have found the courage to speak can be as re-traumatizing as delving and probing for disclosure of specifics and details. However, if staff and clients spend a great deal of time discussing the details of the past abuse, it's bound to take a toll on both and may not help clients feel better.

Rules of thumb: allow the client to take the lead on bringing up trauma in conversations; do not probe or silence or fail to acknowledge. It is not always useful to reflect back what you hear, but it is helpful to acknowledge it on an emotional level, and master open ended questions that re-direct to the impact on the client in the present. Always and unconditionally stay on the side of the wounded child. Help clients make connections between trauma and substance use, shared triggers-- for distressing memories and emotions, urges to use and drug cravings. Encourage self-soothing or grounding if there is distress.

When details of trauma are shared in groups, there is the risk of triggering other group members. The principle, 'headlines, not details (Najavits, 2007) is a helpful guideline to avoid "vicarious re-traumatization" (when clients become reactive from hearing details of other people's trauma during treatment).

Mentioning past trauma in general terms such as 'child abuse,' 'rape,' etc., is acceptable but setting ground rules for keeping details of traumatic experiences to a minimum to avoid triggering effects is essential (Zlotnick, Najavits, Rohsenow, and Johnson, 2003). This can be approached as a means of ensuring safety and supporting self-care for both staff and clients. Educating clients about trauma intrusion, sensory recall and triggers, and modeling safe language to name their experiences helps clients with boundaries for self-disclosure.

### **Respect, Information, Connection and Hope** (*Risking Connections- Sidran Press*)

One trauma-informed approach used in correctional facilities is the **RICH** model, which to frame healing relationships and communication with offenders in ways that benefit staff and clients.

The RICH Models states every encounter with offender should communicate the following:

- **Respect**—this may be a very different response than expected. It can be challenging to convey respect consistently. Clients may also may view staff and authority through the lens of past abuse from dominating figures or neglectful mothers and abusive fathers.

- **Information**—let clients know what is going to happen and why. Provide education on the relationship between trauma and substance use, addiction recovery and how others have successfully overcome the effects of trauma.
- **Connection**—with the here-and-now and connections with people, as well as internal connections; between the mind, body and spirit, between actions and values. Safe connections with others re-write the patterns of abuse within relationships and ground survivors in today.
- **Hope**—remind clients that they have many strengths and have survived many things; recount their recent successes, small victories and strengths. The successes of others in recovery and those who have undergone trauma treatments helps sustain hope for staff and clients alike.

*And there is always reason for hope...*

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People with trauma histories in addiction recovery find their way back to varying degrees of health of through the practice self-regulating and self-healing, using the strengths and skills many already possess. Studies show that between 60% and 70% of those who complete trauma-specific treatments report a reduction in symptoms (Jennings, 2004).

### **Self-Assessment Exercise:**

The chart compares trauma-informed staff to untrained staff. Think about your level of comfort with the material in this module and your professional development goals and training needs.

In the light purple shaded columns rate each of the statements according to how accurately they describe your readiness to deal with trauma on a scale of 1 to 4.

- 1= strongly agree with the statement
- 2= somewhat agree the statement
- 3= somewhat disagree the statement
- 4 = strongly disagree with the statement

Rating	Trauma-Informed Staff	Untrained Staff	Rating
	Comfortable with grounding and de-escalation techniques that connect people to the here and now	What's going on for you? What are you flashing back to?	
	Adaptive behaviors are assumed to have a function and escalation is connected to unsafe feelings.	Pejorative labeling language: manipulative, needy, "attention-seeking"—playing games	
	Focus is on person not task	Focus on task, not person	
	Comfortable and confident helping clients with trauma, recognizes strength, listens.	Overwhelmed by addressing trauma, avoidant, silencing and pathologizes.	
	Forms healing, equitable relationships, exercises self-care and boundaries	Focuses on confrontation, pushes people's limits in group, and neglects therapists process	

How did you do?

### C. Integrating Trauma-Specific Treatment Approaches

Individuals with either a substance abuse problem or mental health problem should be assessed for the presence of the other (NIDA, 2006). High rates of mental health problems are found in offender populations, among trauma survivors and in those with substance abuse problems. In module III we reviewed some of the *Principles of Drug Abuse Treatment for Criminal Justice Population* (NIDA, 2006). Before we look at the ways trauma and PTSD is treated, it is useful to revisit principle 11, which refers to integrated treatment.

Offenders with trauma histories may also have a number of other co-occurring mental health disorders in addition to or instead of PTSD. Women are more likely than men to have accompanying depressive disorders and additional anxiety disorders and veteran that have experiences trauma have a high rates of depression (National Center on PTSD, 2011).

**Principle 11: Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.**

In depth research on offenders with co-occurring disorders has also shown that the Risk, Need and Responsivity (RNR) approach also works well for people with mental illness in the criminal justice system. Recent recidivism studies have validated the same risk factors as the strongest predictors of recidivism for offenders with serious mental illness as they are for other offenders (Prins and Draper, 2009). RNR along with

the following practices are known to be particularly effective for offenders with co-occurring mental health disorders:

- Cognitive-behavioral treatment interventions that address the irrational thoughts and beliefs that can lead to anti-social behavior.
- Illness self-management and recovery, in which people learn skills to monitor and control their own well-being.
- Integrated mental health and substance use services, in which specific treatment strategies and therapeutic techniques are combined to address both mental illnesses and substance use disorders together.
- Targeted trauma interventions for people with mental illnesses and extensive histories of trauma (especially women), including physical and sexual abuse (Prins and Draper, 2009).

