Chapter 4
Incarceration and Trauma: A Challenge for the Mental Health Care Delivery System

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Introduction

More than 11 million people are incarcerated worldwide (Walmsley, 2018). The rates of the incarcerated population vary widely by country with 53% of countries reporting incarceration rates below 150 per 100,000 people and 15 countries reporting rates exceeding 400 per 100,000 people (Walmsley, 2018). The United States has the highest incarceration rate exceeding 650 per 100,000 residents (Bureau of Justice Statistics, 2018; Sawyer & Wagner, 2019; Walmsley, 2018). Since year 2000, the global incarceration rate has increased on pace with the 24% global population increase, with some geographical differences: Europe has decreased their incarcerated population by 22%, while the Oceania region has increased their incarcerated population by 86% (Walmsley, 2018). Although the correctional population in the United States has seen some decline over the past decade (Bureau of Justice Statistics, 2018), the same population has quadrupled since the 1970s and it continues to account for about one quarter of the world's total incarcerated population (National Research Council, 2014).

Racial disparity is apparent in incarceration rates in the United States (National Research Council, 2014; Sawyer & Wagner, 2019). Although incarceration rates for minorities have always been disproportionate to White offenders (National Research Council, 2014), the difference has increased over time. In 2010, African Americans and Hispanics were incarcerated at six to seven times the rates of White offenders (National Research Council, 2014), with African Americans making up approximately 40% of the total incarcerated population (Sawyer & Wagner, 2019).

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Trauma histories are widespread amongst incarcerated individuals. Studies consistently find alarming rates of trauma symptoms and posttraumatic stress disorder (PTSD) in incarcerated individuals (DeHart, Lynch, Belknap, Dass-Brailsford, & Green, 2014; Goff, Rose, Rose, & Purves, 2007; Green, Miranda, Daroowalla, & Siddique, 2005; Greenberg & Rosenheck, 2009; Lynch, DeHart, Belknap, & Green, 2013; Prins, 2014; Wolff, Huening, Shi, & Frueh, 2014), with the trauma event occurring prior to incarceration (Blaauw, Arensman, Kraaij, Winkel, & Bout, 2002; Clements-Nolle, Wolden, & Bargmann-Losche, 2009; Gunter, Chibnall, Antoniak, Philibert, & Black, 2013; Komarovskaya, Booker Loper, Warren, & Jackson, 2011; Maschi, Gibson, Zgoba, & Morgen, 2011; Morrissey, Courtney, & Maschi, 2012; Zgoba, Jennings, Maschi, & Reingle, 2012), though individuals may become further traumatized, or traumatized for the first time, through the conditions in prisons and jails (Beck & Harrison, 2008; Crisanti & Frueh, 2011; National Research Council, 2014; Struckman-Johnson, Struckman-Johnson, Rucker, Bumby, & Donaldson, 1996; Wolff, Blitz, & Shi, 2007). The experience of trauma either prior to or during incarceration is associated with post-release outcomes, including increased recidivism rates (Brennen, 2007; Kubiak, 2004; Morrissey et al., 2012; Zgoba et al., 2012). The consequences of not treating trauma are significant (Clements-Nolle et al., 2009; Kubiak, 2004; Maschi, Viola, & Morgen, 2013; Salina, Lesondak, Razzano, & Weilbaecher, 2007).

The rate of PTSD among incarcerated individuals is significantly higher than in the general population, with research reporting PTSD rates up to 55% (Kubiak, 2004), compared to 3.5% in the general population (APA, 2013). Also, many offenders experience trauma (Komarovskaya et al., 2011) and develop PTSD (Goff et al., 2007) while incarcerated.

The presence of trauma and PTSD has been widely linked to increased risk for mental health problems, including among incarcerated populations. For example, the destabilizing impact of early childhood trauma can make individuals less psychologically equipped to remain resilient when coping with stressors associated with incarceration (e.g., National Research Council, 2014). Inmates with trauma histories are at increased risk for suicide attempts (Blaauw et al., 2002; Clements-Nolle et al., 2009; Gunter et al., 2013; Mandelli, Carli, Roy, Serretti, & Sarchiapone, 2011; Moloney, van den Bergh, & Moller, 2009; National Research Council, 2014), further victimization (Bradley & Davino, 2002; Crisanti & Frueh, 2011), violence (Green et al., 2005; Neller, Denney, Pietz, & Thomlinson, 2006), and other general disciplinary problems while incarcerated (Komarovskaya et al., 2011). Trauma histories may serve as a predictor of incidence and severity of violence in jails and prisons, reflecting a continuation of similar behavior in the community (Neller et al., 2006).

The purpose of this chapter is to provide a comprehensive review of the empirical and theoretical literature that examines the problem of trauma in incarcerated individuals. The focus is on trauma experienced both before and during incarceration, and its impact on post-incarceration. The various types of trauma experience, including sexual, physical, and emotional trauma, as well as the multitude of demographic factors, such as age, ethnicity, gender, and sexual identity, and its impact on

the diverging rates of incarcerations will be critically reviewed. Additionally, the importance of treatment of trauma among incarcerated individuals is examined in the context of different types of interventions, as well as building resilience and psychological well-being. Lastly, the chapter will, in the context of trauma treatment, discuss the challenges the mental health care delivery system faces in adapting and creating new approaches to work within a correctional health care system often fraught with obstacles, while also adapting these new approaches to the larger integrated, continuity-of-care-focused model.

Trauma and Gender Differences

Trauma and Men

There is a disparate gender focus in trauma research among inmates. Anecdotally, trauma and PTSD have been considered more prevalent and problematic in women. However, literature suggests similarly high rates of PTSD for each gender, with male prisoners being exposed to similar degrees of trauma as female prisoners (Prins, 2014). Identifying the ubiquitous magnitude of the problem, Wolff et al. (2014) concluded that "trauma was a universal experience" for incarcerated men (p. 715).

Studies (Table 4.1) examining the incidence of trauma and PTSD among incarcerated men consistently find rates much higher than among the general population where 1.8% of men meet criteria for current PTSD (symptoms within the past 12 months; Harvard Medical School, 2007a) and 3.6% meet criteria for lifetime PTSD (symptoms at any time during a lifetime; Harvard Medical School, 2007b). Beyond the high rates of diagnosable PTSD, the rates of any trauma exposure are often much higher (Table 4.2), though not always. Disparity of reported trauma rates exist in the literature, with a relative low rate of 35% for at least one lifetime traumatic event in a sample of incarcerated men (Gibson et al., 1999), to rates as high as 96% of surveyed incarcerated men experiencing or witnessing trauma (Neller et al., 2006). Research suggests that many incarcerated men experience their first traumatic event as a teenager, with trauma-related symptoms lasting over a decade following the event (Gibson et al., 1999). One study described incarcerated men's history of traumatic events as "violent, interpersonal, sudden and life threatening" (Wolff et al., 2014, p. 716). Compared to some community samples, incarcerated men tend to have higher rates of assault victimization (96% in one study) and rape histories (Gibson et al., 1999; Wolff et al., 2014) (Tables 4.1 and 4.2).

Incarcerated men exposed to trauma or diagnosed with PTSD are likely to experience comorbid mental health problems, including major depressive disorder, obsessive compulsive disorder, and generalized anxiety disorder (Gibson et al., 1999; Wolff et al., 2014). Trauma and incarceration are also associated with higher incidence of aggression in men. Sarchiapone, Carli, Cuomo, Marchetti, and Roy (2009)

Table 4.1 Studies reporting on current and lifetime posttraumatic stress disorder (PTSD)[a] rates among incarcerated men and women

Study	*N*	Gender	Sample description	Current PTSD[b]	Lifetime PTSD[c]
Gibson et al. (1999)	213	Men	Randomly selected men in jails (n = 95) and prison (n = 118) in rural New England	21%	33%
Lynch et al. (2013)	491	Women	Randomly selected women in rural and urban jails from four geographic regions in the U.S.	28%	53%
Hutton et al. (2001)	177	Women	Volunteer sample of women in a minimum- to maximum-security prison in Maryland	15%	33%
DeHart et al. (2014)	115	Women	Randomly selected women in jail from four geographic regions in the U.S.	**	51%
Green et al. (2005)	100	Women	Convenience sample of female inmates in jail in Maryland	22%	**
Salina et al. (2007)	283	Women	Women with co-occurring disorders on a specialized treatment program in prison in Washington state	**	75%
Komarovskaya et al. (2011)	239	Men (125) and Women (114)	Randomly selected men and women in prisons in a Midwestern state	**	12.5% (men) 40.2% (women)
Kubiak (2004)	199	Men (139) and Women (60)	Volunteer sample of men and women in prison in a residential substance abuse treatment program	**	53% (men) 60% (women)

Notes. ** Rate not examined in study

[a]Studies were using DSM-III (Gibson et al., 1999), DSM-IV (DeHart et al., 2014; Green et al., 2005; Hutton et al., 2001; Lynch et al., 2013; Salina et al., 2007), or DSM-IV-TR (Komarovskaya et al., 2011; Kubiak, 2004) criteria

[b]Current PTSD refers to individuals who have experienced symptoms within the past 6 or 12 months. Not all studies specify what timeframe "current" refers to

[c]Lifetime PTSD refers to individuals who have experienced symptoms at any point during their life

found that high levels of lifetime aggression among male prisoners were linked to higher trauma scores. This, in turn, is concerning, as increased risk for violence perpetration impacts behaviors associated with criminal conduct. Also, individuals who are exhibiting trauma-associated aggression are likely to have difficulty adjusting to the correctional environment and trauma can serve as a predictor of who tends to exhibit violence while incarcerated, though having a diagnosis of PTSD may mediate this relationship (Sarchiapone, Carli, Cuomo, et al., 2009).

Not all studies have found a clear association between trauma, aggression, and other behavioral problems. Cuomo, Sarchiapone, Di Giannantonio, Mancini, and Roy (2008) examined the relationship between trauma, aggression, personality traits,

Table 4.2 Studies reporting on any history of trauma exposure[a] among incarcerated men and women

Study	*N*	Gender	Sample description	Any trauma history
Gibson et al. (1999)	213	Men	Randomly selected men in jails ($n = 95$) and prison ($n = 118$) in rural New England	35%
Neller et al. (2006)	93	Men	Convenience sample of men from a maximum-security detention center in the Midwest	96%
Wolff et al. (2014)	269	Men	Randomly selected men in a high-security prison in Pennsylvania	96%
Green et al. (2005)	100	Women	Convenience sample of women in jail in Maryland	98%
Bradley and Davino (2002)	65	Women	Randomly selected and volunteer sample of women in a medium-security prison in a southeastern state	95%
DeHart et al. (2014)	115	Women	Randomly selected women in jail from four geographic regions in the U.S.	86%

[a]Any trauma history includes the nine trauma events from the Diagnostic Interview Schedule for the DSM-III-R (Gibson et al., 1999), experiencing or witnessing 11 types of trauma from the Trauma Events Questionnaire (Neller et al., 2006), 24 life-threatening or traumatizing experiences from the Trauma History Questionnaire (Wolff et al., 2014), 12 categories of trauma from the trauma screening measure from the National Comorbidity Survey (Green et al., 2005), sexual violence or physical abuse as measured by the Conflict Tactics Scale (Bradley & Davino, 2002), and any sexual violence history (DeHart et al., 2014)

and substance abuse in male prisoners. Interestingly, they found no overall trauma difference between the total sample and a subsample of male prisoners abusing substances. However, those with substance abuse problems were more likely to report experiences of emotional abuse and physical neglect as children.

Trauma and Women

An abundance of research has examined trauma and PTSD in incarcerated women. Studies find high rates of female inmates meeting current criteria for PTSD and/or lifetime criteria for PTSD (see Table 4.1), and rates are significantly higher than reported rates among the general population where 5.2% meet current criteria for PTSD (Harvard Medical School, 2007a) and 9.7% meet lifetime criteria (Harvard Medical School, 2007b).

Additionally, and similarly to findings in male inmates, the prevalence of any trauma exposure among incarcerated women is high (Table 4.2). Research shows that the majority of incarcerated women experience trauma as both a child and an adult, with the most common types being intimate partner violence (Green et al., 2005) and sexual and physical abuse (Bradley & Davino, 2002; DeHart et al., 2014). When considering histories of sexual abuse in female prisoners, prevalence rates are

proportionally significantly higher compared to community samples of women (Bradley & Davino, 2002; DeHart et al., 2014). The presence of trauma in incarcerated women is also associated with a multitude of other problems (Hutton et al., 2001; Lynch et al., 2013), and the psychological and behavioral impact only increases with cumulative trauma (Messina & Grella, 2006). Messina and Grella (2006) found that the presence of five or more childhood adverse experiences was associated with a myriad of medical, substance use, and behavioral issues in a convenience sample of 500 incarcerated women involved in a prison-based substance abuse program. A higher number of childhood adverse experiences were associated with earlier involvement in drug use, criminal behavior, and more arrests. Furthermore, higher numbers of childhood adverse experiences were associated with adolescent conduct problems, homelessness, drug and alcohol problems, and higher likelihood of involvement in prostitution, having eating disorders, increased rates of sexually transmitted diseases, and overall gynecological problems. Additionally, Messina and Grella (2006) reported that these women were more likely to have previous mental health and substance abuse treatment.