Drug abuse treatment can sometimes help to address depression, anxiety, and other mental health problems. Sometimes clients with trauma require combined substance abuse treatment with psychiatric treatment and the use of medications that are helpful to clients with PTSD. Personality, cognitive impairment, psychosis and other serious mental disorders can be more difficult to accommodate in substance abuse programs.

Other mental health disorders that commonly co-occur in people with histories of trauma include:

Depression  
Anxiety  
Agoraphobia  
Personality Disorders  
Dissociative Disorders  
Panic Disorder  
Obsessive-Compulsive Disorder  
Social Phobia and Specific Phobias  
Bipolar Disorder  
Eating Disorders  
Psychotic Disorders

PTSD is an anxiety disorder, but people vary in their degree of symptom severity. It is important to work with mental health services to ensure clients with serious symptoms or additional mental health issues can benefit from RSAT programs and cognitive behavioral approaches to integrated substance abuse and trauma group therapy.

Staff should also monitor and report changes in symptom severity if clients worsen in RSAT programs. As with any other co-occurring disorder, a qualified behavioral health professional should diagnose PTSD and other trauma-related mental health disorders. Collaboration with mental health providers during RSAT treatment and appropriate linkages prior to release are critical (Osher and Steadman, 2007).

Screening for co-occurring disorders should be an ongoing process. Many changes can take place in a client's mood, memory and functioning over the course of long term treatment. Mental health disorders can emerge, get better or get worse over the course of early recovery.

### ***How is PTSD treated?***

#### **Trauma Specific Treatment Approaches**

- Pharmacological treatment
- Physiological approaches
- Past-based approaches
- Present-based approaches

The main treatments for people with PTSD are psychotherapy, medications, or both. Everyone is different, so a treatment that works for one person may not work for another. Some people with PTSD need to try different treatments to find what works for their symptoms and many try a variety of different treatments over the course of their recovery. Many types of psychotherapy can help people with PTSD. Alternative therapies are popular, including body work and other physiologically-based treatments.

<p><b>Criteria that Mental Health Clinicians Use to Diagnose PTSD</b> 309.81 Post-traumatic Stress Disorder</p> <p>A. The person has been exposed to a traumatic event in which both of the following were present:</p> <ol style="list-style-type: none"><li>(1) The person experienced, witnessed, or was con-fronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others</li><li>(2) The person's response involved intense fear, helplessness, or horror.</li></ol> <p>Note: In children, this may be expressed instead by disorganized or agitated behavior</p> <p>B. The traumatic event is persistently re-experienced in one (or more) of the following ways:</p> <ol style="list-style-type: none"><li>(1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.</li><li>(2) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.</li><li>(3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.</li><li>(4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event</li><li>(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event</li></ol> <p>C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:</p> <ol style="list-style-type: none"><li>(1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma</li><li>(2) Efforts to avoid activities, places, or people that arouse recollections of the trauma</li><li>(3) Inability to recall an important aspect of the trauma</li><li>(4) Markedly diminished interest or participation in significant activities</li><li>(5) Feeling of detachment or estrangement from others</li><li>(6) Restricted range of affect (e.g., unable to have loving feelings)</li><li>(7) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)</li></ol> <p>D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:</p> <ol style="list-style-type: none"><li>(1) Difficulty falling or staying asleep</li><li>(2) Irritability or outbursts of anger</li><li>(3) Difficulty concentrating</li><li>(4) Hyper vigilance</li><li>(5) Exaggerated startle response</li></ol> <p>E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.</p> <p>F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.</p> <p>Specify if: Acute: if duration of symptoms is less than 3 months Chronic: if duration of symptoms is 3 months or more Specify if: With Delayed Onset: if onset of symptoms is at least 6 months after the stressor</p> <p style="text-align: right;"><b>American Psychiatric Association (2000).</b></p>
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Past-based treatment works with the trauma memory, while present-day approaches work with the trauma effects. Present-day interventions are structured; focus on gaining control of trauma responses such as intrusive memories and the effects of trauma on current behavior and thinking. Past-oriented, like exposure therapies and EMDR (Eye Movement Desensitization and Reprocessing) therapies focus on processing the memory and desensitizing the client to its triggering effect.

Present day oriented therapies teach new coping skills, and focus on safety and self-care. They don't concentrate on the past event, but rather on managing the difficulties clients are having at the present time as a result of the trauma. These treatments have led to improvements in the majority of people with PTSD (Najavits, 2008). Integrated substance use treatment tends to favor structured present-day approaches that help clients gain control of trauma responses, and reduce trauma's effects on current behavior and thinking. However, exposure therapies have been very effective, especially for veterans and EMDR has very good outcomes with clients who experience single event traumas such as airplane accidents and fires (Saxon, et al., 2001).