A high rate of problematic substance abuse among female inmates with trauma histories is a common finding in the literature (Driessen, Schroeder, Widman, Schonfeld, & Schneider, 2006). For these women, the abuse of substances may serve several purposes, including a means to self-medicate and numb the emotional distress related to past trauma experiences (Brady, 2001; Khantzian, 1985; Quina & Brown, 2007). Similar to male inmates, substance abuse among female inmates may, in itself, increase the risk of incarceration for drug-related offenses and behavior associated with unlawfully obtaining illicit or prescription drugs.

Risky sexual behaviors among incarcerated women, and subsequent health concerns, have been linked to trauma and a diagnosis of PTSD. Studies show that women with PTSD or trauma histories are more likely to engage in risky sexual practices, such as prostitution or being less likely to practice safe sex and use a condom, which increase their risk for exposure to sexually transmitted infections and diseases, along with higher risk for experiencing further trauma (Green et al., 2005; Hutton et al., 2001; Messina & Grella, 2006; Salina et al., 2007).

A less researched area is the effects of trauma experiences on parenting skills. Women with trauma histories tend to have poor parenting skills (Green et al., 2005). Poor parenting may increase the risk of further violence exposure on children, resulting in higher likelihood of trauma, and perpetuating a cycle of incarceration. There is also evidence of an intergenerational transference of trauma (Lev-Wiesel, 2007; Schwerdtfeger & Goff, 2007). The negative influence of trauma on parenting skills and parent–child attachment in mothers can result in the children not only inheriting trauma-altered genes, but the children also experience their own trauma through maltreatment, neglect, and other forms of abuse. Thereby, the cycle of criminal behavior and incarceration is ongoing. Evidence suggests a similar route of transmission for fathers (Dekel & Goldblatt, 2008).

Gender Differences

In the general population, women experience PTSD at twice the rate of men (APA, 2013). This difference is smaller and more complicated for incarcerated men and women where gender differences exist in the experience of and coping with trauma, as well as the development of PTSD (Miller & Najavits, 2012). Men tend to exhibit externalizing behaviors as a reaction to trauma through substance use, violence, and crime, while women tend to exhibit internalizing behaviors to trauma through self-injurious behaviors, eating disorders, and avoidance. Additionally, incarcerated men are more likely to experience interpersonal nonsexual trauma and witnessing harm, while women tend to experience interpersonal sexual trauma (Komarovskaya et al., 2011). For other forms of trauma, such as physical neglect, witnessing family violence, and separation from caregivers, there are limited gender differences (Messina, Grella, Burdon, & Prendergast, 2007).

Some studies show that men are exposed to more traumatic events as a child or adolescent than women (Komarovskaya et al., 2011), while other studies find that men experience more traumatic events in the 12 months preceding study participation (Kubiak, 2004). Conversely, research indicates greater repeated episodes of trauma and more trauma-related symptoms in women compared to men (Komarovskaya et al., 2011; Kubiak, 2004). These gender differences may result in disparate negative developmental trajectories that contribute to a myriad of mental health, substance use, and conduct problems. In fact, research suggests that predictors of symptom severity vary based on gender, with nonsexual trauma for men and sexual trauma for women predicting higher levels of symptom severity (Komarovskaya et al., 2011). In men, the early nonsexual trauma influences the development of conduct problems, along with exposure to further violence as an adolescent (Komarovskaya et al., 2011). In women, who experience more sexual trauma at all stages of life (Komarovskaya et al., 2011; Messina et al., 2007), repeated exposure to sexually traumatizing events, along with other forms of trauma, has a negative effect, with more childhood adverse experiences being associated with early onset of and more extensive mental health history, as well as more serious problems with drugs and crime (Messina et al., 2007).

Concerns have been raised about the accuracy of gender differences in trauma experiences among incarcerated individuals. Many studies rely on self-reported trauma history and symptoms, which may be biased based on how questions are worded (Crisanti & Frueh, 2011), failure to remember incidents of trauma (Gibson et al., 1999), unwillingness to disclose trauma to correctional staff (Grella & Greenwell, 2007), or not considering the experience as out of the ordinary (Moses, Reed, Mazelis, & D'Ambrosio, 2003). Moreover, findings of higher incidents of trauma among women may be biased by extensively more research on trauma among incarcerated women compared to men (Komarovskaya et al., 2011), misleadingly suggesting that trauma is more prevalent in that population.

Trauma and Unique Populations

Trauma and Incarcerated Older Adults

From 1980 to 2010, the United States experienced an increase of 222% in incarceration rates, much of which has been linked to lengthier prison sentences (National Research Council, 2014). As of 2010, one in nine prisoners faced life sentences and a third of those had no chance of parole. Subsequently, rates of incarcerated older adults—usually defined as individuals 55 years and older—have increased fivefold since 1990 (Aday, 2003). More recently, Carson and Sabol (2016) found that rates of incarcerated older adults increased by 400% from 1993 to 2013. This population now represents the largest-growing segment of prisoners in not only the United States, but in many other countries (Psick, Ahalt, Brown, & Simon, 2017).

As with studies examining younger people, incarcerated older adults appear to experience trauma at greater rates than the general population (Maschi, Morgen, Zgoba, Courtney, & Ristow, 2011). Given the higher probability of longer incarcerations and repeated prison sentences, risk for in-facility trauma is greater. Prior victimization also predicts increased risk for victimization while incarcerated (Morrissey et al., 2012), while trauma experienced while incarcerated may exacerbate old traumas. Incarcerated older adults have been found to have a greater risk for reemergence of trauma-related symptoms compared to younger prisoners (Maschi, Morgen et al., 2011).

Many older adult inmates have experienced at least one type of trauma in their lifetime, often occurring before 16 years of age and commonly a physical or sexual assault (Maschi et al., 2013; Morrissey et al., 2012; Zgoba et al., 2012). There may be less of a cumulative effect for trauma experiences among older inmates, compared to younger inmates, as recent subjective distress appears to have a greater impact on trauma symptoms compared to the number of traumas experienced. Resilience factors and the impact of positive coping may help to stave off negative effects of trauma among older inmates who have been found to report higher rates of well-being (Maschi et al., 2013).

Research contrasting younger and older prisoners shows similarities between the two groups on the experience of physical assault occurring during any stage of life, with older adults having experienced slightly more physical assaults during adolescence (Maschi, Gibson et al., 2011). Also, older adult inmates are more likely to have witnessed a sexual assault and to have lived in a violent neighborhood, while younger inmates are more likely to have witnessed someone physically assaulted and experienced a human-made disaster such as a plane crash (Maschi, Gibson et al., 2011).

Some racial differences among incarcerated older individuals have been found. Older African-American and Hispanics prisoners report significantly lower trauma symptoms, compared to older Caucasian prisoners (Zgoba et al., 2012).

Trauma and Incarcerated Youthful Offenders

Determining accurate and reliable rates of PTSD among incarcerated youth is difficult as many studies have small samples (Abram et al., 2004) or have samples that include *all* justice involved youth (e.g., both incarcerated youth and non-incarcerated criminal justice involved youth), resulting in disparate estimates of PTSD (see Table 4.3). Regardless of these differences, the rates of PTSD, as well as any type of trauma among criminal justice involved youth, are alarming. As noted in Table 4.3, research has found PTSD rates as high as 45.7% among criminal justice involved youth. However, rates of any type of trauma experience are even higher. In a youth detention sample, 92.5% had experienced at least one trauma event, 84% had experienced more than one event, and 56.8% had experienced six or more events (Abram et al., 2004). In a nationally representative sample of criminal justice-involved youth, 90% had experienced multiple forms of trauma events, with

Table 4.3 Studies reporting on current posttraumatic stress disorder (PTSD)[a] rates among justice-involved youth

Study	*N*	Gender	Sample description	Current PTSD[b]
Dierkhising et al. (2013)	658	Boys (355) and Girls (303)	A national sample of adolescents, 13–18 years, referred for trauma-focused treatment and who had criminal justice system contact within the last 30 days	23.6%
Abram et al. (2004)	898	Boys (532) and Girls (366)	Randomly selected youth, aged 10–18 years, incarcerated in a youth detention center in Cook County, Illinois	11.2%
Ford, Hartman, Hawke, and Chapman (2008)	264	Boys (193) and Girls (71)	Youths aged 10–17 years admitted to a pretrial juvenile detention center in the State of Connecticut.	5%
Wasserman and McReynolds (2011)	9819	Boys (5201) and Girls (4618)	Youth (average age 16 years) entering a juvenile justice agency (e.g., probation or family court intake, detention centers or correctional facility) from 57 sites in 19 states	3.7%
Rosenberg et al. (2014)	350	Boys (262) and Girls (83)	Youth aged 11–17 years who were incarcerated, in a residential treatment facility or involved in family court in New Hampshire (n = 269) and Stark County, Ohio (n = 81)	45.7%

[a]Studies were using DSM-IV (Abram et al., 2004; Rosenberg et al., 2014; Wasserman & McReynolds, 2011), DSM-IV-R (Ford et al., 2008), or DSM-IV-TR (Dierkhising et al., 2013) criteria

[b]Current PTSD refers to individuals who have experienced symptoms within the past month (Ford et al., 2008; Dierkhising et al., 2013; Rosenberg et al., 2014; Wasserman & McReynolds, 2011) or 12 months (Abram et al., 2004)

an average of almost five different events of trauma, including a significant loss or separation from a caregiver (61.2%), domestic violence (51.6%), and physical abuse (38.6%; Dierkhising et al., 2013) (Table 4.3).

Few studies on incarcerated youth have focused on the age of trauma exposure. Dierkhising et al. (2013) reported that a third of their national sample of criminal justice involved youth had been exposed to a traumatic event within the first year of their life as reported by a caregiver. By 5 years of age, 62.14% of the sample had been exposed to at least one trauma event, while a third had experienced multiple trauma events. In another sample of incarcerated youth, most participants had experienced their worst traumatic event in the past 2 years prior to the study and age of trauma onset was associated with more severe traumatic events among incarcerated girls, while it was associated with higher numbers of traumatic events and more externalizing and internalizing problems in both girls and boys (Abram et al., 2004).

Trauma and Veterans

A 2012 report from the U.S. Department of Justice found that veterans accounted for about 8% of the total prison population in the United States (Bronson, Carson, Noonan, & Berzofskym, 2015). This is a substantial decrease from 24% in 1978, corresponding with less military veterans in the general population. Only a minority of the incarcerated veterans has seen combat (25% in prison and 31% in jail; Bronson et al., 2015).

The rate of PTSD among incarcerated veterans is much higher than in the general population (Greenberg & Rosenheck, 2009; Saxon et al., 2001). Saxon et al. (2001) found that 39% of incarcerated veterans met criteria for PTSD and most of the sample had experienced at least one traumatic event (87%). The most common precipitating event to developing PTSD was seeing someone badly injured or killed, and those with PTSD tended to have a myriad of other problems as well, including a wider variety of traumas, more substance use problems, more psychiatric problems, worse health, and a more severe legal history (Saxon et al., 2001). While Saxon et al. (2001) noted that these veterans had PTSD rates similar to other incarcerated individuals, Bronson et al. (2015) found in a separate national sample of veterans twice the rate of PTSD among incarcerated veterans (23%), compared to incarcerated non-veterans (11%).

While the rate of PTSD is high among incarcerated veterans, trauma may not necessarily be the causative factor in arrest and incarceration. In a sample of non-incarcerated veterans, those who met criteria for PTSD and reported problems with anger and irritability were more likely to have more criminal arrests than those with only PTSD, while combat exposure was not found to be a significant predictor of criminal arrest (Elbogen et al., 2012). Military experience and related trauma may play less of a role in criminal behavior as compared to other common risk factors, such as drug abuse, exposure to domestic violence, and younger age.

Trauma and Sex Offenders

Individuals who commit sexual offenses tend to have been exposed to multiple childhood adverse experiences, including victimization, at rates much higher than the general population and even other offenders (Levenson & Socia, 2016; Levenson, Willis, & Prescott, 2014). In one study, 45% of sex offenders reported four or more childhood adverse experiences, compared to only 12.5% in the general population (Levenson & Socia, 2016). Also, sex offenders often have high rates of physical and sexual abuse as children (Morrissey et al., 2012; Weeks & Widom, 1998), with one study revealing three times the rate of sexual abuse and two times the rate of physical abuse among sex offenders compared to other offenders (Levenson et al., 2014). Another study of only incarcerated female sexual offenders reported that 69% of the participants had been sexually abused and 57% had been physically abused as a child (Turner, Miller, & Henderson, 2008).

Consistent with findings among other populations, childhood traumas in sex offenders, combined with the negative cumulative effects of other risk factors, are associated with broad criminal behaviors, not only sexual offending, as well as subsequent incarceration (Levenson & Socia, 2016). Among incarcerated sex offenders, emotional neglect from mothers has been associated with intrafamilial child molesters, while unsympathetic and abusive fathers have been linked to stranger rapists (Smallbone & Dadds, 1998). Research suggests that various risk factors, such as insecure childhood attachments, interpersonal deficits, and emotional dysregulation, are related to deviant sexual behavior, in which certain combinations of traumatic childhood experiences may relate more specifically to different kinds of sexual offending (Levenson & Socia, 2016; Smallbone & Dadds, 1998).