Some of these treatments have been developed especially for clients with addiction issues, integrating cognitive behavioral approaches, increasing coping skills and reducing unsafe behaviors and drug and alcohol use. These interventions are also helpful to the large numbers of clients with addiction and trauma histories that do not have a diagnosis of PTSD (Jennings, 2004). These are the types of interventions can be used safely in RSAT programs and facilitated by staff with many different levels of experience. They require training, practice and fidelity monitoring, but not extensive clinical training or advance degrees. They are preferred for use correctional facilities and completely compatible with cognitive behavioral interventions (Miller and Najavits, 2011). They have been used safely and successfully in correctional programs, studies have been conducted in prisons and with justice-involved veterans and women (Zlotnick, Najavits, Rohsenow and Johnson, 2003; Gillece, 2002).

## **Stages and Tasks of Trauma Recovery**

Before examining individual curricula, it is useful to understand a well-known model of recovery from trauma. Judith Herman (1992) identified three stages of trauma recovery. These stages involve specific tasks. Each person's path is unique and some tasks are easier than others. Substance use disorder treatment for people with co-occurring PTSD has used effective treatments that help clients master Stage One trauma recovery tasks, which are quite compatible with addiction recovery. Although recovery is seldom a linear process, Stage One recovery tasks should be the focus of initial integrated treatment in RSAT programs.

<b>Tasks of Trauma Recovery</b>
<b>Gain authority over the memory</b>
<b>Safety</b>
<b>Self-soothing</b>
<b>Grounding</b>
<b>Self-regulation/affect regulation</b>
<b>Identifying and eliminating triggers</b>
<b>Grieving</b>
<b>Empowerment</b>



Clients who are healing from the effects of trauma may try a range of approaches at different points in ongoing recovery, but for clients in RSAT programs, there is usually an immediate need to learn substance-free coping skills and increase safety. The focus on establishing safety gives offenders with trauma a foundation to build upon.

Stage One: Establishing Safety

Stage Two: Remembrance and Mourning

Stage Three: Reconnection

Although remembrance and mourning tasks are not to be discouraged and reconnection is a constant process in recovery, remembrance and mourning is usually a task that involves vulnerability, which requires stability, safety and a long term commitment to therapy. It is probably not desirable for offenders to delve into interventions in prison or jail that involve the later stages of trauma recovery. The requisite stability and longevity of the therapeutic alliance would rarely be possible. However, aftercare resources for offenders with PTSD should include appropriate referrals for follow up aftercare after release with providers familiar with various trauma approaches. This is especially important to keep in mind with veterans in RSAT programs that have PTSD. The VA uses a variety of supportive approaches for vets with PTSD, but the intensive PTSD programs use Prolonged Exposure Therapy, which is a past-based approach.

### **Relationships and Belief Systems**

Relationships can be difficult and even painful for trauma survivors. They may have stayed safe by sizing up people in terms of victim-perpetrator dynamics and may view all relationships through that lens. Abuse often takes place in the context of relationships where there is an imbalance of power; healing takes place in the context of relationships without those imbalances (Herman, 1992). Peer support is an important healing venue for people recovering from trauma, and has been particularly beneficial to veterans with trauma, as are relationships with staff based on collaboration. Many women offenders were sexually abused in childhood and had mothers who did not intervene, sometimes leaving them more mistrustful of women than men. Modeling and practicing new safety skills, good coping and boundaries in healing relationships with other women can re-frame those connections.

### **Consistent with Personal Responsibility**

As we learned in module III, evidence-based approaches to substance abuse treatment with offenders seek to enhance motivation. As is consistent with motivational enhancement therapy, it is important to stress the client's responsibility for change. Decisions to try new coping skills and attending to trauma in treatment must be strictly the offender's choice. This empowerment approach is critical, not only because it returns a sense of control to the offender, but also because it prevents transference and trauma re-enactment. Some people with trauma histories, especially those with childhood trauma, are prone to trauma re-enactments that cast counselors in the role of rescuer. This is a trap that counselors need to avoid. The credit for treatment success

and responsibility for treatment failure belongs to the offender. Pushing an offender to deal with his or her trauma is counterproductive.

## **Manualized Treatments for Integrating Trauma Recovery**

The use of present-focused, cognitive-behavioral, and coping skills treatments for trauma, with strong educational components, have also helped stabilize inmates with histories of violence or self-injury (Zlotnick, Najavits, Rohsenow and Johnson, 2003; Gillece, 2002). The approach tends to be compatible with the correctional culture of responsibility, consistency, accountability and targeted behavioral change. Manualized, present-focused approaches to trauma, such as Seeking Safety (Najavits, 2002), have been effective with offenders without causing distress or decompensation that requires attention from prison mental health staff (Najavits, 2006).

The following are well-known and widely used trauma-specific interventions with educational components, which result in increased coping skills and stability for individuals in substance use disorder treatment. Several of them use a treatment manual to guide group facilitation. More information on training and implementation for each of these and others is listed at the end of this module.

[Seeking Safety](#)

[Essence of Being Real](#)

[Trauma, Addiction, Mental Health, and Recovery \(TAMAR\)](#)

[Trauma Recovery & Empowerment Model \(TREM\)](#)

[Addiction & Trauma Recovery Integration Model \(ATRIUM\)](#)

[Trauma Affect Regulation: Guide for Education & Therapy \(TARGET\)](#)

Four of these models were tested in SAMHSA's Women with Co-Occurring Disorders and Violence Study (WCDVS) along with one other model that was developed especially for women in correctional facilities. These approaches can be used to establish safety and stabilization in the first stage of treatment:

*ATRIUM* (Miller & Guidry, 2001), *Helping Women Recover* (Covington, 1999), *Seeking Safety* (Najavits, 2002), *Trauma Recovery and Empowerment Model (TREM)* (Harris, 1998), *Triad* (Clark & Fearday, 2003) and TAMAR.