Trauma During Incarceration

Much has been written about whether the experience of incarceration is inherently traumatic (National Research Council, 2014). Bonta and Gendreau (1990) concluded that the experience of incarceration is not in itself necessarily traumatic. However, there are certain risk factors that may place some individuals at higher risk for victimization and traumatization. Further, harsher prison environments may increase risk for negative outcomes. For example, policy changes through the 1980s and beyond led to the creation of more maximum-security conditions and the advent of "supermax" facilities (National Research Council, 2014). These settings established a more punitive approach to incarceration that emphasized dehumanization and isolation. Some states, like Arizona, have passed specific legislation that arguably increases the harshness of the prison environment by reducing programming and using attack dogs to extract prisoners (Lynch, 2010).

Research has reported that the experience of incarceration may exacerbate existing trauma or cause trauma for prisoners (Miller & Najavits, 2012; Moloney et al., 2009 ; National Research Council, 2014). A literature review found rates

ranging from 4% to 21.4% for PTSD developed during incarceration among prisoners across the world (Goff et al., 2007), while other research emphasizes higher rates of incarceration-related PTSD in the United States compared to the rest of the world (National Research Council, 2014).

Studying the exposure of trauma that develops over the course of incarceration is rife with challenges. Often, there is a wide disparity between official reports of abuse versus inmate self-report, which creates challenges for accuracy and reliability (Byrne, 2011). Inmates may be reluctant to reveal incidents of trauma for multiple reasons, including a lack of trust in clinical staff (Grella & Greenwell, 2007; Struckman-Johnson et al., 1996), they may consider their experiences as normal (Moses et al., 2003), reluctance to "snitch" on staff or other inmates, and concerns about negative stereotypes or judgment (e.g., it is unmanly to reveal vulnerability; Goff et al., 2007). Some inmates may fail or be reluctant to disclose trauma in order to hide their sexual identity or hide psychiatric symptoms to avoid unwanted attention (Miller & Najavits, 2012).

Gibson et al. (1999) raised the possibility of underreporting of sexual assaults during incarceration. In their prison sample, 50% of the respondents indicated that the first time they reported sexual victimization was at the time of the study survey. Only 29% of the sample reported a sexual assault to the prison administration. Also, the accuracy of sexual victimization rates may differ based on instruments used to measure trauma-related symptoms, as well as the skill level of the assessors (Goff et al., 2007).

Gender differences is a major concern, especially since the United States correctional system is designed on a male model, and incarcerated women may be particularly vulnerable to trauma in these settings (Moloney et al., 2009). By design, the system may recreate aspects of past abuse, including elements of power and control, humiliation, and lack of privacy (Moloney et al., 2009; National Research Council, 2014). Women (and men) with trauma histories are more vulnerable to re-experience trauma in a correctional system (Miller & Najavits, 2012) and research suggests that past trauma experiences can weaken a woman's resilience and ability to cope with the stressors associated with incarceration, including interacting with male staff (Gilfus, 2002; Moloney et al., 2009; Van Voorhis, Salisbury, Wright, & Bauman, 2008).

Research on incarcerated women in female correctional settings has shown that there are fewer services available compared to male correctional settings, including services that specifically address the unique medical needs of women (Moloney et al., 2009). Further, preexisting trauma histories may interfere with women's ability to benefit from these programs, when offered (Miller & Najavits, 2012).

Despite the increased risk for victimization within a correctional facility, some research has pointed out that women are actually less likely to be victimized in prison compared to the community (Loper, 2002; Miller & Najavits, 2012). In fact, some studies show that women feel subjectively *safer* in the prison environment than in the community (Bradley & Davino, 2002;Loper, 2002 ; Miller & Najavits, 2012). Bradley and Davino (2002) described that while a portion of their sample of incarcerated women believed that prison was safer, they did not prefer incarceration over freedom. Further, it is important to note that the perception of *safer* is not equal

to *safe*. Many incarcerated women have a global perspective that the world is unsafe, including prison. However, women with histories of sexual and physical abuse as a child or adult perceive no environment as safer, including prison (Bradley & Davino, 2002).

In contrast, men encounter higher risk of victimization while incarcerated than in the community (Miller & Najavits, 2012). In a self-report study, men were more likely to have been exposed to trauma during incarceration than women who were more likely to be exposed prior to incarceration (Kubiak, 2004).

One may question whether general exposure to a correctional environment can cause trauma symptoms, or whether one has to experience an actual traumatic event in prison before symptoms of PTSD are evident. Results of one study suggest that development of trauma-related symptoms is more likely to be associated with actual trauma exposure during incarceration than simply being in a general prison environment (Kubiak, 2004). Also, other factors associated with an oppressive and punitive prison environment may serve as triggers to already vulnerable individuals, who will repeat dysfunctional patterns already long present in their life (Miller & Najavits, 2012). Studies appear to confirm that punitive measures to address behavioral concerns are largely ineffective (Andrews, Bonta, & Hoge, 1990; Landenberger & Lipsey, 2005). Experts argue that the punitive approach in the criminal justice system has led to "a wide range of social costs" and has had a "highly uncertain" effect on reducing crime while doing little to act as a deterrent (National Research Council, 2014, p. 339).

Sexual Victimization During Incarceration

Data from the U.S. Bureau for Justice Statistics on 80,600 incarcerated people indicate that 4% of prison inmates and 3.2% of jail inmates have experienced in-facility sexual victimization (Beck, Berzofsky, Caspar, & Krebs, 2014). Further, 2% of inmates and 2.4% of staff were reported to be perpetrators. A small number of victims (0.4%) were perpetrated by both inmates and staff. In a gender comparison study, rates for inmate-to-inmate sexual victimization were higher for women than men (Beck et al., 2014). This study also found that the rate of sexual victimization in prisons has decreased from 2007 (4.5%) to 2012 (4%), while rates remained steady for jails (Beck et al., 2014).

Rates of sexual victimization vary based on demographic variables and instrumentation differences (e.g., wording of questions; Wolff, Blitz, Shi, Bachman, & Siegel, 2006). For example, studies that average rates of sexual victimization and limit analysis to particular types of sexual victimization may leave out important and crucial data (Beck et al., 2014; Wolff et al., 2006). Moreover, inadequate designs of surveys or other instrumentation limitations may set limits on perceptions of victimization severity and associated problems. One study noted that some respondents actually added higher rating items to their Likert scales (Struckman-Johnson et al., 1996).

Sexual victimization in female correctional facilities is greater than in most male facilities (Beck et al., 2014; Wolff et al., 2006), though there are conflicting reports

(Struckman-Johnson et al., 1996). Struckman-Johnson et al.'s (1996) sample of incarcerated men and women reported sexual victimization rates of 22% and 7%, respectively.

Research has speculated that male correctional officers may use their position of authority or otherwise use frisk requirements or room searches as opportunities to sexually assault women. While some sources suggest that women's greatest risk comes from male correctional officers (Human Rights Watch, 1996), other data suggest that there may be an even greater risk from other inmates (Beck et al., 2014; Wolff et al., 2006). Wolff et al. (2006) found that the rate of inmate-to-inmate sexual victimization was two times higher in female correctional facilities than in male facilities. Women with histories of being the victim of domestic violence or sexual assault are at increased risk for sexual violence while incarcerated (Beck et al., 2014; Human Rights Watch, 1996). Other vulnerable individuals include lesbian and transgendered prisoners, along with women who have attempted to shed light on the abuses that are occurring (Human Rights Watch, 1996). A U.S. Bureau of Justice Statistics report (Beck et al., 2014) found much higher rates of sexual victimization between non-heterosexual inmates, with rates of 12.2% for prison inmates and 5.4% for jail inmates.

Surveys of inmates and staff within correctional facilities find similar reported rates of pressured and forced sexual contact compared to officially reported incidents (approximately 20%; Struckman-Johnson et al., 1996). These findings illustrate that both inmates and staff are aware of sexual victimization occurring in correctional settings. Individuals who are sexually assaulted in a correctional facility are prone to becoming victimized multiple times and research has found that some victims are victimized by up to four different perpetrators (Struckman-Johnson et al., 1996). Men may be at higher risk of "gang rape" compared to women, with most offenders being male and the most severe incidents (e.g., forced rape) being perpetrated by another inmate about half the time and prison staff about 20% of the time (Struckman-Johnson et al., 1996). Vulnerability factors for sexual victimization include being older, white, bisexual, a sex offender, and an inmate with a longer prison sentence (Beck et al., 2014; National Institute of Corrections, 2007; Struckman-Johnson et al., 1996).

The magnitude and consequence of sexual victimization in correctional settings are a major concern that results in increased risk for a variety of medical and mental health problems (Wolff et al., 2006), including depression and suicidal ideation (Struckman-Johnson et al., 1996). Moreover, considering research findings on long-term effects, the trauma related to sexual victimization is likely to increase the risk for criminal recidivism.

Serious Mental Illness and Trauma During Incarceration

Serious mental illness is more prevalent in jails and prisons than in the general population, with some reports indicating that the rate of seriously mentally ill inmates is somewhere between 15% and 20%, if not higher (Treatment Advocacy

Center, 2016). Moreover, adding to the complexity, the proportion of seriously mentally ill inmates to other inmates has grown at a troublesome rate over the past couple of decades, bringing with it challenges to both administrators and treatment providers who work in a system not built to house and treat large populations of seriously mentally ill individuals.

There is a dearth of research on the victimization of seriously mentally ill inmates and exact rates of victimization are difficult to determine (Crisanti & Frueh, 2011). Extant research reports that incarcerated individuals with serious mental illness experience higher rates of sexual violence (Wolff et al., 2007) and physical assaults than other inmates (Blitz, Wolff, & Shi, 2008). Understanding the extent of psychological and other problems among the incarcerated mentally ill is complicated by factors unique to these individuals. For example, compared to non-mentally ill inmates, individuals with serious mental illness may be more distrustful of staff, not know how to report problems, or may experience acute psychiatric symptoms that interfere with their ability to report problems, all contributing to underreporting of trauma (Crisanti & Frueh, 2011). One study speculated that among inmates who refused to participate in a survey was a subset of individuals with paranoid schizophrenia (Treatment Advocacy Center, 2016). Crisanti and Frueh (2011) concluded that while actual rates remain unclear, people diagnosed with serious mental illness are at an increased risk for any type of victimization in jails and prisons, compared to other non-mentally ill incarcerated individuals.

Trauma and Suicide During Incarceration

A number of studies have highlighted the association between trauma and increased risk of suicide attempts among people who are incarcerated (Blaauw et al., 2002; Mandelli et al., 2011; Sarchiapone, Carli, Di Giannantonio, & Roy, 2009; Sarchiapone, Jovanović, Roy, et al., 2009). Suicidal behavior is often a result of a multitude of problems that can develop as a direct consequence of not being able to cope with a traumatic experience or as a means to escape ongoing trauma occurring in a correctional facility (National Research Council, 2014).

Inmates who exhibit suicidal behaviors typically have more traumatic life events, such as sexual abuse, physical and emotional maltreatment, abandonment and suicide attempts of significant others, than those without suicide histories (Blaauw et al., 2002; Clements-Nolle et al., 2009). Additionally, disruption of interpersonal social networks early in life (Blaauw et al., 2002) and cumulative effects of negative life events occurring in all phases of life (Clements-Nolle et al., 2009) have been associated with higher levels of suicide risk. A link between childhood trauma and suicidal behavior has also been established in Italian prisoners (Mandelli et al., 2011; Sarchiapone, Jovanović, Roy, et al., 2009) and findings indicate that, with the exception of sexual abuse, all forms of trauma are associated with younger age of first suicide attempt (Mandelli et al., 2011). Sexual abuse is associated with an increased risk for repeated suicide attempts (Mandelli et al., 2011), which is consis-

tent with other research showing that about a third of victims of sexual assault in prison experience suicidal ideation (Struckman-Johnson et al., 1996).

There is limited research on trauma and personality risk factors among inmates presenting with suicidal behavior. However, consistent with other literature on personality traits (Brezo, Paris, & Turecki, 2006), personality features such as trait-level impulsive aggression, overall aggression, and neuroticism have been linked to suicidal behavior among inmates (Sarchiapone, Carli, Di Giannantonio, & Roy, 2009). Though traumatic experiences are likely to exacerbate problematic personality features, more research is warranted to determine the specific link between trauma, personality traits, and suicidal behavior in inmates.

Impact of Trauma

Trauma and Increased Incarceration Risk

Exposure to trauma, particularly repeated exposure, starting at an early age has clear implications on the development of emotional regulation systems in the brain and increased risks for impulsivity and aggression (e.g., Braquehais, Oquendo, Baca-Garcia, & Sher, 2010; Mandelli et al., 2011; Morrissey et al., 2012; Sergentanis et al., 2014). Problems regulating emotions and disruptions in the behavioral disinhibition system increase risk for impulsive behaviors, which in turn may contribute to engaging in risky behavior and novelty seeking, thus resulting in drug use (Sergentanis et al., 2014) and other conduct problems. Long-term, these individuals are more likely to engage in criminal behaviors that result in incarceration. Underlying neurobiological alterations caused by early trauma also increase the risk for developing psychopathology (Teicher, Andersen, Polcari, Anderson, & Navalta, 2002).