Although, originally TAMAR was developed for women jails and prisons, it has been adapted for use with male offenders through jail diversion programs for veterans with trauma histories. The present-focused approaches require training, but not the degree of training and experience that past-based PTSD treatments, such as exposure therapy, require.

Trauma can change one's basic assumptions about the world and the self. Trauma and abuse, in many cases, takes place in relationships where one person has power over another. Often, people who were traumatized as children internalize messages given to them by abuser(s) and may harbor the belief that they are worthless, damaged, and deserve what happens to them. They may also lose confidence in their judgment, their ability to protect themselves, and view the world as a dangerous and frightening place. They have a difficult time trusting people and forming connections. At the same time people with trauma heal within the context of safe relationships where power is shared, and through re-connecting with others. Forming new relationships that model safety, boundaries and depart from the dynamics of victim, abuser and rescuer are the basis of trauma-informed therapeutic communities.

#### **D. Secondary Trauma, Burnout and Counter Transference**

Trauma has touched the lives of many professionals working in correctional settings. Most people have family or friends that have experienced trauma, whether during a car accident, an assault, a hurricane or while serving in the military. When personal experiences begin to affect the way we deal with offenders or when our work with offenders begins to affect the way we deal with people in our personal lives, it is termed counter transference. Below is the strict definition of the terms transference and counter transference as they are used in psychology.

**transference** - the client's displacement of feelings toward others (usually the parents) onto the therapist

**counter transference**- the therapist's emotional involvement or displacement of feelings onto the client in reaction to the emotions, experiences, or problems of the person undergoing treatment. American Heritage Dictionary 2000

Offenders with trauma frequently transfer emotions toward past authority figures on to correctional staff, especially emotions associated with childhood abuse and resentment of authority. But, when burnout, overload and neglect of self-care all come together, counter transference can become an occupational hazard for people who work in correctional settings. For our purposes counter transference means staff becomes emotionally reactive when working with people with trauma.

Empathy is an important characteristic of a good counselor and also a technique used in Motivational Interviewing, substance use disorder treatment and trauma treatment. Empathy is also a normal human response to inhumane stories of childhood sexual abuse, multiple foster homes, violence and loss after loss. How do you know when empathy has become over identification? The answer is, sometime you don't, but a supervisor or co-worker may. Extremely strong reactions of anger, impatience, empathy or sadness can be signs. Excessive work, preoccupation or a feeling of hopelessness and pessimism can also be indicators of counter transference or burnout.

Good clinical supervision is an important part of effective trauma-informed practice. By communicating and staying connected with co-workers and supervisors staff can learn

to identify uncomfortable feelings, times when work is out of balance and vet other issues that come up when working with emotionally intense clients. When an encounter with a client does illicit a personal reaction, having strong relationships with co-workers and supervisors will make it easier to discuss these issues.

### **Secondary or Vicarious Trauma**

*“Extensive literature reviews of vicarious trauma recognize this issue as a serious challenge faced by those in the helping profession. They identify compassion fatigue, intrusive imagery, distressing emotions, burnout, somatic complaints, and changes in identity....On the other hand, the literature also cite concrete strategies individuals and organizations can employ to ameliorate its effects.”*

*-Vicarious Trauma and Its Impact*

Secondary or vicarious trauma refers to changes in the inner experience of service providers that come about as a result of empathic engagement with the people who have experienced trauma. Secondary trauma among providers can result in responses that resemble PTSD symptoms, such as:

- Intrusive flashbacks or obsessive thoughts
- Difficulties with emotional regulation
- Physical symptoms such as frequent illness

Staff working in RSAT programs can help each other identify these changes and support self-care. Taking a break, rotating job duties, recreation and outside support are important. Secondary trauma can also result in changes that follow staff out of the facility:

- Beliefs about self, others and the world can change; a sense of control over one’s destiny may diminish
- Sense of trust of self or others can erode; self-esteem may be low and guilt may set in
- Perception of safety for self or others can change, fear for children or loved ones can become excessive
- Feelings of disconnectedness, numbing or callousness and anger are common

Examining negative beliefs and assumptions as they emerge and engaging in stress-reducing activities outside of your workplace can help. Participating in nurturing activities that involve gentleness, pleasure, beauty, comfort, relaxation and play is a good remedy. Activities that allow you to forget about work are important chances to escape and renew a connection to the larger purpose or meaning of your life such as creative expressions, spiritual activities and community building activities.

But, if these types of signs persist it is important to seek outside help before they interfere with relationships, family or work.

### **Where you go for help?**

If you are unsure where to go for help, contact your Employee Assistance Program or ask your family doctor. Others who can help are listed below.