While incarcerated women have high rates of trauma, determination of a causal relationship is difficult. Does trauma increase risk of incarceration or are other mediating variables responsible? Widom (2000) found that women who were abused as children were twice as likely to be arrested. However, DeHart et al. (2014) did not find that a PTSD diagnosis was predictive of any type of offending. Instead, DeHart et al. (2014) described that some forms of abuse were more frequently associated with certain types of offending. For example, the experience of intimate partner violence was associated with property crime, drug offending, and prostitution, whereas witnessing violence was associated with property crime, violence, and use of weapons (DeHart et al., 2014). In examining the trajectory of trauma to incarceration, Lynch et al. (2013) speculated that child and adult trauma histories result in an exacerbation of mental health problems, which subsequently, but not necessarily directly, elevates the risk for increased legal involvement. In other words, trauma in itself may not have a causative effect on the commission of crime leading to incarceration; however, it may lead to development of other associated psychological, personality and social problems that can have an impact on criminal

behavior. For example, a woman may flee abuse as a teenager, putting her at risk for homelessness and stress, which increases substance abuse risk (Covington & Bloom, 2007; Tompsett, Domoff, & Toro, 2013). In turn, they may engage in risky behaviors that lead to criminal offending (Harris & Fallot, 2001). Some research indicates an intricate link between women with sexual abuse histories and criminal behaviors (Brennen, 2007) and arrests (Hubbard, 2002).

Trauma and Recidivism

The exact relationship between recidivism and trauma is complex, especially considering that trauma may have occurred before, during, and after an incarceration. Also, as explored above, traumatic events that occur while incarcerated may exacerbate existing trauma problems. Since women tend to experience more trauma in the community, re-entering the community may mean continued risk of exposure to further trauma or reminders of past trauma, which may increase their risk for returning to behaviors that resulted in incarceration previously (Kubiak, 2004).

Whether a diagnosis of PTSD in itself accounts for a higher risk for recidivism is unclear. One study found that a greater portion of men with PTSD recidivated (17%) compared to men without such a diagnosis (6%); however, the difference was not statistically significant (Kubiak, 2004). Conversely, findings from the same study showed that women without a PTSD diagnosis were more likely to recidivate than those with a PTSD diagnosis (Kubiak, 2004). Those with a PTSD diagnosis, however, had a higher likelihood of a drug relapse after incarceration. Kubiak (2004) surmised that the trauma symptoms act as a destabilizing factor, thus increasing the risk for future drug use. This hypothesis is consistent with reports from other literature (e.g., Najavits, Gastfriend, & Barber, 1998; Najavits, Weiss, & Shaw, 1997; Ouimette, Brown, & Najavits, 1998) suggesting that the use of drugs serves a self-medicating role for trauma symptoms, while also resulting in behaviors that increase the risk for re-incarceration.

Treatment and Management of Trauma in Incarcerated Populations

Addressing preexisting trauma, along with traumatic experiences during incarceration, presents significant challenges for mental health professionals in correctional settings. As reviewed above, it is essential to consider a host of complex factors in implementing any form of treatment to incarcerated individuals with trauma-related symptoms. For example, mental health professionals must consider issues related to gender, race, age, veteran status, presence of serious mental illness, and substance abuse, among other factors. A one-size-fits-all approach to treating trauma is likely to be inadequate. Furthermore, failing to address and treat trauma can result in

higher lethality risk, disciplinary problems, vulnerability to further victimization, worsening of clinical symptoms, and increased risk for recidivism. Appropriate treatment of trauma-related symptoms, including targeting factors associated with increased suicide risk while incarcerated and after, through skill and resilience-building, has been linked to a reduction in recidivism and suicide risk (Blaauw et al., 2002; Clements-Nolle et al., 2009; Zgoba et al., 2012). Thus, substantial resource allocation toward the treatment and prevention of trauma may have significant benefits, especially long term. However, obtaining valuable resources needed to offer additional programming that targets trauma-related issues is a challenge, given the current sparse resources available for mental health care in the correctional system.

An important aspect of treatment to consider is the negative impact trauma may have on the treatment of other problems (Salina et al., 2007). For example, the success of substance abuse treatment may be negatively impacted by a history of trauma. Similarly, Miller and Najavits (2012) noted that the efficacy of cognitive behavioral treatment may be affected by active trauma symptoms. Trauma-informed care has been highlighted as essential in any programming offered to inmates; however, it is particularly difficult to attain in a correctional setting (Miller & Najavits, 2012).

Inmates with serious mental illness pose multiple additional issues for treatment. For example, it is well known that many of these individuals have histories of trauma that need treatment attention; however, they are also susceptible to victimization which should be another goal of treatment and programming to reduce or minimize this risk (Crisanti & Frueh, 2011), along with strengthening psychological health and well-being (Leidenfrost et al., 2016).

Not surprisingly, it is crucial to identify trauma experiences and symptoms of PTSD early in incarcerated youth. In fact, incarceration may serve as an opportunity for early intervention and treatment, which should occur with proper assessment and development of appropriate treatment planning. It is important that detention facilities work to avoid further traumatizing these youth. Thus, placing youth in facilities designed and modeled after adult correctional environment, or with adult male inmates, may have detrimental effects.

Identification of trauma starts with initial admission and screening procedures. A high number of prisons and jails inadequately screen for trauma histories or are not asking about it at all (Maschi, Morgen et al., 2011), let alone taking a gender-sensitive approach. Staff who are conducting mental health and trauma screens should have education about how to assess for trauma, including being able to consider individual differences in presentation, and they should be trauma-informed trained, which includes a comprehensive understanding of how trauma may impact an inmate's presentation in the correctional facility.

Mental health professionals involved in admission and screening assessment may also need to confront personal attitudes about the danger of addressing trauma in correctional setting and beliefs that it is unsafe, since it has been shown that the cost of not addressing trauma-related problems is too great (Miller & Najavits, 2012). At the same time, "delivering these services in an environment that is known for being predatory, harsh, and violent will require sensitivity to privacy, confidentiality, and safety" (Wolff et al., 2014, p. 718).

Mental health professionals have steep obstacles to overcome in order to be able to effectively treat trauma in incarcerated men and women. Treatment of trauma should focus on both short- and-long term aspects of trauma (Maschi et al., 2013). Trauma treatment that focuses more on present aspects of treatment (e.g., active coping, addressing current emotions), versus the past, may offer the best way to provide treatment in a "safe" manner (Miller & Najavits, 2012). Although exposure techniques have been found to be effective in certain populations, it is likely better to avoid exposure interventions in a correctional setting to avoid re-traumatizing and destabilizing people, and instead there should be a focus on improving coping skills (Maschi et al., 2013).

Unfortunately, staff, including mental health staff, may be woefully unprepared to address trauma among incarcerated offenders. As has been discussed throughout this chapter, it is abundantly clear that an overwhelming number of inmates have experienced various degrees of trauma. Without proper training and supervision, working with populations with such overwhelming trauma histories may leave staff susceptible to developing vicarious trauma (Miller & Najavits, 2012). Staff may require diverse and extensive training to become equipped to address trauma. Any efforts to affect institutional change, such as implementing trauma-informed approaches and programming, require substantial buy-in from correctional administration and staff (Miller & Najavits, 2012).

Extant literature acknowledges that treating trauma in incarcerated populations is crucial. Most of the literature on treatment, however, focuses on women, while there is a dearth of studies on treatment programming in incarcerated men. There is also a paucity of studies on treatment modalities available for older adults and ethnically diverse populations (Maschi et al., 2013). While various treatment modalities exist that are designed for delivering treatment for trauma in the community (e.g., eye movement desensitization and reprocessing, and the Sanctuary Model), caution should be made in assuming that these interventions will translate to the unique needs of a correctional environment. Also, limited assumptions can be made that treatments developed for younger people will translate to the needs of older adults. Developing reliable and efficacious treatment programs that target the needs of men, older adults, and other diverse populations is paramount. These treatment programs need to be gender-sensitive and consider the unique aspects of getting men to report and discuss trauma in a correctional setting (Wolff et al., 2014). Treatment programs that focus on women with trauma have been more widely studied and one such program found to be efficacious in correctional settings is *Seeking Safety*.

Seeking Safety

Seeking Safety is one of the few evidenced-based treatment modalities for incarcerated women that address trauma history in a correctional environment. Specifically, Seeking Safety is a manual-based treatment that uses a cognitive behavioral treatment strategy to address PTSD and substance abuse issues (Najavits, 2002). The program is described as follows:

> The treatment consists of 25 topics (e.g., asking for help, coping with triggers) that addresses the cognitive, behavioral, interpersonal, and case management needs of persons with SUD [substance use disorder] and PTSD. *Seeking Safety* is a first-stage therapy, emphasizing stabilization, coping skills, and the reduction of self-destructive behavior. Therefore, the primary goals of treatment are abstinence from substances and personal safety (p. 100; Zlotnick, Najavits, Rohsenow, & Johnson, 2003).

The efficacy of Seeking Safety has been examined in specialized treatment units and in the general prison population within correctional settings, finding mostly positive results; however, not all studies had a control group (e.g., Zlotnick et al., 2003) or showed improvements in both the experimental and wait-list control group (Lynch, Heath, Mathews, & Cepeda, 2012). Women who participate in the Seeking Safety program appear to experience a decrease in PTSD-related symptoms, with a significant portion (about 50% in some studies) no longer meeting criteria for PTSD after completion of the program (Gatz et al., 2007; Lynch et al., 2012; Wolff, Frueh, Shi, & Schumann, 2012; Zlotnick et al., 2003), along with decreases in depressive symptoms, improvement in interpersonal functioning, coping skills (Gatz et al., 2007; Lynch et al., 2012), and marked decreases in substance use 6 weeks post-release (Zlotnick et al., 2003). Examination of the reception of the treatment by participants generally appears positive and shows superior retention rates compared to other forms of treatment (Gatz et al., 2007; Wolff et al., 2012). Follow-up examinations of the positive effects of Seeking Safety indicate that the remission of trauma symptoms remains longer term, though there is limited evidence of any impact on recidivism (Zlotnick et al., 2003). Overall, Seeking Safety appears to be a promising treatment model for incarcerated individuals, though it is in need of further research.

Conclusion

High rates of trauma histories appear ubiquitous in incarcerated populations. Many of these individuals have been diagnosed with PTSD prior to incarceration and many others go on to develop it during the course of incarceration. Unfortunately, most current treatment models for incarcerated populations are not designed to specifically address trauma, and some models may even exacerbate associated problems.

Failing to address trauma among incarcerated populations may lead to significant consequences, including worsening mental health, problems adapting to the correctional environment, recidivism, and increased risk of death through suicide. Correctional administration and mental health professionals are charged with delivering appropriate care to imprisoned individuals. Efforts must start with screening for trauma, taking a gender-sensitive approach that considers a myriad of factors, including age-related concerns, gender identity, sexual orientation, and the presence of serious mental illness.

While addressing and treating trauma symptoms in incarcerated individuals may be resource-intensive, the risk of not doing so may result in greater resource utilization later. Also, focusing on individuals at high risk for multiple problems fits the risk-need-responsivity model. That is, resources should primarily be devoted to

those individuals with the highest degree of need. Screening may help identify the at-risk individuals.

Few specific evidence-based treatment approaches exist for addressing trauma in a correctional environment. Those that do – such as *Seeking Safety* – have been developed for women. While adapting existing trauma treatments may be a good place to start, caution should be made in assuming that they will apply to a correctional environment without modification. For women, *Seeking Safety* has been found to be efficacious.

A large portion of the incarcerated population presents with a complex set of issues, including mental health and substance use issues that may be associated with a history of trauma exposure. These factors contribute to criminal offending behavior and repeated incarceration. While many of these individuals may best be treated in the community, incarceration offers an opportunity to implement appropriate treatment interventions. Failing to do so may lead to long-term consequences, including repeated incarcerations. Mental health professionals have an obligation to treat inmates while incarcerated, though clearly face substantial obstacles from a lack of resources to administrative buy-in. Until the trend of mass incarceration changes, the mental health delivery system must find ways to identify and treat trauma among incarcerated individuals in jails and prisons.

Questions/Activities for Further Exploration

1. A history of exposure to trauma is associated with increased risk of violence in male inmates. Consider and discuss how trauma may impact violence risk for some inmates in a correctional setting.
2. Research suggests that women have a lower risk of victimization in correctional settings compared to the community. Men appear to have an increased risk for victimization during incarceration. What are the implications of these findings?
3. Individuals with serious mental illness are at a higher risk for victimization within correctional settings compared to other inmates. Consider and discuss factors that may contribute to this problem.
4. Various treatment modalities exist for treating trauma-related symptoms in the community, but there are few developed specifically for correctional settings. Discuss the potential pitfalls and challenges in adapting these interventions for a correctional environment.

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