- Family services, social agencies, or clergy
- Peer support groups
- Health maintenance organizations
- Community mental health centers
- Social workers, counselors

### **Building Personal Resistance to Secondary Trauma**

The ABC's of self-care that help build resistance are:

- A. Awareness—monitor emotions, needs, limits and resources.
- B. Balance—set aside time for reflection, play, relaxation and family.
- C. Connections—utilize social support, resist tendencies to isolate.

Please review the self-care plan from the beginning of this training. Is there anything to add after completing this module?

You can link to an *excellent* free online course developed for humanitarian workers worldwide, on preventing secondary trauma from the Headington Institute available at <http://www.headington-institute.org/>

## Ongoing Recovery

The effects of trauma can be devastating, but people heal and recover. Many cultures have traditional ways of healing and faith-based supports; there are domestic and sexual violence services, victim's services, veterans' programs, the recovery community, peer mental health centers and others offering support for survivors of abuse and trauma. Many clients may seek out alternative medicine, the arts and other treatments.

Studies show that between 60% and 70% of those who complete trauma-specific treatments report a reduction in symptoms (Jennings, 2004). Professional treatment for those with co-occurring disorders and PTSD may not end the day a client is discharged.

Re-entering offenders may wish to accrue a length of time in stable recovery before seeking additional treatment. Others may find medications essential to maintaining stability. Others may have no need to revisit trauma-related issues beyond learning the basic skills they need to manage their triggers. Just as no one SUD treatment is right for everyone, no single path to trauma recovery is required. RSAT programs can provide a start by promoting safety and teaching clients to manage the shared triggers for trauma responses and substance use, resulting in better outcomes for clients.

## CONCLUSION-Harriet, Pete and Ashley's Moment

*"In treatment I got in touch with my anger at the injustices my family endured. I was a child who was victimized. When the only person I could rely on tried to defend me-- he was imprisoned instead of the perpetrator.*

*I had lost contact with Pete when I was using. I was too scared and ashamed to let him know he was an uncle. But I wrote to him in prison while I was in treatment and told how much I loved him.*

*I was able to work on reuniting with Ashley and having her live with me as I completed the phases of long term treatment. In the TC, I had realized that the older Ashley got the more terrified I had become for her. I started to understand what triggered me. I knew I couldn't protect her, and I hated myself for that. So, one of my goals was to reunite with her before she turned 11, the age I was when it all started.*

*For Ashley's 11<sup>th</sup> birthday, she had her uncle Pete with her, her mom by her side and her choice of any dog she wanted from the animal shelter. She chose a greyhound; we named her Hope."*

## D. Review and Resources

### Module Review

- The prevalence of traumatic histories is so high for offenders with substance use disorders that trauma-informed principles should be used with all clients in RSAT programs.
- Some of the core principles of trauma-informed approaches are: empathy, reframing behaviors as adaptive responses to trauma, identifying and minimizing triggers and modeling and supporting self-care.
- Psycho-educational groups can teach clients in recovery new coping skills such as, grounding techniques, self-soothing strategies, self-care, and other trauma stabilization measures. They focus on present day functioning.
- Trauma-specific programs offer specific interventions and treatments aimed at reducing the effects of trauma and have specially trained staff experienced in implementing these practices.
- Past-based interventions, such as exposure therapy, focus on the trauma memory and present-based interventions focus on the trauma response. Generally present-based interventions are used in substance use disorder treatment and in correctional settings.
- Safety and gaining authority over the memory and symptoms are first stage trauma recovery tasks. RSAT programs can integrate the basics of first stage trauma recovery into substance abuse treatment by using manualized, cognitive behavioral trauma interventions developed for addiction treatment settings.
- Staff can be affected by repeated exposure to clients with traumatic histories and experience secondary trauma. It is important to remain aware, take steps to schedule supervision, and provide training and opportunities for support and self-care.

## Take Home Messages

**Module I-** Trauma and trauma related mental health disorders are common among RSAT clients. They have a distinct effect on their recovery, their behavior and their health.

**Module II-** Childhood trauma, sexual trauma and interpersonal violence contribute to serious mental health disorders with physical effects that interfere with behavior and treatment.

**Module III-** Trauma has been linked with substance use and higher risk of criminal behavior. Effective long-term treatment motivates, educates and also addresses criminal risk factors.

**Module IV-** A simple set of trauma-informed principles can be helpful even when trauma treatment is not available. RSAT programs benefit from these approaches and a balance of empathy and structure. Manualized curricula appropriate for RSAT programs may be implemented as well.



## Resources:

### Substance Abuse and Mental Health Administration Resources

1. Alcohol Screening and Brief Intervention of Trauma Patients: Treatment Improvement Protocol (TIP) Series 16  
<http://www.samhsa.gov/csatdisasterrecovery/featuredReports/01-alcohol%20SBI%20for%20Trauma%20Patients.pdf>
2. Understanding Links between Adolescent Trauma and Substance Abuse: A Toolkit for providers <http://www.nctsn.org/products/understanding-links-between-adolescent-trauma-and-substance-abuse-toolkit-providers-2nd-edit> (available from National Child Traumatic Stress Network)
3. Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues: Treatment Improvement Protocol (TIP) Series 36 and related KAP keys  
<http://radar.boisestate.edu/pdfs/TIP36.pdf>
4. Safety planning for women returning to dangerous living situations: *Silence Hurts: Alcohol Abuse Violence Against Women*- CSAP Pathways on-line course.  
[http://pathwayscourses.samhsa.gov/vawp/vawp\\_intro\\_pg1.htm](http://pathwayscourses.samhsa.gov/vawp/vawp_intro_pg1.htm)

National Institute of Corrections: <http://nicic.gov/> (home page and connection to resources)

**The RICH Model** (*From Risking Connections*- Sidran Press) Risking Connection teaches a relational framework and skills for working with survivors of traumatic experiences. <http://www.riskingconnection.com/>

Office of Victims of Crime. <http://www.ojp.usdoj.gov/ovc/assist/welcome.html>. The Website offers any resource including vicarious trauma information:  
[http://www.ojp.usdoj.gov/ovc/publications/infores/faith\\_based\\_vict\\_asst/vicarious\\_trauma.htm](http://www.ojp.usdoj.gov/ovc/publications/infores/faith_based_vict_asst/vicarious_trauma.htm)

The Homeless Resource Center- Archived webcast  
<http://homeless.samhsa.gov/Resource/HRC-Webcast-Resource-Responding-to-Vicarious-Trauma-Self-Care-for-Homeless-Service-Providers-52133.aspx>

The Vicarious Trauma Institute <http://www.vicarioustrauma.com/blog.html>

## **Trauma-Specific Service Models for Adults**

Adapted from: Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services. (2004). Prepared by: Ann Jennings, Ph.D. for: National Technical Assistance Center for State Mental Health Planning (NTAC), National Association of State Mental Health Program Directors (NASMHPD). Full report available at <http://www.theannainstitute.org/MDT.pdf>

**Note: Items listed with an \* have an integrated PTSD and addiction recovery focus.**

### **\*Addictions and Trauma Recovery Integration Model (ATRIUM)**

Developed by Dusty Miller, Ed.D., and Laurie Guidry, Psy.D., ATRIUM is a manualized, sequentially organized, 12-week curriculum designed for people who are survivors of sexual and physical abuse, those with substance abuse and other addictive behaviors, those who are actively engaged in harmful relationships, who self-injure, have serious psychiatric diagnoses, and for those who enact violence and abuse against others. ATRIUM is designed to work as a peer-led (as well as professionally led) group model and can be used for individuals working with therapists or counselors, or in group or peer support settings. ATRIUM is implemented within substance abuse and mental health treatment settings as well as in peer group environments. The model has primarily been used with single-sex groups. To obtain the manual, and for information on training and technical assistance (in English and Spanish), visit [www.dustymiller.org](http://www.dustymiller.org), e-mail [dustymi@valinet.com](mailto:dustymi@valinet.com), or call Dusty Miller at 413-584-8404.

### **\*Beyond Trauma: A Healing Journey for Women**

Developed by Stephanie S. Covington, Ph.D., L.C.S.W., co-director of the Institute for Relational Development and the Center for Gender and Justice, *Beyond Trauma: A Healing Journey for Women* (Covington, 2003) is a manualized curriculum for women's treatment based on theory, research, and clinical practice. While the materials are trauma-specific, the connection between trauma and substance abuse is recognized and integrated throughout the curriculum. The program is designed for use in outpatient, residential, and criminal justice settings. *Beyond Trauma* has a psycho-educational component that teaches women what trauma is, its process, and its impact on both the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). The major emphasis is on coping skills with specific exercises for developing emotional wellness. The curriculum includes a facilitator manual, participant workbook, and three instructional videos (two for facilitators, one for clients). ALSO... **\*Helping Women Recover (HWR): A Program for Treating Addiction** Developed by Stephanie S. Covington, Ph.D., L.C.S.W., with a special edition for criminal justice settings entitled *Helping Women Recover: A Program for Treating Substance Abuse*. This is an integrated, manualized curriculum for treating women with histories of addiction and trauma. It is designed for use in a variety of settings including outpatient and residential substance abuse treatment programs, domestic violence shelters, and mental health clinics, as well as jails, prisons, and community corrections. The facilitator's manual for the 17-session program is a step-by-step guide containing the theory, structure, and content needed for running groups. *A Woman's Journey*, the participant's workbook, allows women to process and record the therapeutic experience. The program model is organized into four modules: self, relationships, sexuality, and spirituality. To obtain *Beyond Trauma* the *HWR* facilitator's manual and a *Woman's Journal* and for information on training and consultation, contact Stephanie S. Covington, Ph.D., L.C.S.W., 7946 Ivanhoe Avenue, Suite 201B, La Jolla, CA 92037 or at 858-454-8528, via e-mail at [sscird@aol.com](mailto:sscird@aol.com) or online at [www.stephaniecovington.com](http://www.stephaniecovington.com)

### **\*Seeking Safety Model**

Developed by Lisa Najavits, Ph.D., at Harvard Medical/McLean Hospital, Seeking Safety is a manualized 25-topic, flexible, integrated treatment designed to address safety and recovery for persons with the dual diagnosis of PTSD and substance abuse (as well as persons with a trauma history who do not meet clinical criteria for PTSD). Seeking Safety is designed to be used in a wide variety of settings including substance abuse treatment (outpatient, inpatient, residential), correctional facilities, health and mental health centers, etc., as well as for both group and individual format, females and males. Flexible and adaptable, topics can be conducted in any order, the number of topics covered can be changed depending on a client's length of stay, and groups can be facilitated by a wide variety of counselors. It can

be implemented by a very wide range of counselors, including those without a degree in mental health (e.g., substance abuse counselors, case managers). Seeking Safety recognizes establishing safety as the most urgent clinical need for persons with PTSD and substance abuse problems, and teaches a range of more than 80 “safe-coping” skills to work toward discontinuing substance use, letting go of dangerous relationships, and gaining control over dissociation and self-harm (e.g., grounding, self-nurturing, asking for help, setting boundaries in relationships). Rethinking is used to challenge demoralizing or risky beliefs, including distortions specifically related to PTSD and addiction, and to restore ideals that have been lost, including respect, care, protection, and healing. The treatment manual, *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*, (Najavits, 2002) includes client handouts and clinician guidelines. [www.seekingsafety.org](http://www.seekingsafety.org) or e-mail [info@seekingsafety.org](mailto:info@seekingsafety.org) or call Lisa Najavits, Ph.D. at 617-855-2305, McLean Hospital, 115 Mill Street, Belmont, MA 02478.

#### **\*TRIAD Women’s Group Model**

Developed by and implemented at one of the SAMHSA Women Co-Occurring Disorders and Violence Study sites, this manualized, 16-session (2-hours a week for 16 weeks) cognitive behavioral group model is based on the perspective that complex disorders arise from trauma and that particular fundamental issues must be addressed for long-term recovery to occur (Herman, 1992). It is designed for and takes an integrated approach to women who experience challenges around the three issues of trauma, mental health, and substance abuse. TRIAD is structured into four phases: Mindfulness, Interpersonal Effectiveness Skills, Emotional Regulation, and Distress Tolerance, with four weekly sessions in each phase. This design allows for a “modified open” format in which women can join the group at the beginning of each of the four phases. Each session includes specific goals and objectives to facilitate short-term treatment planning. A leaders manual, *Triad Women’s Project Group Treatment Manual*, was developed by the Clinical Interventions Committee of the Triad Women’s Project. TRIAD’s primary treatment goals are to reduce psychiatric and trauma-related symptoms associated with histories of violence/abuse and substance use for those with substance abuse disorders. This cognitive behavioral model is based, in part, on Linehan’s Cognitive-Behavioral Treatment model, Evans and Sullivan’s work on substance abuse and trauma and Harris’ work on trauma and serious mental illness. To obtain the manual and for information on training and consultation, contact Colleen Clark, Ph.D., at 813-974-90

#### **\*Trauma, Addictions, Mental Health and Recovery (TAMAR) Trauma Treatment Group Model**

Developed as part of the first phase of the SAMHSA Women, Co-Occurring Disorders and Violence Study, TAMAR Trauma Treatment Group Model is a structured, manualized 14-week, 13-module trauma-specific group intervention combining psycho-educational approaches with expressive therapies. TAMAR was originally used with women but is now used with men in correctional setting. Groups are run inside detention centers, in state psychiatric hospitals, and in the community. Group sessions meet twice weekly for 90 minutes, an interval that fits smoothly into the daily schedules of county detention centers. Women taking part in groups while detained in the detention center complete it on-site or continue in a community group if released before completion. The Trauma Addictions Mental Health and Recovery Treatment Manual provides basic education on trauma, its developmental effects on symptoms and current functioning, symptom appraisal and management, the impact of early chaotic relationships on health care needs, the development of coping skills, preventive education concerning pregnancy and sexually transmitted diseases, sexuality, and help in dealing with role loss and parenting issues. To obtain the manual and for information on training and technical assistance, contact Joan Gillece, Ph.D., at 410-724-3238 or [gillecej@dnhm.state.md.us](mailto:gillecej@dnhm.state.md.us), or contact Jenny Howes, L.G.S.W. at 410-724-3180 or [howesj@dnhm.state.md.us](mailto:howesj@dnhm.state.md.us)

### **\*Trauma Recovery and Empowerment Model (TREM)**

Developed by Maxine Harris, Ph.D., and the Community Connections Trauma Work Group, TREM is a manualized, sequentially organized, 24–33 session group approach to healing from the effects of trauma. It is designed for women with major mental health, PTSD, and/or substance abuse problems. **A men's version (M-TREM) is also available.** The TREM model was developed and refined over a period of five years by 27 clinicians and more than 500 participants. TREM combines elements of recovery skills training, psychoeducation, and other cognitive-behavioral techniques, and emphasizes peer support, which has proven to be a highly effective approach with survivors. TREM focuses initially on the survivor's personal and relational experience, with emphasis on empowerment and skill building. At this stage, members learn strategies for self-comfort and accurate self-monitoring as well as ways to establish safe physical and emotional boundaries. TREM then provides a supportive (gender-separated) group peer environment in which each survivor can explore current life problems as they relate to past or present experiences of physical, sexual, and emotional abuse. TREM Instructional Video: *Trauma Recovery and Empowerment: A Clinician's Guide to Working with Women in Groups*, by Maxine Harris, Ph.D. and the Community Connections Trauma Work Group, is an 8.5-hour instructional video designed for clinicians to learn the rationale and philosophy behind the TREM intervention, with focus on the content and format of each of the 33 sessions. The video provides general information about sexual and physical abuse and can be used as part of a curriculum on trauma. To obtain the manual or the instructional video, visit [www.ccdc1.org](http://www.ccdc1.org) or contact Aisha Meertins, M.S.W., at 202-608-4734 or [ameertins@ccdc1.org](mailto:ameertins@ccdc1.org). For information on training and consultation, contact or contact Rebecca Wolfson Berley, M.S.W., director of Trauma Training, at 202-608-4735 or [rwolfson@ccdc1.org](mailto:rwolfson@ccdc1.org)

### **Growing Beyond Survival: A Self Help Toolkit for Managing Traumatic Stress**

Created by Elizabeth G. Vermilyea, M.A., this manualized approach teaches skills that empower survivors to take control of and de-escalate their most distressing trauma related symptoms. The workbook is intended for use in therapist-run symptom management therapy groups. It can also be used effectively by survivors for managing trauma symptoms between therapy sessions and for individual survivor self-help. It teaches trauma survivors to recognize, contextualize, and understand distressing dissociative and posttraumatic reactions. It also creates a structure in which to learn and practice skills for self-regulation of the troublesome thoughts, feelings, and impulses related to traumatic experiences. Developed in part and extensively field tested at Trauma Disorders Programs at Sheppard Pratt Hospital in Baltimore, Growing Beyond Survival offers tools enabling survivors who suffer from trauma-related symptoms (including poor concentration, sleep disturbances, panic attacks, nightmares, flashbacks, and other physical responses) to find relief. It also examines the relation between trauma and self-harming behaviors, difficulties with sexuality, and substance abuse. To obtain this resource and for additional information, contact the Sidran Institute at 410- 825-8888 or online at [www.sidran.org/catalog/vegb.html](http://www.sidran.org/catalog/vegb.html) or via e-mail at [orders@sidran.org](mailto:orders@sidran.org)

### **Trauma Adaptive Recovery Group Education and Therapy (TARGET)**

Developed by Julian Ford, Ph.D., TARGET is a manualized gender-specific group or individual treatment that begins with 3 to 12 sessions of self-regulation skills based on the neurobiology of complex trauma, and may continue for up to 26 sessions. The model is more commonly implemented in versions of different lengths: 3 to 5 sessions, 12 sessions for groups in addiction treatment programs, and 26 sessions for groups in community mental health or inpatient/residential psychiatric programs, and 16 sessions for one-to-one outpatient psychotherapy. TARGET teaches a practical 7-step sequence of skills for processing and managing the trauma-related components of current stressful experiences (e.g., PTSD symptoms, rage, traumatic grief, survivor guilt, shame, interpersonal rejection, and existential/spiritual alienation). To obtain a manual and for information on training and consultation, contact Eileen Russo, M.A., L.A.D.C., at [Russo@psychiatry.uchc.edu](mailto:Russo@psychiatry.uchc.edu) or online at [www.ptsdfreedom.org](http://www.ptsdfreedom.org)

### **The Trauma and Recovery Group: Cognitive Behavioral Therapy Approach for PTSD in People with Serious Mental Illness**

Developed by Stanley Rosenberg, Ph.D., and Kim Mueser, Ph.D. of the New Hampshire Dartmouth Psychiatric Research Institute, the Trauma and Recovery Group model is a manualized, 16-session one-to-one psychoeducation intervention for women or men with chronic and persistent mental illness and PTSD. It is intended for use in community mental health or inpatient psychiatric settings. Offered individually and in groups, the model contains relaxation exercises, video facilitated psychoeducation about trauma and its effects, and cognitive restructuring to address unhelpful thoughts, beliefs and behaviors related to trauma. In addition to teaching clients to recognize specific PTSD symptoms and how they can exacerbate mental illness symptoms, this model uses cognitive restructuring (CR) to assist clients in challenging and revising distorted beliefs. Stress Inoculation Training (SIT) is used to instill skills for actively managing stress reactions that can exacerbate mental illness or PTSD symptoms. This model does not utilize prolonged exposure, but instead focuses on here-and-now coping skills to assist clients in managing intrusive memories. To obtain the manual, *The Trauma and Recovery Group*, the educational videotape, *Recovery From Trauma*, and for information on training and consultation, contact Kim.T.Mueser@Dartmouth.edu or Stan.Rosenberg@Dartmouth.edu

### **Trauma Safety Drop-In Group: A Clinical Model of Group Treatment for Survivors of Trauma**

Designed by Pat Gilchrist of Ulster County Mental Health and Peri Rainbow of Women's Studies at New Paltz State University of New York, this model provides trauma survivors with basic safety skills. A low-intensity group model that requires no commitment from participants, the group is open to all survivors regardless of diagnosis, level of functioning, and place in the healing process. Goals of the group include increasing the survivor's ability to function and feel safe in a more intensive level of group treatment, to learn about the healing process and the after-effects of trauma, and to assess readiness for further treatment. The drop-in nature of the group is an essential and unique feature. Survivors who are beginning trauma-specific treatment are often not prepared to fulfill the commitment of consistent attendance required by traditional group therapy. The group is structured so that survivors can join at any point and complete the cycle at their own pace. Manuals are available from the New York State Office of Mental Health Trauma Unit at nominal cost from the NYS OMH Printing and Design Services. Their fax number is 518-473-2684.

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